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The role of the community psychologist in preventing youth suicide and self-harm

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While a number of international guidelines and practice recommendations in relation to the clinical management of suicide and self-harm currently exist, resources to support community psychologist prevention efforts in both the clinical and community practice setting are limited. The aim of this paper is to provide an up-to-date summary of primary, secondary, and tertiary level prevention initiatives that can be delivered by community psychologists practising in both clinical and community-based settings.

Approximately one in ten adolescents engage in self-harm, a term used in this paper to refer to any form of intentional self-injury irrespective of motive or intent (Hawton et al., 2003; NICE, 2011). Although most acts are not medically serious (self-cutting is the most common form; see Hawton et al., 2002; Madge et al., 2008; Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005), many young people who self-harm do so with some suicidal intent (De Leo & Heller, 2004; Evans, Hawton, Rodham, & Deeks, 2005; Hargus, Hawton, & Rodham, 2009; Hawton, Rodham, Evans, & Weatherall, 2002; Madge et al., 2008; Moran et al., 2012). It has been reported, for example, that approximately one in eight adolescents who self-harm in the community will require hospitalisation (Hawton et al., 2002; Madge et al., 2008). Globally, suicide accounts for 8.5% of all deaths for those aged 15-29 years (WHO, 2014) and is the most common form of death for females aged 15-19 years and the third most common form of death for male adolescents, after road traffic accidents and violence (Patton et al., 2009).

The risks of both self-harm and suicide in adolescence increase substantially when mental health problems are present. Elevated risk is not only associated with depressive disorders, but also a range of other diagnoses including bipolar, eating disorders, post-traumatic stress disorder, and schizophrenia (Belfer, 2008; Costello, Foley, & Angold, 2006; Esposito & Clum, 2002; Palmer,

Pankratz, & Bostwick, 2005). It therefore seems reasonable to expect psychologists to have a key role to play in the prevention of suicide and self-harm in young people. The aim of this paper is to provide an overview of the different types of prevention interventions that community psychologists might consider when working in both clinical and community-based settings.

Prevention is, of course, the foundational platform of the community psychology approach with community psychologists keenly focused on identifying and addressing systemic barriers to positive health and well-being (Gridley & Sampson, 2010). Primary prevention is a term used to refer to those interventions that aim to stop self-harm and suicide by focusing on universal factors that reduce opportunity and strengthen individual, family, community and social structures. Secondary prevention targets those individuals and/or communities which are identified as at risk, whilst tertiary prevention responses occur after self-harm has occurred. This public health framework provides a useful way to conceptualise the different roles that community psychologists can play in this area of practice (see Table 1), extending international guidelines and practice recommendations that have been published in relation to the clinical management of suicide and self-harm (ASCEM & RANZCP, 2000; Jacobs & Brewer, 2006; New Zealand Ministry of Health, 2003; NICE, 2004, 2011; Victorian

Department of Health, 2010) to include community-based health promotion and intervention programs.

Primary Prevention

The major goal of primary prevention initiatives is to reduce the number of new cases of suicidal young people or young people who engage in self-harm. Community psychologists can contribute to this in four ways, as outlined below.

1. *Build and foster resilience among young people.* There is an ever- growing body of research highlighting the importance of strengthening those factors that have been shown to protect against suicidal and self-harm behaviours in young people (e.g., Eisenberg, Ackard, & Resnick, 2007; Fleming, Merry, Robinson, Denny, & Watson; Taliaferro & Muehlenkamp, 2014; Whitaker, Shapiro, & Shields, 2016). Resilience is a strength-based concept that emphasises exposure to adversity and "positive" adaptation (Fergus & Zimmerman, 2005; Luthar & Cicchetti, 2000) which acts as a life-long buffer to potential threats to wellbeing over time and transition, and has been shown to influence suicide risk for persons of all ages (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011).

A number of psychosocial factors have been shown to be associated with resilience to stress and stress-induced mood and anxiety disorders (Luthar & Cicchetti, 2000; Southwick, Vythingam, & Charney, 2005), including positive emotions (such as optimism and humour), cognitive flexibility (positive explanatory style, positive reappraisal, and acceptance), meaning (religion, spirituality, and altruism), social support (role models), and active coping style (Southwick et al., 2005). Accordingly, interventions such as cognitive behavioural therapies that encourage young people to utilise more positive emotions, alter pessimistic explanatory styles of thinking, cognitively reappraise negative events, and find positive meaning in difficult circumstances (Southwick et al., 2005) can play an important role in the prevention of self-harm and suicide. Community psychologists are particularly adept at

identifying and responding to risk and protective factors and are well-placed to assist young people to develop and refine the problem-solving and conflict resolution skills which have been shown to also be protective against suicide (WHO, 2012).

2. *Encourage and facilitate social support and help-seeking behaviours.* Strong connections to family and community support have been found to be protective against suicidal behaviours in people of all ages (Kleiman, Riskind, & Schaefer, 2014; WHO, 2012, 2014). Social support not only buffers the relationship between depressogenic risk factors and depression, which is highly related to suicide (Charyton, Elliott, Lu, & Moore, 2009; Cohen, McGowan, Fooskas, & Rose, 1984; Cohen & Hoberman, 1983; Cohen & Wills, 1985), but also has been shown to alter negative appraisals of the self after the occurrence of negative events (Panzarella, Alloy, & Whitehouse, 2006) and reduce suicidal feelings (Johnson, Gooding, Wood, & Tarrier, 2010). It is unsurprising then that the majority of interventions that have positive effects in reducing adolescent suicidal ideation, suicide attempts, and self-harm have some focus on family interactions or non-familial sources of support (Brent et al., 2013). Parental support and monitoring, in particular, has been shown to protect against suicidal behaviour (Resnick et al., 1997; Toumbourou & Gregg, 2002).

Help-seeking, a term used to describe how individuals utilise networks to gain support in coping with mental health problems, is also regarded as an essential link between the recognition of a problem and receiving the necessary care (Cauce et al., 2002; Srebnik, Cauce, & Baydar, 1996). A review of international community epidemiological studies examining help-seeking in young people (up to the age of 26) who experienced suicidal thoughts or had self-harmed concluded that the majority did not seek help for their difficulties (Michelmore & Hindley, 2012). This may be a consequence of the stigma surrounding seeking help for suicidal behaviours (Fortune, Sinclair, & Hawton, 2008; WHO,

Table 1. *Primary, secondary and tertiary suicide/self-harm prevention strategies that may be utilised by community psychologists*

PRIMARY PREVENTION	SECONDARY PREVENTION	TERTIARY PREVENTION
Build and foster resilience among young people • Utilise cognitive behavioural strategies to teach young people to be more optimistic, use more positive emotions, alter pessimistic explanatory styles of thinking, cognitively reappraise negative events and find positive meaning in adverse circumstances • Teach young people techniques to assist them in managing stress • Teach young people conflict resolution and problem-solving skills	**Increase awareness of young people who may be at-risk of suicide/ self-harm behaviours** • Community psychologists should be aware of the *current* physical, emotional, social and environmental factors that place some young people at greater risk of suicide or self-harm	**Provide support to family, peers, and community members** • Postvention care and support should be provided to bereaved families and friends of people who have died by suicide • Community psychologists must be alert not only to the mental health risks of those in proximity to the young person who died by suicide but also to the mental health risks of young people who may perceive similarities between themselves and the deceased • Community psychologists can assist family members of young people who self-harm by providing psycho-education, teaching communication and parenting skills, and by providing practical support
Encourage and facilitate social support and help-seeking behaviours • Encourage and facilitate the expansion of positive and emotionally meaningful sources of social support including family, friends, co-workers, and organisations • Develop interventions or programs designed to normalise help-seeking care for self-harm, suicidal ideation, or suicidal behaviours • Develop interventions or programs designed to decrease the stigma surrounding mental illness	**Integration of suicide/self-harm screening into practice** • All young people who may be at-risk should be screened for suicidal or self-harm behaviour (see WHO mhGAP recommendations) • Risk screening should be considered a *process* and may occur on multiple occasions over the course of young person's contact with the community psychologist • Risk screening tools should be used within the therapeutic context, in combination with clinical judgement and in communication and negotiation with the young person and their family	
Promotion of healthy lifestyle behaviours • Promote healthy behaviours such as adequate sleep, healthy diet, effective management of stress (including the use of meditation techniques), regular exercise (particularly aerobic exercise), and awareness of the health impact of alcohol and drug use		
Implement mental health literacy practices and policies in health care settings • Ensure that mental health literacy policies and practices are implemented within the health practice or organisation in order to encourage and facilitate health care access for young people who need assistance		

2014), as well as fears that asking for help will result in other people finding out about their behaviour (Fortune et al., 2008). When young people do seek help, however, there is evidence that they prefer to turn to informal (i.e., non-professional) sources of support such as family and friends with whom they are familiar (Boldero & Fallon, 1995; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Community psychologists can play a key role in facilitating community-based social support and informal help-seeking by thoroughly assessing the extent of social networks and the level of emotional support that exists in the young person's life. Where necessary, they can encourage and facilitate the expansion of positive and emotionally meaningful sources of social support (Southwick et al., 2005). Psychologists can also increase access to care by reducing the stigma surrounding self-harm and suicide by normalising help-seeking (Fortune et al., 2008). More broadly, mental health awareness campaigns that encourage help-seeking in young people can have a positive impact on community attitudes and increase public dialogue on these issues (Klimes-Dougan, Klingbeil, & Meller, 2013; WHO, 2014). The most effective campaigns have a narrow focus on one or two mental health issues, utilise multimodal strategies, adapt messages where appropriate, and target specific populations at a local level (Matsubayash, Sawada, & Ueda, 2014; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014). These interventions are examples of how a community psychology framework applied at both an individual level (encouraging social and familial support and connection) and at a broader level (through the raising of community awareness about mental illness) can build social support and encourage help-seeking behaviours among young people.

3. *Promotion of healthy lifestyle behaviours.* Given that prevention is the foundational platform of community psychology, community psychologists can also play a key role in the promotion of healthy lifestyle behaviours which are likely to lead to good mental and physical health (Gridley & Sampson, 2010). This might include the promotion of adequate sleep, healthy diet, effective management of stress, regular exercise, and helping young people to consider the health impact of alcohol and drug use (Jane-Llopis, Barry, Hosman, & Patel, 2005). Aerobic exercise and meditation are, for example, both associated with resilience to stress and stress-related mental illness (Southwick et al., 2005) and young people who engage in frequent physical activity are likely to be more resilient than those who do not (Moljorda, Moksnesb, Espnesc, Hjemdalf, & Eriksena, 2014).

4. *Implement mental health literacy practices and policies in health care settings.* Community psychologists are especially skilled and experienced at empowering consumers to make fully informed health decisions (Gridley & Sampson, 2010). Therefore, it is recommended that community psychologists employed in health practices and organisations accessed by young people, have comprehensible health literacy policies and practices in place, with mental health literacy a distinct part of these strategies (WHO, 2013). Mental health literacy consists of the knowledge and beliefs about mental disorders which aid their recognition, management, or prevention (Jorm et al., 1997). Mental health literacy strategies might include providing intelligible messaging to young people on available services, using clear and accessible language when engaging with young people, and ensuring that information is provided to help young people navigate the health system (WHO, 2014).

Secondary Prevention

Interventions at the secondary prevention level aim to decrease the likelihood of suicide attempts or self-harming behaviour among those considered to be at high-risk. At-risk young people include those with mental health problems (Fleischmann et al., 2005; Marttunen, Aro, & Lönnqvist, 1993), young people who have experienced a recent stressful life-event or trauma (Gould, Greenberg, Velting, &

Shaffer, 2003; Plener, Singer, & Goldbeck, 2011), as well as indigenous young people, same sex attracted young people, and young people incarcerated within (or recently released from) youth justice facilities (Gilchrist, Howarth, & Sullivan, 2007; King et al., 2008; McNamara, 2013; Reynolds, 2011).These particular groups of young people often experience acute and multiple forms of disadvantage which are frequently rooted in underlying social inequalities (World Conference on Youth, 2014). The primary goal for community psychologists in providing secondary prevention is to identify and assist young people before they engage in self-harm or suicidal behaviours.

2.1 *Increase capacity for suicide risk assessment and crisis intervention.* The factors associated with both suicide and self-harm among young people have been well documented (Hawton, Saunders, & O'Connor, 2012; WHO, 2014), and yet are not always assessed. Australian research has shown that younger, less experienced psychologists are more confident in their ability to treat someone who engages in self-harm (Gagnon & Hasking, 2012). A possible reason for this finding is that younger clinicians are more likely to have had recent training in suicide risk assessment and treatment strategies, thereby increasing their confidence when working with these individuals (Gagnon & Hasking, 2012). Psychologists often receive limited formal training in working with suicidal clients (Palmieri et al., 2008; Schmitz et al., 2012) and this is of particular concern in light of evidence that many young people who commit suicide have been in contact with primary health care and mental health care services in the year prior to their death (Luoma, Martin, & Pearson, 2002). Training of various health practitioners in the area of suicide prevention has been shown to improve knowledge, attitudes, confidence, and skills (da Silva Cais, da Silveira, Stefanello, & Botega, 2011; Jacobson, Osteen, Jones, & Berman, 2012; Smith, Silva, Covington, & Joiner, 2014) and thus represents an important secondary prevention initiative.   There is also some evidence,

albeit limited, that training results in positive changes to healthcare practice by enhancing clinician interviewing skills and prompting change in clinic policies and procedures (Gask, Dixon, Morriss, Appleby, & Green, 2006; Oordt, Jobes, Fonseca, & Schmidt, 2009).

2.2 *Integration of suicide and self-harm screening into routine practice.* The early detection of suicidal ideation and self-harm behaviours is of great importance, yet screening tools are often underused (Patel, 2013). The WHO Mental Health Gap Action Programme (mhGAP) recommends undertaking suicide/self-harm screening with any person over the age of 10 years who has experienced self-harm/suicide, depression, alcohol use disorders, drug use disorders, bipolar disorders, psychosis, epilepsy, developmental and behavioural disorders, mild dementia, chronic pain, acute emotional distress, or any other significant emotional or medically unexplained complaint (WHO, 2008). The WHO mhGAP recommends that these people should be asked about thoughts or plans of self-harm in the past month and about acts of self-harm in the past year (WHO, 2008).

Screening tools are a reliable method for gathering key information; however they will not always predict future behaviour (Khan, 2011; Randall, Colman, & Rowe, 2011). One study, a systematic meta-analysis of controlled studies of suicide within a year of discharge from psychiatric hospitals, concluded that about 60% of patients who committed suicide were likely to be classified as 'low risk' (Large, Sharma, Cannon, Ryan, & Nielssen, 2011). However, risk screening may be better at identifying those who will attempt suicide, a far more common behaviour than suicide itself (Mann et al., 2006). Among young people, the risk factors for suicide are the same as risk factors for suicide attempts (Beautrais, 2000).

Screening should occur on multiple occasions over the course of a young person's contact with a service, and particularly when there has been some change in circumstance (De Gioannis & De

Leo, 2012; Donely, 2013; Wasserman, 2011). Community psychologists should ideally develop and utilise methods of screening which are appropriate to the context in which they practise (Fountoulakis et al., 2012) and only use screening tools in conjunction with clinical judgement, and in communication and negotiation with the young person and their family (Ryan & Large, 2013).

Tertiary Prevention

Tertiary prevention targets those young people who have already been affected by suicidal or self-harming behaviours. This may involve responding to not just the consequences of the behaviour for the young person, but also to the needs of their network of family and friends.

3.1 *Provide support to family, peers, and community members.* The families of young people who engage in self-harming behaviour face particular emotional and practical challenges. Parenting a young person who engages in self-harm is deeply distressing and is frequently accompanied by feelings of isolation, fear, guilt, anger, frustration, and a lack of confidence, in response to their child's self-harm (Byrne et al., 2008; Raphael, Clarke, & Kumar, 2006). Given the significance of parental support, it is important that parents are provided with emotional support to manage their distress (Morgan et al., 2013). Community psychologists can also assist by providing psycho-education, teaching communication and parenting skills, and offering practical support in how to handle self-harm incidents (Byrne et al., 2008).

'Postvention' is a term used to describe the care and support provided to the families and friends of people who have committed suicide and is considered an essential component of any suicide prevention strategy given that these individuals are at increased risk of developing mental health problems such as depression and anxiety, or engaging in copycat suicidal behaviour (Bolton et al., 2013; WHO, 2014). It is possible, although rare, that a number of suicides occur following an initial death, with young people appearing to be more vulnerable to imitative suicide than adults, possibly because they

identify more readily with the behaviour and qualities of their peers (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990; Insel & Gould, 2008). Therefore, community psychologists must be alert not only to the mental health risks of those in proximity to the person who committed suicide but also to those of other young people who may identify with the deceased (de Le & Heller, 2008).

Community psychologists are particularly skilled at empowering people affected by a tragedy such as suicide, to be actively involved in building stronger, healthier communities (Gridley & Sampson, 2010). Community psychologists can support the grieving process in those who are bereaved by either providing individuals with support or by facilitating access to other services that are able to provide support. The significant contribution that community psychology can make to postvention response to suicide is best illustrated by the Western Australian Active Response Bereavement Outreach (ARBOR) program, a program established, implemented and evaluated by a team of community psychologists (AnglicareWA, 2016; Gridley & Sampson, 2010). ARBOR utilises a peer-support model to actively engage individuals affected by suicide to work alongside professionals in supporting other families who have also experienced suicide. The knowledge, skills and experiences of those affected by suicide are therefore used to support others experiencing the same trauma, ensuring that the support provided is relevant to the needs of families while at the same time facilitating stronger community connections (AnglicareWA, 2016; Gridley & Sampson, 2010). Other research has also shown that the provision of outreach services to family member survivors at the time of suicide results in increased use of services that assist with the grieving process (Szumilas & Kutcher, 2011). Advice in helping bereaved children and young people, and for handling communication problems in the family is often needed (Andriessen, 2009; Dyregrov, 2002; Murphy, 2000; Wilson & Clark, 2005) as the bereaved often have a

desire for information about the medical aspects of the suicide, the grief process, and about how the death can affect family members and the family as a unit.

Conclusion

The prevention of suicide and self-harm behaviour among young people presents significant challenges for community psychologists. However, they can play a key role in implementing interventions at the primary, secondary, and tertiary prevention levels. At the primary prevention level, they can work to strengthen factors that have been shown to protect young people against self-harm and suicide. The overarching goal here is to increase psychological wellbeing regardless of whether this is undertaken in the context of direct clinical care or through working with young people in the community. Programs or interventions to increase resilience, encourage and facilitate social connectedness and support, promote healthy lifestyle choices, and support psychological skills development should be the focus. Community psychologists should also encourage and facilitate access to health care by offering interventions that normalise and promote help-seeking and in doing so reduce stigma. Organisations should ensure that they have clear mental health literacy policies and practices in place. The main challenge for the community psychologist in the area of secondary prevention is to ensure that they are up-to-date and knowledgeable about the risk-factors for young people and skilled in suicide/self-harm screening. The degree and depth of this screening will depend very much on the scope of practice, but all community psychologists who work with young people can play a role in identifying those at risk and providing (or facilitating) care when necessary. Finally, community psychologists can intervene at the tertiary prevention level by containing the consequences of suicide, suicide attempts, or self-harming behaviour. In the wake of such acts, community psychologists can assist by providing postvention outreach care and support to the families and friends of young people, ensuring that they receive the information and crisis support that may

very likely be required at this time.

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"Because the Bible tells me so": Religious conservatism and gender role attitudes in Christian campus-ministry groups at public universities

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Understanding how student religious beliefs and religious settings on college campuses may contribute to student gender role attitudes is crucial to help community psychologists better work with religious students to challenge sexism and promote the full potential of women. To further such understanding, the present investigation examines students attending Christian campus-ministry groups at public universities in the United States for a multilevel understanding of how individual and group religious conservatism are associated with student gender role attitudes. We used data from 32 campus-ministry groups from public universities representing Catholic, Mainline Protestant, and Evangelical Protestant Christian traditions. One leader (n = 32) and multiple student members (n = 324) within each of the 32 groups participated. Using multilevel modeling, results showed within- and between-group effects such that religious conservatism of students and groups were negatively associated with more egalitarian gender role attitudes. Also, student religious commitment interacted with the religious conservatism of the group to predict egalitarian gender role attitudes such that the effect for student commitment was stronger and more negative in more religiously conservative groups. Overall, these findings show how aspects of a college student's religious context were associated with student gender role attitudes. Implications for community psychologists working with Christian religious students also are discussed.

A rich literature in social psychology (e.g., Eagly, 1987, Eagly & Karau, 2002) and sociology (e.g., Biddle, 1986) proposes that social roles, or the shared expectations and norms for how individuals should behave, are based on individual's social identifications (e.g., gender, race/ethnicity, sexual orientation). Gender is proposed as one type of social identification with associated "gender roles," described by scholars as attitudes about acceptable qualities and behaviors of men and women (e.g., Eagly, 1987; Eagly & Crowley, 1986). A large body of research has examined attitudes about gender roles across life domains such as employment, education, leadership, household division of labour, and childrearing (e.g., Eagly & Crowley, 1986;

Fields, Swan, & Kloos, 2010; Larsen & Long, 1988; McHugh & Frieze, 1997). Often attitudes about gender roles are construed as more "traditional" versus "egalitarian." The traditional attitude assumes specific roles based on gender (e.g., men should be the financial provider and women responsible for childcare) and egalitarian assumes roles should be chosen based on preference rather than gender (Larsen & Long, 1988; McHugh & Frieze, 1997).

Adhering to traditional gender roles limits women's and men's choices and has been linked to gender segregation in academic majors and career fields (Frehill, 2012; Sax & Bryant, 2006), lower pay for women (Judge & Livingston, 2008), unequal distribution of household labor (van Hooff,

2011), and emotional distress in men (Houle, Mishara, & Chagnon, 2008). Feminist community psychologists have asserted the need to better understand predictors and consequences of gender role attitudes in efforts to then expand choices for women and men (e.g., Bond & Mulvey, 2000; Wasco & Bond, 2010). To contribute to this literature, we examine links between religious conservatism and gender role attitudes with a focus on religious settings.

In this study we examine college students who attend a particular type of religious setting, Christian campus-ministry groups. Similar to religious congregations (Chaves, 2004) but focused on college students, these groups constitute a social setting where weekly gatherings are held for students to practice their religious faith and rituals. These groups typically are headed by a formal adult leader and often are linked to a sponsoring congregation or religious denomination (Mankowski & Thomas, 2000; Schmalzbauer, 2013). Determining the exact number of Christian campus-ministry groups in the U.S. and their members is challenging, but Schmalzbauer (2013) estimates such groups are present on almost every campus. Also, he estimates that in 2012 there were over 250,000 students attending just Evangelical protestant groups. When that figure is combined with an estimated 1,350 Catholic campus-ministry groups, and over 2,800 Mainline Protestant campus-ministry groups, each with hundreds of thousands of their own members, it is safe to conclude that such groups are a relevant religious setting on college campuses. Understanding the impact of such groups on students is of great interest to community psychologists, religious leaders, and educators because college is a developmental period where young people make major life decisions such as career choice. Greater understanding can help these professionals work with religious individuals to help navigate the delicate balance of synthesising religious and gender role attitudes in a way that challenges sexism and promotes the full potential of women.

A central focus of this study is how aspects of a religious context, in this case of

a campus-ministry group, may be linked to student gender role attitudes (Henry, Cartland, Ruchcross, & Monahan, 2004; Ridgeway & Correll, 2004; Tseng & Seidman, 2007). We thus examine how religious conservatism, both of individuals and of the group, may predict a student's gender role attitudes. In addition to direct effects, we explore the cross-level interactive effects for student (a) religious commitment and (b) religious conservatism with the religious conservatism of the group to understand how individual characteristics may be stronger or weaker predictors of gender role attitudes depending on the conservatism of the campus-ministry group. This focus on a religious social setting extends prior research demonstrating how religious peers may shape traditional gender role attitudes (Bryant, 2003; Denton, 2004; Peek, Lowe, & Williams, 2012) by examining peers and leaders within a particular setting. To develop the rationale for the study hypotheses, we now discuss gender role attitudes, religious conservatism, and campus-ministry groups as social settings.

Gender Role Attitudes

There are various ways to conceptualise gender role attitudes (Eagly, 1987; Fields, Swan, & Kloos, 2010; McHugh & Frieze, 1997; Osmond & Martin, 1975). One common approach, which we follow in this study, is to define gender role attitudes along a continuum stretching from "traditional" to "egalitarian" (Bryant, 2003; Larsen & Long, 1988). "Traditional" gender role attitudes reflect the belief that men and women are intrinsically different and as a result are suited for gender-specific roles (Eagly & Crowley, 1986). These attitudes are predicated on the assumption that men are competent, assertive, independent, and ambitious (yet cold) and thus more suited to be the financial provider, leader, and protector (Livingston & Judge, 2008). Women are viewed as warm, sociable, interdependent, and relational (yet incompetent and weak) and thus assumed more suited for domestic and childcare roles (Colaner & Giles, 2007; Jost & Kay, 2005).

In contrast, the "egalitarian" perspective asserts that gender roles are not innately determined, and that men and women are equally suited for household labour, childrearing, and work outside the home (Livingston & Judge, 2008). Thus, traditional gender role attitudes assume that men and women should assume roles and behave in ways that align with assumed gender differences (Eagly & Crowley, 1986), whereas the egalitarian perspective asserts all social roles and behaviours should be open to both genders.

Feminist scholars assert that traditional gender role attitudes are a manifestation of sexism, defined as "the systematic inequitable treatment of girls and women by men and by the society as a whole" (Bearman, Korobov, & Thorne 2009, p. 11; Bond & Mulvey, 2000). Glick and Fiske (1996, 2001) further posit that sexism also stems from paternalism and gender differentiation. Gender differentiation emphasises biological differences between the two sexes that justify confining women to domestic roles (Glick & Fiske, 2001). Paternalism is the assertion that women require the help and protection of men in order to survive, which legitimises male privilege and oppressive actions by disguising them as caring for the "weaker sex" (Sidanius, Pratto, & Bobo, 1994). However, research shows that being the recipient of paternalistic protection creates a sense of inferiority (Nadler & Halabi, 2006), increases a woman's acceptance of behavioural restrictions created by men (Moya, Glick, Expósito, De Lemus, & Hart, 2007), and has a negative impact on women's workplace performance (Vescio, Gervais, Snyder, & Hoover, 2005). Clearly, traditional gender role attitudes both rely on and perpetuate sexism, gender differentiation, and paternalism. Understanding how campus-ministry groups may further such gender role attitudes resonates with community psychology's interest in promoting greater egalitarianism. Research is thus needed to understand how religious beliefs, and campus-ministry groups, may perpetuate more traditional or egalitarian gender role attitudes.

Stemming from values of equality and justice, community psychologists may be interesting in promoting more egalitarian gender role attitudes given the vast literature documenting the impact of gender role attitudes on men and women (Bond & Mulvey, 2000; Fields et al., 2010; McHugh & Frieze, 1997; Osmond & Martin, 1975). For women, adherence to traditional gender role attitudes often results in women providing the bulk of care giving for children and elderly parents (Szinovacz & Davey, 2008). Research further indicates that when women embrace traditional gender role attitudes they get married younger (Colaner & Giles, 2007), spend more time on domestic labour (Greenstein, 1995), and lower their career aspirations in comparison to women who adhere to more egalitarian gender role attitudes (Colaner & Warner, 2005). Traditional gender role attitudes are a strong predictor of economic inequality because they tend to limit the career options of women (Colander & Giles, 2007; Frehill, 2012; Sax & Bryant, 2006). In fact, for women, endorsing traditional gender role attitudes correlate with lower salaries (Judge & Livingston, 2008) and predicts traditionally feminine college majors and subsequently lower-paying jobs (Karpiak, Buchanan, Hosey, & Smith, 2007). Although women are disadvantaged, men also suffer negative repercussions in health and emotional well-being, including increased rates of depression and risks of suicidal behaviour (Good & Mintz, 1990; Good at al., 1995; Houle et al., 2008; Kimmel, 2004). Although men may benefit financially from traditional gender role attitudes, they may pay an emotional price.

Gender role attitudes are not static and change across the lifespan. For example, children and adolescents' gender role attitudes tend to match that of their parents (Lottes & Kuriloff, 1992). College also is a critical time in the development of gender role attitudes such that students tend to become more egalitarian; however, this shift is less pronounced among religious students (Lottes & Kuriloff, 1992). Although many

social forces shape gender role attitudes (Cobb & Boettcher, 2007; Swim, Aikin, Hall, & Hunter, 1995), research shows religious conservatism (Colaner & Giles, 2007) and interacting with religious peers (Bryant, 2003) predict more traditional gender role attitudes. The current study extends this research by examining students within a particular religious setting, a campus-ministry group, to understand the interplay among students and settings in predicting gender role attitudes.

Religious Conservatism

In general, the location of Christian individuals and groups on a continuum from religiously conservative to more liberal is typically determined by self-identification, denominational affiliation, and specific beliefs such as biblical literalism (Kellstedt & Smidt, 1993; Steensland et al., 2000; Woodberry & Smith, 1998; Wuthnow, 1996). Steensland and colleagues (2000) note three broad religious traditions within Christianity of Mainline Protestant, Evangelical Protestant, and Catholic, with Evangelical and Catholic traditions tending toward greater conservatism (with Evangelical traditions being the most conservative) and Mainline Protestant toward greater liberalism, though there is variation within each tradition (Steensland et al., 2000). Additionally, scholars note liberal-conservative diversity within Catholicism (Starks, 2013). In fact, research confirms significant differences among these religious traditions on a number of political issues including opposition to abortion, gay marriage, contraception, and support for the Equal Rights Amendment (Gonsoulin & LeBoeuf, 2010), with Evangelical Protestants holding the most conservative attitudes. For example, at the individual level, religious conservatism predicts opposition to gay marriage, abortion, and lack of willingness to recognise or remedy societal inequalities that impact racial minorities (Edgell & Tranby, 2007; Todd & Ong, 2012; Wilcox, DeBell, & Sigelman, 1999).

Traditional gender role attitudes are woven into the fabric of religious conservatism. For example, religious conservatives, especially Evangelical Protestants, rely on religious scripture such as, "Wives, submit yourselves to your own husbands as you do to the Lord" (Ephesians 5:22; NIV) to justify why women should submit to their husbands and interpret verses such as, "the head of every woman is man…" (First Corinthians 11:3; NIV) to explain why there should exist a hierarchical order in the family with a woman's position being below that of a man (Colaner & Warner, 2005). Evangelical Protestants also place emphasis on traditional gender roles as evidenced through the many books, articles, workshops, and sermons that teach the man is the head of the family and deserving respect and obedience (Colaner & Giles, 2007; Gallagher & Smith, 1999). This emphasis on complementary roles may seem innocuous, but as noted by Glick and Fiske (2001), gender differentiation is one of the key drivers of sexism (i.e., the inequitable treatment of women; Bearman, Korobov, & Thorne 2009). In contrast, Mainline Protestants have historically been more supportive of feminist movements and inclusion of women in leadership positions (Braude, 2012). They interpret the Bible differently, emphasising such scriptures as, "There is neither male nor female, for you are all one in Christ Jesus" (Galatians 3:28, NIV) with the interpretation focusing on both genders being equal partners in church, home, and career (Colaner & Giles, 2007). Because there appears to be differences in gender role attitudes among religious liberals and conservatives, we hypothesise that student religious conservatism will predict less egalitarian (more traditional) gender role attitudes.

Campus-Ministry Groups as Social Settings

Campus-ministry groups provide a social setting where students gather to practice their religious beliefs and rituals (Mankowski & Thomas, 2000). Scholars assert that within social settings, social processes (i.e., the consistent interactions among people within a setting) are key in shaping attitudes and behaviour (Seidman, 2012; Tseng & Seidman, 2007). In campus-ministry groups, social processes may be

interactions with peers or leaders (Mankowski & Thomas, 2000). These social processes may help to establish or reinforce group norms (i.e., the expected behaviours and beliefs within a setting) through approval or disapproval from others in the group (Bearman et al., 2009; Henry et al., 2004; Tseng & Seidman, 2007). Other research on peer groups shows that peer attitudes predict an individual's racist and homophobic attitudes, over-and-above one's personal attitudes (Poteat & Spanierman, 2010; Sechrist & Stangor, 2001). This demonstrates the power of peers in shaping individual attitudes. Also, interacting with religious peers lessens the shift toward endorsing egalitarian gender role attitudes that tends to occur for men and women in college (Bryant, 2003; Lottes & Kuriloff, 1992). Thus, we hypothesise that group religious conservatism, as defined by the mean student religious conservatism within each group, will be negatively associated with egalitarian gender role attitudes, even after controlling for student religious conservatism. This type of between-group effect would indicate that campus-ministry groups with higher average levels of conservatism also have lower average levels of egalitarian gender role attitudes; showing how an effect may operate at the group level.

In addition to direct effects, social settings theory also proposes that social processes may interact when predicting outcomes (Tseng & Seidman, 2007). Conceptually, this question of moderation asks "when" or "for whom" a predictor is more strongly related to an outcome (Frazier, Tix, & Baron, 2004); however, for social settings the question is "in what type of social setting" is an effect stronger, weaker, or in a different direction. For example, in social settings research, scholars have examined interactions between characteristics of teachers and peers in predicting student outcomes (Chang, 2003) and peer groups and family characteristics in predicting student outcomes (Criss, Pettit, Bates, Dodge, & Lapp, 2002). Across this research, characteristics of the social setting moderated other associations. Moreover, a

context with greater religious conservatism may exert a stronger press for individuals to conform to group norms (Iannaccone, 1994). Thus, we explore two cross-level interactions to examine how the religious conservatism of the group may moderate individual-level associations among (a) religious commitment and (b) religious conservatism with gender role attitudes. Although exploratory, we expect stronger associations in more conservative campus-ministry groups.

Present Study

Understanding how student religious attitudes and religious settings on college campuses may contribute to gender role attitudes will help community psychologists and educators better work with religious students to promote the full potential of women. In this study, we use multilevel modeling to examine the individual, group, and cross-level interactive effects of religious conservatism in predicting gender role attitudes for students attending a Christian campus-ministry group at a public university. We recruited from public (rather than religious) universities to minimise possible confounding effects due to religious differences between universities and because some religious universities may sponsor campus-ministry groups. We extend previous research by examining a specific social setting (i.e., campus-ministry groups) at multiple levels of analysis to understand how individual and group religious conservatism may directly or interactively predict gender role attitudes. We control for demographic variables such as religious commitment, religious tradition (Mainline, Evangelical, or Catholic), and gender since previous research shows each to be associated with gender role attitudes (Gonsoulin & LeBoeuf, 2010; Judge & Livingston, 2008). We also examine the gender of the leader who completed the survey as an indication of a possible role model in the group. Gender role attitudes vary by region, with the Southern U.S. tending to be more traditional than areas like the Northeast (Carter & Borch, 2005), thus we also control for geographic region. Findings hold promise to further an understanding of how religion may shape

gender role attitudes with implications for community psychologists and educators working with religious college students.

Method

Recruitment and Participants

Participants were 324 students recruited through 32 Christian campus-ministry groups at public universities in the U.S. We recruited participants from campus-ministry groups that identified as Evangelical Protestant, Mainline Protestant, or Catholic (following Steensland et al.'s (2000) classification of religious tradition). Specifically, we identified groups associated with the following Mainline Protestant denominations: United Methodist, Evangelical Lutheran, United Church of Christ, Presbyterian Church USA, and Episcopal. We identified groups that self-identified as Evangelical, were associated with Evangelical denominations as defined by Steensland et al. (2000), or have been described as Evangelical by other scholars (Schmalzbauer, 2013). This resulted in the identification of Evangelical groups including Intervarsity, Campus Crusade for Christ, Young Life, National Baptist Collegiate Ministry, and Navigators. We identified Catholic groups including The Newman Center, FOCUS, and Catholic Connection. To increase geographic representation, we recruited groups from the West, Midwest, South, and Northeast U.S. (U.S. Census Bureau, 2010).

Guided by these criteria, we identified Christian campus-ministry groups at public universities in the U.S. through online searches of university club/organisation sites and national religious organisations' directories of campus-ministry groups. Once identified, we attempted to contact a group leader via email or phone and asked the leader to distribute information about the study and a link to an online survey to students who participated in their group. We attempted to contact over 1,200 groups. However, we had no response from many of these groups, which is likely due to outdated contact information or because some campus-ministry groups may no longer have been in existence. Of the groups we attempted to

contact, 11% had at least one student or leader participate. Because multilevel modeling requires multiple students per group, we examined groups that had one leader and at least 5 students participate per group.

This recruitment strategy resulted in 324 student participants from 32 different groups. There were a few additional respondents over 25 years of age; because these students may have different life experiences impacting gender role attitudes, we dropped the students over 25 years of age to focus on a college-aged sample. The mean number of student participants from each group was 10.13 ($SD = 9.20$), ranging from 5 to 48. Also, each group had one leader participate. Demographic information for students and leaders is presented in Table 1.

Measures

Gender role attitudes We used the Traditional Egalitarian Sex Role scale to assess gender role attitudes (i.e., traditional versus egalitarian; Larsen & Long, 1988). This scale uses a Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) with higher scores indicating more egalitarian and lower scores more traditional gender role attitudes. The scale includes items that relate to the education of women (e.g., "it is just as important to educate daughters as it is to educate sons"); women's employment (e.g., "having a job is just as important for a wife as it is for her husband"); type of employment (e.g., "the role of teaching in the elementary schools belongs to women" reverse coded); women in leadership (e.g., "men make better leaders" reverse coded); man's authority (e.g., "as head of the household, the father should have the final authority over the children" reverse coded); and gender-prescribed attitudes towards appearance (e.g., "women should be more concerned with clothing and appearance than men" reverse coded). The internal consistency for the scale in previous research is α = .85 (Larsen & Long, 1988; Livingston & Judge, 2008). Previous research demonstrates evidence of construct validity as traditional gender attitudes correlates with religious orthodoxy

Table 1: *Demographic Information for student and Leaders*

Variable	Students (*n* = 324) Mean (SD) n (%)	Leaders (*n* = 32) i Mean (SD) n (%)
Age	20.32 (1.73)	36.00 (13.33)
Gender		
Women	228 (70%)	16 (50%)
Men	96 (30%)	16 (50%)
Race/Ethnicity		
White	283 (88%)	28 (90%)
African American/Black	5 (2%)	0 (0%)
Asian/Pacific/Islander	13 (4%)	1 (3%)
Hispanic/Latino/a	9 (3%)	0 (0%)
Native American	2 (0.6%)	1 (3%)
Biracial/Multiracial	8 (2%)	1 (3%)
Other	3 (0.9%)	0 (0%)
Did Not Report	1 (0.3%)	1 (3%
Political Affiliation		
Republican	165 (51%)	15 (47%)
Democrat	64 (20%)	12 (38%)
Independent	61 (19%)	5 (16%)
Other/Did Not Report	34 (10%)	0 (0%)
Religious Tradition of Campus-Ministry Group		
Evangelical Protestant	155 (48%)	12 (38%)
Mainline Protestant	62 (19%)	10 (31%)
Catholic	107 (33%)	10 (31%)
Year in School for Students		
First	88 (27%)	
Second	61 (19%)	
Third	82 (26%)	
Fourth	50 (16%)	
Fifth	40 (12%)	

($r = .31$), authoritarianism ($r = .36$), and women score significantly higher in the direction of egalitarian attitudes than men (Larsen & Long, 1988). In the current study the internal consistency of the scale was adequate with $\alpha = .90$.

Religious commitment We used the Religious Commitment Inventory to assess religious commitment (Worthington et al., 2003). This scale uses a Likert-type scale ranging from 1 (*not at all true of me*) to 5 (*totally true of me*) where participants report agreement with items such as, "My religious beliefs lie behind my whole approach to life." Higher scores indicate greater religious commitment. Worthington and colleagues (2003) provide evidence for construct validity through correlations with other religious commitment scales. Estimates of internal consistency range from .87 - .96 and demonstrate test-retest reliability. In the current study the internal consistency of the scale was adequate with $\alpha = .90$.

Religious conservatism To measure student religious conservatism, we followed common practice in the psychology and sociology of religion and used attitudes toward biblical interpretation with a more literal interpretation indicating greater religious conservatism (Green, Guth, Smidt, & Kellstedt, 1996; Kellstedt & Smidt, 1993; Woodberry & Smith, 1998). Unfortunately, validated scales of religious conservatism tend to be outdated or include many different theological beliefs (e.g., Hunsberger, 1989; Stellway, 1973). However, scholars assert that biblical literalism (i.e., the tendency to interpret the bible in a literal manner) continues to be a key indicator of religious conservatism (Green et al., 1996; Woodberry & Smith, 1998). Kellstedt and Smidt (1993) note that biblical literalism often is assessed with only one item, and that measurement would be strengthened by including multiple items about biblical literalism. Thus, for a specific measure of biblical literalism to assess religious conservatism, we used 5 items focused on literal interpretation and the importance of the Bible in guiding one's life. The five items were as follows: "The Bible is literally true in all its parts," "The Bible does

not contain all the important truths about life (reverse coded)," "The Bible is the inspired word of God," "All the miracles in the Bible are probably not true (reverse coded)," and "The Bible guides how I live my life." This scale uses a Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*) with higher scores indicating greater biblical literalism. In the current study, internal consistency was adequate with $\alpha = .75$. Exploratory factor analysis of these items indicated a single factor (analyses available upon request).

Individual and Group

Demographics Demographic questions were included in both leader and student surveys, such as race/ethnicity, gender, and age in years. Based on information from the group regarding religious tradition and geographic location, students were coded as attending a particular type of campus-ministry group (Evangelical Protestant, Mainline Protestant, or Catholic) from a particular geographic region (West, Midwest, Northeast, or South). Effect coded variables were formed for gender (men as base group), religious tradition (Catholic as base group), geographic location (Northeast as reference group), and race/ethnicity (students of colour as the base group; Cohen, Cohen, West, & Aiken, 2003).

Procedures

We administered the online survey via Qualtrics (Qualtrics Labs Inc., Provo, UT). Leaders and students completed separate surveys; we linked responses to the same group with a unique code. All participants read an informed consent document, indicated consent by proceeding, and then completed the measures described above and other measures about abortion, gay marriage, and religious attitudes as part of a larger study conducted in 2012-2013. After completing the survey and distributing the link to students, leaders were given a gift card. Students who completed the survey were entered into a random drawing for a gift card.

Analytic Strategy: Multilevel Modeling

We used multilevel modeling to examine study hypotheses. In general,

multilevel modeling allows for the separation and simultaneous testing of Level 1 (i.e., individual, in this study student) and Level 2 (i.e., group, in this study campus-ministry group) effects for nested data structures. In the current study, students were nested within Christian campus-ministry groups. Furthermore, multilevel modeling accounts for dependence in the data that may be present due to this nested data structure and accurately estimates standard errors (Raudenbush & Bryk, 2002; Snijders & Bosker, 1999). Also, simulation studies show that having at least 5 participants per group helps to minimise bias when using multilevel modeling (McNeish, 2014), thus we used groups with 5 or more students.

In the current study, student self-report comprised Level 1 variables. We group-mean centered the two continuous student variables of religious commitment and religious conservatism. This method of centering removes the influence of groups, allows for comparison and disaggregation of within- and between-group effects, and conceptually represents student's deviation from the mean of their group (e.g., a "frog pond" effect; Enders & Tofighi, 2007; Shinn & Rapkin, 2000). Higher scores indicate that a student is above the mean of their group whereas a lower scores indicates a student is below the mean of their group; thus scores reflect the relative position of a student in their group. We formed one group level variable for group religious conservatism by taking the mean religious conservatism of all students in the same group. This Level 2 variable was then mean-centered. Models were fit to the data by maximum likelihood estimation and used sandwich (robust) standard errors with the between-within method of degrees of freedom (Snijders & Bosker, 1999). Analyses were conducted using SAS PROC MIXED version 9.3 with descriptive statistics presented in Table 2.

To test study hypotheses we examined a series of models (see Table 3). In Model 1 we tested how demographic variables predicted gender role attitudes. Categorical demographic variables were effect coded so that significant parameters indicate a

significant difference relative to the grand-mean across groups. For example, a significant effect for Mainline indicates that Mainline groups had higher average egalitarian gender role attitudes than the mean across all groups. Also, effect coding allows for more general interpretations of other parameter estimates in the model, such as the average association between religious conservatism and gender role attitudes across levels of the categorical variables (Cohen et al., 2013; Frazier et al., 2004). In Model 2 we tested the within-group effects of how student religious commitment and conservatism predicted gender role attitudes while controlling for demographic variables. In Model 3 we tested the between-group effect of religious conservatism, over-and-above student demographic and religious variables. In Model 4 we tested the cross-level interactions among individual (a) religious commitment and (b) religious conservatism with the average group religious conservatism. This model tested if group religious conservatism (Level 2) moderated how religious commitment and conservatism predict gender role attitudes at the individual level. For significant interactions, we followed Preacher, Curran, and Bauer (2006) to calculate simple slopes at one SD above or below the mean. We followed Snijders and Bosker (1999) to calculate the proportion of explained variance (i.e., R^2) at Level 1 and Level 2, relative to the null model.

Results

Descriptive statistics for study variables are presented in Table 2. We used t-tests and one-way Analysis of Variance (ANOVA) and found no gender, race, or regional differences for religious conservatism or commitment ($p > .05$). However, the ANOVAs for religious tradition were significant for both religious commitment ($F(2, 320) = 13.85$, $p < .05$) and conservatism ($F(2, 316) = 57.97$, $p < .05$). We conducted follow-up t-tests using Tukey's method to control for Type I error (Toothaker, 1993) and found that students attending Evangelical Protestant groups had significant higher levels of religious

commitment (*M* = 4.05 *SD* = 0.68) and conservatism (*M* = 5.29, *SD* = 0.80) than students in either Mainline Protestant (*M* = 3.60, *SD* = 0.92; *M* = 4.08, *SD* = 1.12, respectively) or Catholic (*M* = 3.56, *SD* = 0.88; *M* = 4.33, *SD* = 0.83, respectively) groups, with no significant differences between Mainline or Catholic students. To determine the proportion of variance that was accounted for by the group level (i.e., the campus-ministry group), we computed the intra-class correlation using the components of the random intercept null model (i.e., a model with no independent variables). The result indicated that 29% of the variance in student gender role attitudes was accounted for at the level of the campus-ministry group; thus, we used multilevel modeling (Snijders & Bosker, 1999). We also examined individual and group level correlations (see Table 2) and found strong correlations among religious commitment, conservatism, and gender role attitudes at both levels of analysis.

We then examined the four models, as reported in Table 3. The first model with demographics showed that women and students from Mainline groups had significantly higher levels of egalitarian gender role attitudes than the average student. Students in groups with a woman leader reported marginally significant (*p* < .08) higher levels of egalitarian gender role attitudes. Students in Evangelical groups reported significantly lower levels of egalitarian gender role attitudes. Unexpectedly, groups in the Western U.S. also reported lower levels of egalitarian gender role attitudes, though this may have been driven by only having two groups from this region where one of the groups was Evangelical (also, study findings remain the same if these two groups are dropped from analysis). Significant differences were not present for age, South, Midwest, or student race/ethnicity. Overall, this model explained 29% of the variance at Level 1 and 66% of the variance at Level 2, relative to the null model.

Model 2 added student religious commitment and religious conservatism as predictors of gender role attitudes while controlling for demographics. Results showed significant negative associations for both variables, indicating that students who are more committed or more religiously conservative relative than others in their group also tend to have less egalitarian (i.e., more traditional) gender role attitudes, even after controlling for other variables in the model. Model 2 explained 34% of the variance at Level 1 and 67% at Level 2, relative to the null model.

To examine between-group effects (i.e., if groups with higher average religious conservatism have lower average egalitarian gender role attitudes), in Model 3 we added Level 2 group conservatism. Results showed a significant and negative within- and between-group effect such that greater individual religious conservatism and greater average group religious conservatism predicted lower average egalitarian gender role attitudes. This shows that both individual and group effects were significant and in the same direction. This model explained 37% at Level 1 and 75% at Level 2, relative to the null model.

Model 4 added two cross-level interactions; the first between student religious commitment and group conservatism and the second between student religious conservatism and group conservatism. The religious commitment interaction was significant whereas the religious conservatism interaction was not. The model explained 38% of the variance at Level 1 and 75% at Level 2. To understand the nature of the significant interaction, we followed Preacher and colleagues (2006) and examined simple slopes at 1 *SD* above and below the mean of group conservatism. We found the association between individual religious commitment and egalitarian gender role attitudes was not significant at lower levels of group religious conservatism (i.e., more religiously liberal groups, $b = -0.03$, $SE = 0.04$, $t(276) = -0.72$, $p = .48$) but was significant at higher levels of group religious conservatism (i.e., more religiously conservative groups, $b = -0.15$, $SE = 0.05$, $t(276) = -2.70$, $p < .05$). As displayed in

Table 2 *Means, Standard Deviations, and Inter-correlations at the Individual and Group Level*

Variable	1	2	3	*Mean*	*SD*
1. Student Egalitarian Gender Role Attitudes	−	-.30*	*-.43	3.92	0.63
2. Student Religious Commitment	-.44*	−	.59*	3.80	0.83
3. Student Religious Conservatism	-.80*	.70*	−	4.75	1.02
Mean	3.98	3.83	4.60		
SD	0.41	0.42	0.72		

Note. * p < .05. Intercorrelations for the individual level are presented above the diagonal, and intercorrelations for the group level are presented below the diagonal. Means and standard deviations for the individual level are presented in the vertical columns, and means and standard deviations for the group level are presented in the horizontal rows.

Table 3 *Multilevel Modelling of Egalitarian Gender Role Attitudes*

Variables	Model 1	Model 2	Model 3	Model 4
	b (SE) [95% CI]	*b (SE) [95% CI]*	*b (SE) [95% CI]*	*b (SE) [95% CI]*
Intercept	3.84* (0.05) [3.73, 3.96]	3.84* (0.6) [3.72, 3.96]	3.83* (0.07) [3.68, 3.97]	3.82* (0.43) [2.62, 3.17]
West[a]	-0.18* (0.08) [-0.35, -0.01]	-0.18* (0.08) [-0.35, -0.02]	-0.21* (0.09) [-0.39, -0.02]	-0.21* (0.09) [-0.39, -0.02]
South[a]	0.06 (0.06) [-0.06, 0.19]	0.06 (0.06) [-0.06, 0.18]	0.10† (0.06) [-0.01, 0.22]	0.10† (0.06) [-0.01, 0.22]
Midwest[a]	0.10 (0.07) [-0.04, 0.23]	0.09 (0.07) [-0.04, 0.23]	0.13* (0.05) [0.03, 0.23]	0.13* (0.05) [0.03, 0.23]
Mainline[b]	0.31* (0.06) [0.18, 0.44]	0.31* (0.06) [0.18, 0.44]	0.16* (0.08) [0.00, 0.32]	0.16* (0.08) [0.00, 0.32]
Evangelical[b]	-0.31* (0.06) [-0.44, -0.19]	-0.30* (0.06) [-0.42, -0.18]	-0.08 (0.09) [-0.26, 0.09]	-0.08 (0.09) [-0.26, 0.10]
Age	-0.01 (0.02) [-0.05, 0.04]	-0.01 (0.02) [-0.06, 0.04]	-0.01 (0.02) [-0.06, 0.04]	0.00 (0.02) [-0.04, 0.04]
Race/Ethnicity[c]	0.07 (0.05) [-0.03, 0.16]	0.06 (0.05) [-0.04, 0.16]	0.05 (0.05) [-0.06, 0.15]	0.05 (0.05) [-0.06, 0.15]
Student Gender Women[d]	0.15* (0.04) [0.07, 0.22]	0.15* (0.04) [0.08, 0.22]	0.14* (0.03) [0.07, 0.21]	0.14* (0.03) [0.08, 0.21]
Leader Gender Women[d]	0.08† (0.04) [-0.01, 0.17]	0.08† (0.04) [-0.00, 0.17]	0.06† (0.04) [-0.01, 0.14]	0.06† (0.04) [-0.01, 0.14]
Religious Commitment[WG]	−	-0.09* (0.05) [-0.18, -0.00]	-0.09* (0.05) [-0.18, -0.03]	-0.09* (0.04) [-0.17, -0.01]
Religious Conservatism[WG]	−	-0.11* (0.04) [-0.18, -0.03]	-0.10* (0.04) [-0.18, -0.03]	-0.12* (0.04) [-0.19, -0.04]
Group Religious Conservatism (GRC)[BG]	−	−	-0.32* (0.08) [-0.49, -0.16]	-0.32* (0.08) [-0.49, -0.16]
Religious Commitment*GRC	−	−	−	-0.14* (0.06) [-0.26, -0.02]
Religious Conservatism*GRC	−	−	−	0.03 (0.06) [-0.08, 0.15]
R_1^2	.29	.34	.37	.38
R_2^2	.66	.67	.75	.75
Variance Components				
σ^2	0.28 (0.02)	0.26 (0.02)	0.26 (0.02)	0.26 (0.02)
τ_{00}	0.02 (0.01)	0.02 (0.01)	0.004 (0.01)	0.004 (0.01)
Selected fit statistics				
- 2 log likelihood	511.7	485.1	475.0	470.8
Akaike Information Criterion	535.7	513.1	505.0	504.8

*p < .05. †p < .10. [a]Effect-coded base group Northeast. [b]Effect-coded base group Catholic. [c]Effect-coded base group students of color. [d]Effect-coded base group men. [WG]Within-group effect formed by group-mean centering Level-1 variable. [e]Between-group effect formed as a Level-2 variable by averaging student religious conservatism within each group.

Figure 1, this shows the association between student religious commitment and egalitarian gender role attitudes was stronger and more negative when groups were more religiously conservative.

Discussion

This study examined 324 students attending 32 Christian campus-ministry groups in the U.S. to gain insight into how individual and group religious conservatism predicted gender role attitudes. Using multilevel modeling, we found that individual and group religious conservatism negatively predicted egalitarian gender role attitudes. This shows that students' conservatism, relative to other members of their group, predicted more traditional gender role attitudes and that groups with greater average conservatism also tended to exhibit greater average traditional gender role attitudes. We also found that student religious commitment, relative to other group members, also predicted more traditional gender role attitudes and that this effect was stronger in more conservative groups. These are important findings since gender role attitudes predict a host of social, educational, and economic outcomes that may contribute to gender disparities.

The finding that religious conservatism negatively predicted egalitarian gender role attitudes is consistent with prior research findings (Colaner & Giles, 2007; Lottes & Kuriloff, 1992), but extends this research by illuminating how involvement in a campus-ministry group may buffer (if conservative)

Figure 1. *Predicting egalitarian gender role attitudes. Simple slopes were calculated at ± 1 SD around the mean on all variables*
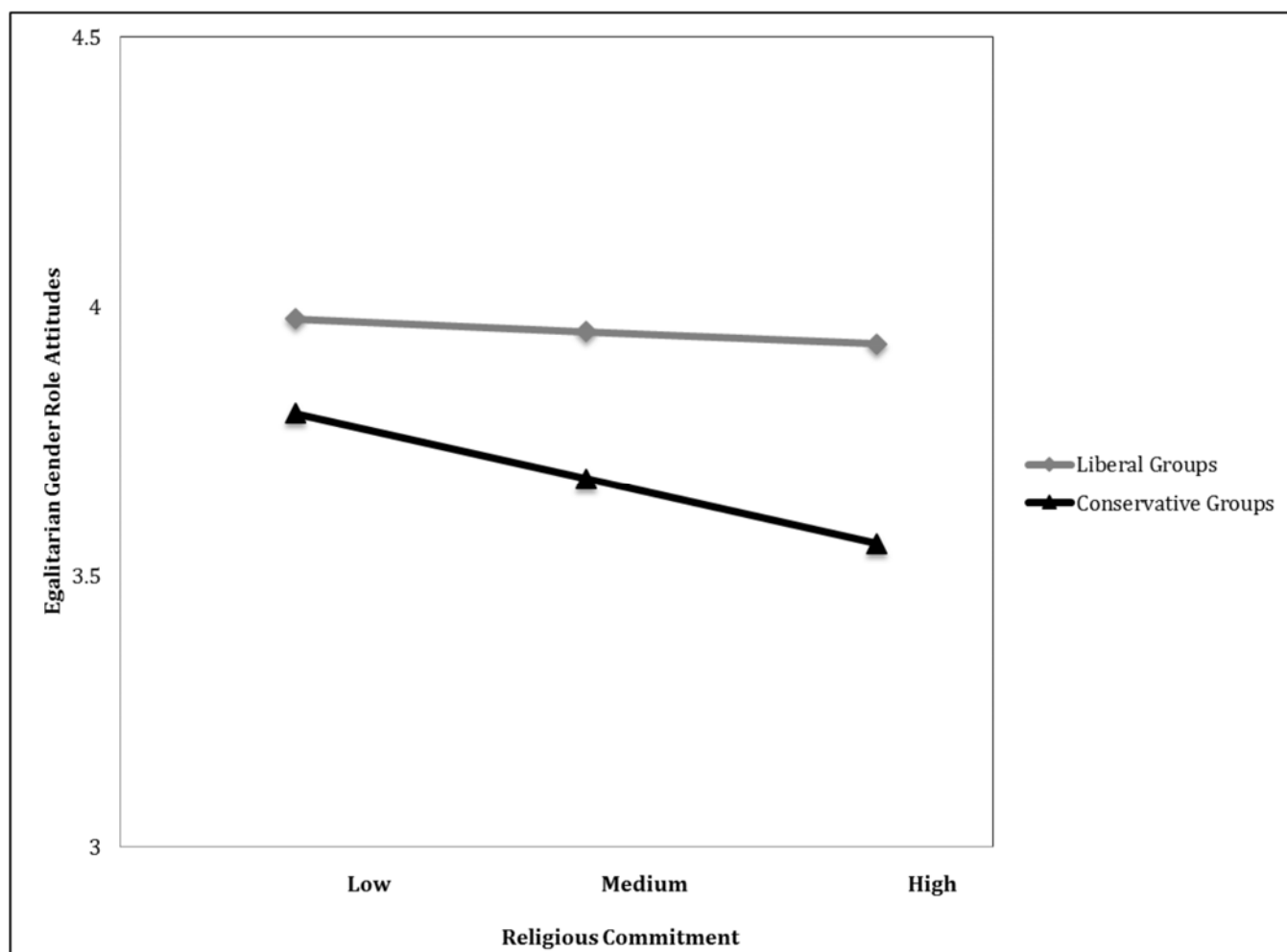
or contribute (if liberal) to the liberalising impact of college on gender role attitudes (Lottes & Kuriloff, 1992). This shows that considering diversity among religious traditions, such as in religious conservatism, may be important to understand not only *how*, but also *for whom* religious participation helps to increase or decrease egalitarian gender role attitudes. Understanding factors that predict gender role attitudes in college is valuable because college is a developmental period where young people make many important decisions, academically, professionally, and personally. For example, if a woman comes from a moderately conservative religious home environment, goes to college and joins a conservative rather than liberal religious group, experiences in this group may shift her path to endorse more traditional gender roles, influencing her choice of career (Frehill, 2012; Gonsoulin & LeBoeuf, 2010), family planning (Colaner & Giles, 2007), and ultimate financial trajectory (Judge & Livingston, 2008). Results also provide insight into how religiously conservative students may maintain traditional gender role attitudes, even when in a "liberal" college environment.

The results of this study also suggest that both relative position within a group and the group's overall religious conservatism may be part of how religious conservatism contributes to gender role attitudes. This expands prior research that shows religious peers to be influential upon gender role attitudes (Bryant, 2003) by locating these religious peers in campus-ministry groups and showing both within- and between-group effects. Though it is likely that students self-selected into a campus-ministry group that reflected their attitudes, these results show that even when controlling for individual religious conservatism, the effect operated at the level of the group. Also, relative position within the group showed significant effects. Future research should examine this process longitudinally in more detail to see how friendship patterns and interactions with leaders shape gender role attitudes over time, especially for students who join a campus-

ministry group that is similar or different from their previous experience.

Religious commitment also emerged as an individual level predictor of more traditional gender role attitudes (i.e., students who were more committed relative to others in their group tended to have more traditional gender role attitudes). However, this effect was moderated by the religious conservatism of the group with the effect being more pronounced in more conservative groups. This may be due to more conservative groups being more insular, having denser social networks, or exerting a stronger press to adhere to group norms than less conservative groups (Iannaccone, 1994; Scheitle & Adamczyk, 2009). In the language of social processes (Tseng & Seidman, 2007), perhaps such conservatism creates a particular set of norms about gender roles and appropriate gender behaviour. Future research is needed to better understand how religious conservatism functions as a group norm in and of itself, and how religious conservatism creates or maintains other types of norms (e.g., more rigidity in how students are expected to hold beliefs, other norms about gender) and how such norms shape relationships within the group. Examining these more specific aspects of campus-ministry groups may yield a deeper understanding of how these groups may shape the development, reinforcement, or alteration of gender role attitudes.

Limitations

The current study is not without limitations. First, the study was conducted with campus-ministry groups from Christian traditions in the U.S., leaving out the voice and perspective of other religious groups and other countries. Although Christianity continues to be the dominant religion in the U.S. (Pew, 2008), other religious traditions may have unique beliefs that translate into gender role attitudes, a rich question for future research. Second, participants were predominantly White, limiting generalisability to religious groups of different racial and ethnic compositions. Third, although we had groups from across the U.S., findings should be generalised with

caution since our sample was not random or representative, and we had a relatively low participation rate. In fact, it is possible that due to the nature of some of the study questions (about gender roles, and gay marriage), the voices of some individuals or groups may have been underrepresented in the findings. Future qualitative interviews or a more focused survey on gender role attitudes may capture these other views. Fourth, the measure of gender role attitudes may be slightly dated and may miss more contemporary gender role attitudes (Larson & Long, 1988); though we did observe variability among individuals and groups. Also, more data is needed as to how endorsement of gender role attitudes translates into actual behavior. Fifth, students were surveyed at one point in time, limiting our ability to study change over time. Future longitudinal research would be helpful to understand students in a larger context, including their parents' religious beliefs, pre-college religious beliefs, and evolution of beliefs across time. Finally, although we found effects using within-group centering, future research is needed to assess how students self-select into campus-ministry groups and how such patterns of selection may change or reinforce student gender role attitudes.

Implications for Working with Christian Students

Findings from this study have practical implications for community psychologists and other professionals working with college students (e.g., diversity educators, counselors, psychologists, educators, administrators, religious leaders) to combat sexism. If students deny the existence of gender disparities or limit their personal or professional options based on traditional gender role attitudes (e.g., a woman student who feels she cannot take on a leadership position over men), it is beneficial to consider what social settings and group processes may be operating to maintain traditional gender role attitudes, such as involvement in a conservative campus-ministry group. Qualitative research has found that students who question the norms

and beliefs taught in campus-ministry groups may pay a social penalty, which can be difficult if the group is their "home away from home" (Mankowski & Thomas, 2000). Thus, care may need to be taken when understanding students as embedded within social settings that may encourage or discourage more egalitarian gender role attitudes and the potential social consequences for attempting to educate or change student attitudes.

When engaging with students who cite religious beliefs as the reason for maintaining traditional gender role attitudes or sexist behaviors, it can be challenging to address the harmful attitudes while being sensitive to religious beliefs (Anton, 2008). The current study considers this dilemma by looking across a range of Christian traditions, rather than viewing Christianity as a homogeneous group. By examining differences among groups from different religious traditions, it appears that Mainline Protestant groups may promote more egalitarian gender role attitudes. Therefore, when working with a Christian student, it may be helpful to connect them to a Mainline Protestant group, especially if they are not finding a good fit in more conservative groups but still desire to explore and practice their religious beliefs. Qualitative research has shown that students often belong to groups that are not the same religious tradition they grew up in, but may choose groups based on their evolving beliefs, convenience, or other group characteristics (Mankowski & Thomas, 2000).

Moreover, participation in certain Christian campus-ministry groups may have the effect of socialising students into more egalitarian gender role attitudes, if a student joins a group that is more egalitarian than their religious home of origin. Some Mainline Protestant dominations, such as the Presbyterians (U.S.A.) and the United Church of Christ, have a history of supporting feminist policies and women in leadership (Braude, 2012). A woman student in such a group may have leadership and mentoring opportunities not otherwise available. Additionally, students are

impacted by their peers, which can be beneficial to students, if the norms being transmitted by those peers are beneficial (Poteat & Spanierman, 2010; Sechrist & Stangor, 2001). Thus, connecting with the leaders of these more liberal and feminist religious groups and promoting involvement for religious students may be one way of honoring religious beliefs while combating sexism and its detrimental impact on students. Perhaps working with and connecting students to religious leaders in more liberal groups also may provide religious models and mentors to help discuss questions surrounding religious beliefs.

Better understanding how religion and other social forces shape gender role attitudes for college students is important because the choices made in college have a lasting impact on students. Campus-ministry groups are a unique setting since they may be the first religious setting students occupy outside of the religious congregation they likely grew up attending. Understanding the social processes (i.e., norms and relationships) that exist in campus-ministry groups in the U.S. may help college professionals unfamiliar with the religious context to understand how individuals, particularly women, are socialised to make decisions that may impede their own success or financial security. Women of all ages show higher levels of religious commitment than men and thus norms in these groups may hold particular importance to women (Collett & Lizardo 2009; Miller & Hoffman 1995; Putnam, 2001). Examining the impact of these religious groups can help community psychologists, in collaboration with feminist religious leaders, work with religious individuals to help navigate the delicate balance of synthesising religious and gender role attitudes in a way that challenges sexism and promotes the full potential of women.

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Historical and social contexts for confronting racism: Contextualising racism experiences across two generations of Vietnamese-Australians

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To document contexts for racism and responding to racism, first and second generation Vietnamese-Australians were asked about their experiences of racism while exploring (1) the historical and political contexts for racism and (2) the social contexts for responding to racism. Both generations agreed that racism seemed less serious in contemporary society than in the 1980s, and more confrontation to racism found than sometimes predicted for people of Asian cultural background. There were also more complexities than a simple division into 'old' and 'new' racism, such as: (1) racism towards the first wave of Vietnamese-Australians was not apparent until the late 1980s, (2) there were many factors reported that led to racism, and (3) what was perceived as racism and the specific contexts in which the events occurred were most important. A contextual analysis of the responses to racism found that responses to similar racisms were different in different situations. Almost all of the responding was strategically negotiated by participants according to the social relationships and actual contexts at the time, suggesting that fixed or standard methods of recommended responding are probably not going to work. People need to be trained in contextual process rather than standard procedural responses to racism.

Many interventions have been proposed to reduce racism. Interventions range from one-on-one counselling to large scale social marketing and promotion campaigns (Guerin, 2005a; Pedersen, Walker, Paradies & Guerin, 2011). In general with these interventions, however, 'racism' has been treated as identical, whether across immigrants, Indigenous Australians, or refugee communities—the recipients change but the processes remain more or less the same regardless of the context.

To be more effective, we must adapt interventions to the specific context or details of the particular groups and circumstances in which racism occurs. All racism is not the same and there is not a single intervention that will address all forms (Guerin, 2003, 2005b). Guerin (2005b), for example, identified many behaviours from the literature, each of which could be called racism, but for which the originating contexts and the interventions might have little in common. Moreover, these behaviours could occur in different contexts and not work the same way. This is especially important in counselling and psychotherapy approaches to prejudice and racism since dealing with individuals requires a strong understanding of the specific contexts (Sandhu & Aspy, 1997).

The aim of this paper is to present some research findings to begin giving a more nuanced picture of racism faced by just one group—Vietnamese-Australians. Rather than homogenising the concept of racism, the research will open up the different historical changes and social contexts for racism against this group using previously suggested behavioural categories for racism (Guerin, 2005b). While this research is of just one community in one setting, it is hoped that by broadening the analysis of typical racism studies to include context, better interventions can be devised—better fitted to the idiosyncratic contexts of any group. All of the contexts that engender behaviour are important for understanding why people do

what they do (Guerin, 2004, 2016; Guerin & Guerin, 2007).

Racism in its Contexts

In terms of the historical contexts of racism, a common position is that racism has moved from 'old', more overt forms, to 'new', more covert forms, perhaps even when unintentionally perpetrated (Sue, Bucceri, Lin, Nadal, & Torino, 2007). Proposals such as these have led to the theorising about 'old racism' and 'new racism', or 'overt' and 'subtle' racisms, where contemporary racism purportedly operates more subtly though stereotypes of cultural traits or surrounding ideas of the 'self' and 'other' (e. g., Dunn, Forrest, Burnley & MacDonald, 2004; Pyke & Dang, 2003). This suggests that the 'types' of racist behaviours against Asian Australian groups such as the Vietnamese might have changed, and the racism experienced during the 1970s would be different to that experienced currently by their Australian-born children. Corey (2000), for example, found that immigrant Asian-Americans in the USA were likely to perceive racism as more significant than their US born counterparts.

While not denying these changes, the divisions of racism into 'old' and 'new' is broad and ignores any context and idiosyncrasies of particular groups at particular times, so racisms need to be further explored than just through this simple, dualistic conceptualization (Nelson, Dunn, Paradies, Pedersen, Sharpe, Hynes & Guerin, 2010). The notion of an old or blatant racism changing into a new or subtle racism is also abstracted from the realities and diversity of what occurs in everyday life on-the-ground. The goal of the present research therefore was to find out more of the complexities of the historical contexts to see the ways in which the whole social environment for racism has changed from the experiences of earlier Vietnamese-Australians to new generations who have been born in Australia, rather than just look for old and new forms.
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The second contextual focus for this research is on the differing social contexts for responding to racism. While the research literature tells us quite a bit about the extent of racism, surprisingly little has been researched about responding to racism and the social contexts for doing this. The second goal of this research was therefore to find out more about how the different generations of Vietnamese-Australians *responded* to the forms of racism they experienced and the contexts in which these occurred. Given the pervasive nature of racism, it is disconcerting that such little research has been conducted on how recipients of racism might respond and whether their strategies are helpful or lead to a worse situation in particular contexts (Nelson, Dunn, Paradies, Pedersen, Sharpe, Hynes & Guerin, 2010).

The underlying assumption seems to have been that 'best practice' or 'standard' ways of responding to racism might be found which will be best across any or many contexts (Guerin, 2005b, Figure 1). For example, one typical blanket strategy often proposed is for the victim to always *confront* the perpetrator when experiencing racism

(Rokeach & Cochrane, 1972). Confrontation does not always need to be aggressive, so it can potentially lead to empathy, challenging false beliefs or stereotypes, and providing accurate information about a particular culture (Pedersen, Walker & Wise, 2005; Pederson, Walker, Paradies & Guerin, 2011). However, confrontation can also potentially escalate a situation and make the conflict worse. Further, some Asian cultural contexts are purported to prefer indirect-problem solving over self-assertion (Noh, Beiser, Kaper, Hou, & Rummens, 1999), so any outward display of emotion or confrontation might not be a normal part of cultural norms. This suggestion would predict that groups which adhere to Asian traditions would engage in passive acceptance of the racism, and perhaps more so due to their vulnerability.

Whatever the case, Czopp, Monteith and Mark (2006) suggested that research is needed to examine what types of confrontations are most effective, when delivered by whom and to what sorts of individuals. The present study will therefore also analyse the contexts in which responding to racism was successful and unsuccessful, rather than assume *a priori* any cultural norms. This was done both by asking about incidents and also by given scenarios and asking how the participants might respond.

The aims of this research, therefore, were to talk in depth to a small number of older and younger Vietnamese-Australians, and find out: (1) their reported details of any historical changes in racism, (2) the different social and political contexts in which they might have responded to any racisms, and (3) how we might put these more into specific real contexts for future research and interventions.

Method

The study focused on the experiences of Vietnamese-Australians because, among all the Asian immigrants to Australia, the Vietnamese have had the most impact on the political, economic and social landscape of Australia. They also are easily targeted for racism because of high concentrations in the large cities, high unemployment rates, and low levels of English proficiency (Thomas, 1997). As Mellor (2004, p. 653) stated, "unless the mainstream English language was mastered… a barrier to full participation in the broader society existed, and individuals were left open to uncontested racism". Research on racism against Asian immigrants has been scarce, in part due to the language barrier and their unwillingness to report racism.

Participants

Twenty four participants from the South Australian Vietnamese community participated in this qualitative research project. Of the twenty-four participants, twelve were classified as Generation 1 participants (G1) because they migrated to Australia immediately following the Vietnam War, and twelve were classified as Generation 2 (G2) participants because they were born in Australia to Vietnamese parents. Generation 1 comprised of seven female and five male participants with an average age of 47.5 years. Generation 2 comprised of six female and six male participants with an average age of 21.5 years. None were related.

Following ethics approval, participants were recruited through direct solicitation and personal requests, and snowballing from earlier participants. While the first author is part of the Vietnamese community, none of those interviewed were relatives or close family friends. All but a few could speak fluent English although they used Vietnamese most of the time. Those few (all in G1) were interviewed in Vietnamese and the transcripts were translated. This might have biased the sample slightly although, as we will see, fluency in English certainly did not preclude their being targets for racism. A larger study might look for differences here.

Procedure

Before starting, all participants were informed that the interviews would be recorded using a voice recorder, and all participants gave permission. The interview consisted of two sections. The first section was a series of open ended, semi-structured questions designed to address the following

issues: (1) What experiences the interviewee had that they considered race-related, and to elaborate on the situation so that the researcher could document the circumstances of the incidents; (2) How the interviewee responded to a series of race-related incidents, and the rationale behind why they felt it was appropriate to respond that way. Although themes and questions were raised by the researcher, participants were also encouraged to raise themes which they felt were of particular significance.

The second part of the interview consisted of the interviewees being presented with four scenarios in which racism was believed to have occurred and asked how they would respond. The scenarios were created by the authors and loosely based on Mellor, Bynon, Maller, Cleary, Hamilton and Watson (2001). They were verbalised depictions of everyday events, in which an ambiguous racist component of varying severity was included. The scenarios are given below.

Scenarios used to Prompt Responses to Racism

1. You are in a clothes store alone and as you decide to leave there are approximately 5 other Caucasian Australians leaving at the same time as you, however the store clerks stops you and asks to check your bag. You know that she has done this because of your race. How do you feel and react?

2. You are standing in line at a grocery store. A Caucasian man pushes in front of you and says 'This is my country - I can do whatever I like. If you don't like it, go back to your own country.' How do you feel and react?

3. You are at the hospital making an appointment to see the doctor. Despite being quite capable of understanding the conversation the receptionist insists that she book an interpreter. How do you feel and react?

4. You and a family member are conversing in Vietnamese because your family member is unable to speak English. While you are talking a stranger approaches you and says

'This is Australia, you have to speak English'. How do you feel and react?

Results

The focus of the study was to explore the experiences of racism and responses to racism by two generations of Vietnamese-Australian participants. It was very clear from the interviews that racism was a common experience in the everyday lives of all the Vietnamese participants, even for those who spoke good English. Participants spoke of a number of highly emotionally charged incidences of anti-Asian vandalism, intimidation, and threat. The results, however, will focus first on the historical changes in their experiences of racism, then on what was said about the contexts for responding to the racisms, and finally on the contexts in which racisms might be targeted for intervention and future research.

Changes in Racial Experiences across Two Generations

Racial discrimination against the Vietnamese-community was experienced on a daily basis and it was clear that the experiences had changed considerably over time. Table 1 provides a 'snap shot' of these historical changes of racism, along with supporting examples from the participants.

These results suggest that racism, even though it is still ubiquitous, is perceived by G1 participants as not as severe now as the violence and unrest that marked the era of the 1990s. While this gives some overall support to the notion of old and new racisms, the situation was more complex than this suggests. Participants of G1 emphasised that racism was not *initially* an issue when they first arrived, but only became problematic fifteen years or so after their arrival. During the first early years, participants described a harmonious and tolerant environment where "many Australians were more than willing to help the newcomers" (G1:4).

Unfortunately, this hospitality was short-lived and became overshadowed by incidents of racism and turbulence in the 1990s, which were attributed by participants largely to Pauline Hanson, who was a politician promoting a return to a white Australia policy. She was well-known in the

media and gave many speeches and offhand comments voicing racist and inflammatory thinking. As Mellor (2004) had found, Hanson's 'sinister' influence on society was very significant, and the participants from the present study began to notice increasing intolerance and hostility towards them during this period. While this should not be personally attributed to Pauline Hanson, she was the high-prolife figure in Australia at that time representing this voice:

> Well I found that people are different after that and there was a period of time. When I push her [daughter] in my trolley and for a walk, just passing the school and youth…they spit to her at her, you know my daughter (G1:2)

Through her political campaign, participants believed that Pauline Hanson encouraged the Australian people to develop negative views of the immigrants, especially evident in her 1996 speech to Federal parliament (Saunders & McConnel, 2000). Furthermore, those who already possessed racist beliefs felt that they could now express these values publicly because they had the support and legitimation from this political leader:

> They already have racism inside them so that's why they think that 'wow' we have a leader and now we have a leader in, she can just tell them to get out of Australia (G1:7)

Although Pauline Hanson's influence was seen as a driving force behind the increase in racism, however, it was not the only significant context and there were more complex factors reported by participants. As other underlying factors that increased racism against their community, participants identified (a) problems assimilating into mainstream society, (b) the behaviour of a minority of Vietnamese people, and (c) the misconception of 'job stealing'.

Following settlement, the majority of Vietnamese people found it difficult to integrate well into society due to language and cultural differences, and a lack of acculturation is known to result in higher levels of racism (Goto, Gee & Takeuchi, 2002). Participants speculated that this created cultural barriers manifested as racism. Some Vietnamese people engaged in traditional practices and tried to continue their Vietnamese lifestyle in Australia. This resulted in a number of 'culture clashes' such as the one described by G1:8 when lining up at grocery stores and how this simple act created racial tension:

> The case of lining up and in Vietnam, it's almost nonexistent and you just don't line up. You just go somewhere and you try to push in and try to get served first. That's the way it was in Vietnam whereas here the society is more orderly… and that's when the culture clash and that's the basis where the racism occurs. Because people that live here feel that they pushed over by immigrants and the immigrants don't know that they did anything wrong because that's the way they did it in Vietnam and they don't understand the culture (G1:8)

The second contributing factor for the increased racism was the highly publicised negative behaviours of a small group of Vietnamese youth. Specifically, G1:8 thought that the formation of some gangs by Vietnamese youths provoked fear in Australian society, which was exacerbated by the media. According to G2:7, "we are stereotyped as getting into fights and stereotyped on the news… as causing trouble". Even today, gangs and violence is still associated with the Vietnamese community where there is an assumption that they are "out to cause trouble or up to no good" (G2:10) when that was not the case. Further, as noted by G1:10:

> There were few Vietnamese people… that did bad things like eat dog which was very common

Table 1. *Categories of Racism Experiences for Participants over Different historical Periods with Examples*

Period	Types of Racism	Examples
1970s - 1980s (initial arrival)	Racism was generally not a prominent part of the landscape or	'I was happy that I came here and that people are very kind and I don't find that people are like racist or anything (G1:2).'
	It was hard to notice or understand the racism	'We were on our way to school … and there were a bunch of teenagers driving pass and give us the finger but … we didn't realise what it so we just wave back and say hello and they just laughed (G2:4).'
	Very welcoming and tolerant environment where much aid was given to the new immigrants.	'There a sponsorship family who … helped us. They taught us English and drove us to places to buy the things we needed. They really helped out with even the second hand things they gave us, was still new and they gave it to us to use (G1:9).' 'Welcome us with open arms at the time (G1:4).'
1990 - 1995	The rise of Pauline Hanson influenced racism at the political increased racism at an individual level.	'The Australian who are already racist to be more, they can stand up and be more racists and they would display their racism more openly. They already have the racism inside them so that's why they think that 'wow we have a leader and now we have a leader in, she can just tell them to get out of Australia (G1:7).'
	Racism was becoming more problematic	'There was a lot of racism…words 'Asians out' on bus stops and when our kids went to school then the kids around the same age as them would say to them 'you are an Asian kid, your parents came here to take our jobs and aren't good people so we don't welcome you (G1:9).'
	Racism was expressed in overt forms in public arenas	'Where I was staying they always painted 'Nips', 'Get out of here' 'Go home' or whatever. They use to throw eggs at the fence (G1:5).' 'My son was at [school] and at that time racism was very strong. The school caught news that some people were coming into protests…So the police was notified and…they [protesters] didn't do anything physical but they were using the speakers and having signs that they wanted to make all the Asians leave the country. I remember there were many of them protesting in front of the school but there was many police as well to protect us. So the police organised a back exit to protect all the Asian parents and students. Sorry, I'm still crying every time I think about it (G1:9).' 'Sometimes you walk along the street and I've had banana skin thrown at you from bus stops (G1:7).'
Post 1995	Racism was less apparent and overt than events of 1990.	'One day in David Jones store there was a sale…there was a lot of clothes on sale and I find a pair of trousers and I just want to take it to the counter and pay for that and I think the lady not believe it on sale she just says 'this is not the price' and I got a feeling that she thought that I re-write the price but I haven't got anything in my hand at the moment (G1:1).'
Current (G1)	Racism is no longer a prominent part of their lives	'I would say it is 90 percent gone (G1:9).'
Current (G2)	Participants felt that they have been well tolerated, assimilated and therefore accepted into Australian society making racism less of an issue	'Some Asians are very 'Aussie' into all sorts of things like footy and stuff… so they have adapted the culture very well (G2:8).'
	Occasional 'comment' or 'look'	'Sometimes they just look at me differently… I get looks here and there (G2:2).'
	Occasional 'joke'	'Every now and then you might hear a 'woahhhhh' Bruce Lee kind of thing (G2:1).'
	Occasional 'stereotype'	'All Asians look the same (G2:1).' 'All Asians are good at maths (G2:5).' 'Asian women are bad drivers (G2:7).' 'All Asians were Chinese (G2:2).'
	Misunderstandings	'Assumption that we're out to cause trouble, up to no good (G2:10).'

in Vietnam because it was such a poor country but over here it is not acceptable and then it got published in the newspapers. Then when the Australian people read it then they think 'oh we loved them and we helped them… and now they go and do these bad things'. From then on, those people who did those bad things gave the Australian people a negative image of the Vietnamese people. There was a reason, it wasn't just like [racist] that in the beginning.

Finally, participants attributed racism to the misconception that they were taking jobs "that might otherwise have been occupied by other Australians" (Mellor, 2004, p. 636). This was an issue acknowledged by all participants. However, they felt that the desperation to avoid unemployment due to financial and family obligations justified this. Many of the participants highlighted the difficulty in financially supporting families both here and in Vietnam which resulted in them taking on two or three jobs simultaneously:

Any job that was offered we would take. Like farming, if other people complained it was too hard or hot then we would just take the job. Or like we would do the jobs that others wouldn't… all we wanted was the job…then whatever they were willing to pay was fine we accept it. Because we didn't have any money and we didn't know anything else so…we would take no matter how hard it was (G1:9)

It is important to acknowledge that some participants felt that this 'hardworking nature' was taken advantage of:

I still recall when I got my first job. They will never hire full-time, you're always on casual or part-time. They pay you minimum. I asked around my workplace and I

was on the lowest pay and you're working twice as hard as them… they know it, but they just still don't pay you the same as the others (G1:5)

According to G2, fear of racism was certainly a factor in why they strive so hard to succeed academically.

My parents basically push for education because they believe that education is one to move into society, become more accepted so that you won't be judged or be victims of racism (G2:10)

This has changed, however, and the image of the Vietnamese migrant working two or three jobs in factories for minimum wage is certainly not the image of the typical Vietnamese-Australian currently.

From the participants' experiences, it appears that the level of racism at both the individual and societal level is no longer an issue for many Vietnamese-participants. Many G1 participants who initially commented on the unrest in previous years now acknowledge that racism is no longer a prominent part of their lives. However it must be emphasised that since the participants' experiences of racism varied in their severity and frequency, the suggestion that racism is no longer problematic may not be true for all Vietnamese-Australians. In general, participants acknowledged a significant decrease in racism to a level now that it has become an insignificant issue, but this is referring to overt forms.

This decline in racism was supported by the response of the G2 participants, who could not comment on the incidents of previous years but offered their opinions on racism in contemporary society. Aside from the 'occasional comments', 'look', 'jokes' or 'stereotypes' all G2 participant felt that they have been well accepted into society where "people don't generally treat us that differently" (G2:9):

You get your normal, when

*you're walking down the street
you might get a guy that drives by
and shouts obscenities at you…
apart from that, I don't really get
that much [racism] to be honest*
(G2:10)

These days, G2 participants believed that stereotyping is more common than serious overt racism. Some common contemporary stereotypes of Vietnamese-Australians are detailed in Table 2. Surprisingly, many of these stereotypes were also found in Sue et al. (2007) study with Asian-Americans. A common theme in both was the assumption that 'All Asians look alike'.

Contrary to participants' thoughts, Edsall and Edsall (1992) and Sue et al. (2007) proposed that racism has only appeared to have declined, because overt forms of racism have been publicly repudiated and highly stigmatised resulting in their manifestation in more subtle and elusive forms. Unlike the participants who believed that these subtle forms were usually 'not detrimental' (G1:10), other participants suggested that contemporary forms of racism are more problematic and damaging than overt racism, often because their seriousness is often downplayed (Sue et al., 2007). Some participants acknowledged that it is sometimes difficult to detect subtle racisms but they did not believe that it was more damaging and problematic than overt forms. More importantly for this report, stereotyping was very common but it was not reported as so negative because they learned to ignore it and some did not even view it as racism. As English improved, they found alternative ways of responding to racism and most of the younger generation reported ignoring or verbally responding to stereotypical remarks.

Results from this study support the changing nature of racisms but suggested three complexities in the historical context rather than old/new racism split sometimes suggested: overt racism was not noted for a number of years after arrival; there were several strong factors reported to be

determining the racisms whether old or new; and while subtle racism was obviously common, many of the younger generation did not think of it as racism and were able to ignore it better than earlier generations. It should be clear from reading the participants' statements that a single form of intervention would not be viable across the very different historical contexts. The environments of racism change over time and group and so must interventions for behaviour change.

Responding to Racism in the Scenarios

The second part of the research asked participants about their responding to the racisms which they had described earlier, and then gave four scenarios from previous research to explore further (see p. 46). It turned out that some scenarios did not apply well, especially for the younger group who spoke English well. These should be further tested.

Table 2 contains the results of the interpersonal strategies from the four prompted scenarios. The examples used in these tables were taken from a variety of respondents. Not all participant answers are presented in the tables; however, those presented exemplify most patterns in the results (Mellor, 2004). The comparison between the two generations of responses aids its generalisability and allows examination of any generational influences on responses. The results indicate a contradiction in the literature in this regard.

Examination of Table 2 suggests unclear generational differences in Scenarios 1 and 3 whereas generational trends emerged in Scenarios 2, and 4. In Scenario 1, there appeared to be individual differences in responding across generations. Both generations had respondents who would have taken a passive approach, "I am not going to make a huge commotion and get everyone to stare at us" (G2:8), others who would have taken an accusatory approach, "why you ask me to stop and not others?" (G2:11), and with the remainder producing no response but believing it was simply store policy. However, it is important to acknowledge that those who had a passive/no response

approach were usually unsure of the racial intent in the scenario—they did not even recognise the racism. Therefore, *the difference in responses was not a result of generation group, but rather of whether the participant perceived the incident as racist.*

In Scenario 2, responses also varied across individuals but G2 participants were less passive in their responses. G1 had a few participants who would have been passive asking "What can we do?" (G1:11). However, G1 participants were only passive if they felt that they lacked the English skills to be able to confront the situation. This was the barrier that would prevent them from producing a passive response, not a fear of breaking cultural norms as suggested by the literature (Noh et al., 1999). The majority of participants were not passive and some were even aggressive in their confrontations. Some G2 participants even stated that they would physically "take back my spot" (G2:7). In both generations it was not the physical act of pushing in front that participants felt warranted a reaction, but the racial slur as this confirmed the racist intent of the perpetrator. Participants in both generations usually reacted by appealing to egalitarian principles such as 'everyone should be treated equally'.

Scenario 3 also produced mixed responses from participants in both generations, with participants giving a calm and rational explanation, ignoring the request, or responding aggressively. G1:12 felt highly offended by this scenario because she felt it violated the very essence of Australian multiculturalism. However most G1 participants felt more inclined to offer explanations. Surprisingly, four of the G1 participants related to Scenario 3, acknowledging that the request to speak English was valid:

> *Well what she said is kind of true, that we do live in Australia and we should try our best to speak the language…even with me, if someone is speaking a language that I don't understand then I feel*

something too (G1:9)

G1 participants were more likely to engage in 'empathy provocation' (Pedersen et al., 2005) in an attempt to stop the racism. Evoking empathy as a strategy of prejudice reduction has been effective as it is known to evoke a complex combination of emotions in perpetrators (Finlay & Stephan, 2000). On the contrary, there were no empathetic responses from G2 participants who were extremely offended by the scenario. Participants felt that it was their given right to be able to speak Vietnamese and that Australia's multiculturalism entails that right: "Why can't we talk in our own language? Why do we have to talk in English? Just because we live in Australia doesn't mean we have to lose all of our culture" (G2:11). Participants' responses were mediated by the manner in which they were approached rather than any generational differences:

> *If they say it in a nice way not just come over and get cross at you and fire at you then you probably say… 'listen this is my mum who can't speak English'. But if they charge over and tell you what to do then who are they?* (G1:7)

Out of all the scenarios, Scenario 4 was the one where a clear difference between the generations' responses was produced. Whereas most G1 participants did not feel it was a racist scenario and were not offended, this was not the case for G2 participants. G1 participants did not see the scenario as racist because they acknowledged that their general lack of English often warranted the use of an interpreter. Two participants (G1:10, G1:11) felt grateful that the receptionist had taken the initiative to book an interpreter, believing that "realistically the majority of Vietnamese people aren't very fluent in English" (G1:10). However those who had mastered the English language were offended by the scenario:

> *If I truly understood what she was saying, probably*

Table 2. *Responses from Two Generations of Vietnamese Australian to prompted scenarios*

First Generation of Vietnamese Australians

	Responses	Examples
Scenario 1	Confrontational response.	'If this happened to me at the time I would certainly asks the store assistant or whoever confronted me to try and search me and assume that I have taken any item in the store. I ask them 'on what evidence or right do you have to check my bag' I wouldn't just let them check my bag. On what grounds and beliefs do they think they have to search me? (G1:4)'
	An empathetic response.	'If the worker doesn't look after the shop then the boss might lose money' (G1:9)
	No response.	'Well this is the policy from every store that when you come in you have to abide the law here if you living here… and that's normal' (G1:6)
Scenario 2	Aggressive response.	'I'd tell him 'this is my country, if you don't like it, piss off' (G1:4).'
	No response.	'I suppose that one of the reasons why we escaped Vietnam was for our safety. And just because someone push in front of us, it's not a life or death matter so it they want to go in front us, that's okay' (G1:8).
Scenario 3	Aggressive response	'Mind your own business (G1:7)'
	Explain the situation	'We escaped Vietnam, a communist country because there is no freedom. So we come here for freedom and we want to speak our language because it is quicker and that is the language we love (G1:12)'
	Empathetic response	'Well what she said is kind of true, that we do live in Australia and we should try our best to speak the language… even with me, if someone is speaking a language that I don't understand then I feel something too (G1:9).
	Other	'I think that what she says is motivational thing that helps us improve' (G1:10).
Scenario 4	Aggressive response	'I would feel pretty pissed off if I truly understood what she was saying probably another way of saying you're not good enough. I'll get an interpreter for you. I'll tell her no, I want to do it now and don't need an interpreter (G1:5)'
	Empathetic response	'realistically the majority of Vietnamese people aren't very fluent in English (G1:10)'
	Other	'well if she wants to send me an interpreter by all means, doesn't worry me, cost the Government' (G1:7)

Second Generation of Vietnamese Australians

	Responses	Examples
Scenario 1	Accusatory response.	'I would be offended… I'd show her my bag and I'd give them a go and ask them exactly why it was they picked me. And why not anyone else and whether I was doing anything in particular that stood out and if they couldn't give me a reasonable answer or answer that I thought was reasonable then I would take it to higher authorities' (G2:1)
	An empathetic response.	'I do understand from their point of view that there are those Asians who do steal… so it's purely from a business perspective then they are just doing their jobs so it's not like a massive insult' (G2:9)
	No response.	'I will show her that I have nothing to hide… and so it would make her feel bad' (G2:11).
Scenario 2	Aggressive response.	'Well I would be pretty pissed off and I would probably… I would take back my spot and be like… we are all equal people there is no need to be racist just cause of your skin colour or what you look like' (G2:7)
Scenario 3	Aggressive response.	'I wasn't talking to you (G2:11)'
	Explain the situation.	'Well I'd explain to her, 'look my friend can't speak English because is new here'. You know whatever the situation maybe, I'll just explain it to them and that I need to translate… and then continue speaking my own language (G2:10''
Scenario 4	Aggressive response.	'Well I don't like being forced to have an interpreter, making myself seem like I am an outsider when I'm obviously not… so don't want them to make me seem like foreign and totally different to them on a whole new level that I can't speak the language' (G2:9)
	Other.	I would say to her, 'does it look like I need a bloody interpreter?' Come on! (G2:7).' 'Me personally, I would throw so many medical terms at her. And I'd just throw drug names at her and I would just explain these mechanisms and pathopsycholgies about my condition…because studying health I know that they are' (G2:9).

another way of saying you're not good enough. I'll get an interpreter for you (G1:5)

Contrary to G1 participants' mixed responses, all G2 participants were offended by the suggestion that they needed an interpreter. None were empathetic towards the receptionist stating that they thought she was 'rude', 'insensitive' and racially stereotyping them as 'foreigners'. Therefore, they would have protested to her directly stating that an interpreter was useless to them. This incident is not uncommon even for second generation Vietnamese-Australians because they are viewed as perpetually foreign. Although they have been in Australia for generations, they are often assumed not to speak English. This reflects a worldview that views them as 'aliens' in their own country (Sue et al., 2007).

In summary, results from the prompted scenarios demonstrate that the Vietnamese-Australian participants were very responsive or at least offended by the scenarios with majority of participants advocating a proactive response. These responses were certainly not atypical:

By not confronting something that is wrong, you are not helping to build a better society but you are making society stand still. So by confronting the issue,

*put your point of view and
when enough people doing
that, you can actually make
this society better… when I
don't believe in something,
I voice my concerns* (G1:4)
*If you don't say anything
back they will just step over
you again and again* (G2:7)

*Contextual Analysis of Anecdotal
Responses*

The responses to the anecdotes and stories given were rich in information about where and when responses might be appropriate or effective. This is clearly a complex situation with many possibilities for contingent relations depending upon the social, historical and cultural contexts.

To bring together the contexts for racism found with this group, Table 3 is a preliminary attempt to present some contextual and environmental factors which should be considered when deciding whether and how, to respond to racism. These were separated according to the environmental/ social context, loosely following the framework of Guerin (2005b) although this is not crucial. The headings are there to group the responses usefully but do not pretend to explain anything about them.

The table was formed based on participants' actual responses to real racial incidents (not the scenarios) in which participants revealed the strategies that were effective or not, and the discussion refers to the table entries. The many examples were loosely put into these categories although this could be done in other ways. What most needs to be noted is that *the specific social contexts and the individuals' historical contexts play a major role in determining the response to racism*. While not a tight experimental control of outcomes, there is clear adaptation of responding to specific contexts for this group. This again suggests that interventions need to be tailored to the contexts and to the social relationships of all the people involved. Most refer to strategies of responding that take the social relationships into account.

Work Environment. First, G2:23 highlighted the importance of remaining professional in a work environment and therefore refrained from confronting a customer that was verbally abusing him. In this environment, he resisted the urge to 'flatten him' and rather opted to alert other staff members who escorted the offender out of the premise. Participants acknowledged that confrontation at work could result in the victim being reprimanded for unprofessional conduct and losing their job. "It might get to the boss and you could lose your job" (G2:7). Notifying security guards or managers would result in the perpetrator being removed from the store without any further negative repercussions for the victim.

Similarly, racism resulting from this environment should not be confronted by the victim in an aggressive manner. Participant G1:6 and G1:1 both described real situations of racial discrimination by co-workers. In both cases participants stressed the importance of ensuring that racism was actually occurring before proceeding to take action. When participants decided to respond it was not through confrontation but approaching a team-leader who could resolve the issue. G1:4 and G1:3 both have leading positions and stated that when approached by concerned workers, they have a duty to eliminate the problem. In such cases permitting the continuing racism was not an option:

*So among the people that I
am in charge, if they show
any indication of racism, I
tend to confront them. I
say… I can't accept this…
here I cannot allow this to
happen* (G1:4)

The reason for such a harsh stance is that racism in the workplace can affect the productivity and morale of the entire team. At work, "we need to solve the problem otherwise we can't work" (G1:4). According to participants, racism in a work environment will likely result in strained relationships and a lack of motivation and productivity thus should not be tolerated.

The Public Arena. The second contextual factor from Table 3, whether or

not a *public* act of racism should be confronted (involving strangers rather than closer relationships), was seen as complex. On the one hand, participants reported that it was best not to confront racial incidents in public places because public acts of racism were usually committed to seek attention or status. Therefore it was best to ignore the situation so the offender "get(s) no satisfaction and backs off" (G2:4). Further, ignoring a public incident could evoke sympathy and support from the general public who acknowledge that racism is wrong:

> Everyone in public knows that you're copping the insult and know what you're going through and they respect that so by you not saying anything and just leave it the way it is, everyone is like 'yeah his copping it' and so they don't look at you differently (G2:9)

On the other hand Czopp et al. (2006) suggested that sometimes 'creating a stir' can induce change in others. By voicing disapproval, people have the opportunity to confront prejudice directly and help reduce future aspersions. In line with this, G1:6, for example, recalled a real incident where confrontation stopped a public display of overt racism. While at the cinema she and her husband were approached by four youths who told them to "go back to your own country". She recalled:

> He just said 'you out of this country'. I say 'excuse me do you know this country not belong to you? Did you know that?' Do you know the history and map of where everyone come from?' and I started to talk about the history. At the time, I know that he is staring to be like, 'Oh my God, this woman knows something'. Because at first they treat us like a dumb

person you know? But when I reacted and talked about it and said... the policy here and such and such. And then he started to, I think at one point he could not confront me anymore and the other guy, started to talk more rude to me. He says, 'you go back to your country, this is not your own country' and I said 'how dare you speak to me that way'. And I talked to him louder voice and then people standing around and starting to watch us but we don't care. But I teach them and let them know that you don't dare to approach the Asian, middle age and try to attack them and whatever. And I think they scare of the aggressive behaviour and they ran away.

Additionally, confrontation may make people aware of their unacceptable behaviour and less likely to engage in future aspersions.

> People can be ignorant and maybe this behaviour can be seem to them that it is acceptable but it's not by any standard and they have to think that we are all humans (G1:7)

Customer Service Environment. Unlike the diversity of responses in public arenas, participants unanimously believed racism in customer service environments should always be confronted. Participants commonly reported receiving no eye contact from staff, being ignored, having money returned to them in a rude fashion, having staff follow them around in a store or being excessively questioned by law enforcement officers. The experience described by G1:6 was typical:

> We arrived at the Casino and we order some coffee... and the waitress, she bring

Table 3. *Contextual responses and their rationales based on responses from participants experiences with racial incidents*

Environment contexts	Ideal responses	Rationale
Work Environment	Avoid confrontation. Rather, make notes of the incident and notify a manager or supervisor or security guard.	Whether racism has been experienced from a co-worker or customer and regardless of severity, it is best to avoid confrontation. Although it is common to report being discriminated at work, a confrontation would lead to adverse consequences both for the worker and the store owner. The worker may be reprimanded and the store could lose business. Therefore it would be advisable to notify either a manager if from a co-worker or security guard if from another customer.
Public places (1)	No clear consensus was found regarding the best way to respond to the incident. In some instances it is best to ignore the situation to not draw attention to the situation.	It may be beneficial to ignore the situation because those who voice racist ideals in public are usually 'seeking attention' 'wanting to cause trouble' or 'wanting to make a scene to get noticed' (G1:9) therefore it may be best to ignore it so the offender 'gets no satisfaction and generally backs off (G2:4)'
Public places (2)	On the other hand, it may be beneficial to use the public arena to voice concerns because it is unlikely the perpetrator will retaliate. Responses then should be dependent on whether the victim feels they can achieve a desirable outcome.	A confrontation in a public place may act as a deterrent because the offender may feel surprised or embarrassed by the response. Also if other people are around then signs of support and unity may act as a discourager for future incidents. If a response is given, confrontational aggressive responses (such as shouting) are generally ineffective. Better responses would be to educate the perpetrator on why racist views are not tolerated in society and if they wish to be racist, they can do so behind closed doors but it is unacceptable in a public arena.
Customer service environments	Always take note of the incident (ie. what makes it racist, how you have been treated differently) and then voice concerns either to the service person or someone with higher authority.	'You are paying for the service and therefore are entitled to feeling welcome (G1:11).' If the situation was not confronted then the business would suffer and remain oblivious to the situation. Usually notification of a manager would result in an apology to the customer and or reprimand of the worker. Unfortunately, although it is common to report being 'ignored', 'treated rudely' or 'served slower' in these environments, the problem lies in the subtle manifestation of racism in these environments, therefore taking notes is essential.
Bullying at school	If bullying from another student, report to either a teacher or principal. It is not advisable to 'fight back' or for parents of the victims to directly confront the parents of the other child.	In a school environment racial bullying should not be tolerated. In such instances reporting the incident to an impartial teacher or principal is advisable because proper precautions can be taken. Confrontation of the parents could quickly result in the situation becoming quickly out of control as parents are often very protective of their children and accusations such as 'racist' will not be well received. Additionally, it has been established that ideals are created at home and often passed from parents to children so such confrontation is likely to result in more problems.

Racism within the school system	Seek help from the school counsellor before taking action against any teacher who is presumed to be racist.	It is easy to see why an accusation of a teacher being racist is serious and can be permanently damaging to the teachers reputation. As such further investigation must be made by a third party such as the school counsellor before accusing the teacher of being racist.
Racism from Groups	When either the perpetrator or the victims are in group environments, it is always best to walk away. Retaliation will almost always lead to aggression.	Any confrontation where there are groups of people involved is generally ineffective. In such cases, the perpetrator is usually trying to 'impress' their friends or gain status by acting racists and therefore looking for a response and confrontation. In such instances the victim's safety will be in danger and therefore walking away is ideal. Particularly, if the victim and the perpetrators are in a group, any confrontation will be 'egged' on.
Jokes (i. e., All Asians look the same)	Laugh it off or say something humorous in return however if the joke is serious then voice concerns.	Jokes are generally not meant to be offensive or harmful therefore an aggressive confrontation may not be warranted. Sometimes it is useful to say something humorous in return 'All Asians look the same? Yeah I know how you feel; all Whites look the same too (G2:4).' However if the joke becomes offensive then voice concerns because majority of the time the perpetrator is unaware of the offensive nature of the joke so once made aware, it generally stops.
Stereotypes (negative or positive) (ie. All Asians are good at maths)	Attempt to change the stereotype by providing correct information (not all Asians are good at maths and those that are only excel through hard work).	Stereotypes are usually not intentional because it is usually just an 'easy way to categorise people, attitudes and behaviours (G2:10)'. Attempting to change the stereotype by providing accurate information or explanations could prevent stereotyping from becoming problematic. Avoid confrontation or actions to support to the stereotypes.
Misunderstandings (ie. Vietnamese are involved in gangs)	Explain the situation or provide accurate information (Only a small minority of people are involved in gangs but that is found across all cultures) to correct the misunderstanding.	When misunderstandings occur, racism is generally not the intention therefore an aggressive response is usually not effective. For example, the misunderstanding that Vietnamese people are involved in gangs, an aggressive confrontation may actually only reinforce the stereotype. A rational explanation may be able to eliminate the misunderstanding before it manifests itself into something more serious. Try to rectify the misunderstanding by challenging false beliefs' or 'imparting knowledge' (Pedersen et al. 2005). It may also be useful to replace false beliefs with stories or anecdotes that do not put abrupt ends to conversations (Guerin, 2005).
Intentional outburst/ racial slur (i. e., ' go back to your own country'	Ignore the slur and event.	Unlike unintentional racism, people who make racial slurs are aware of the offensive nature of their attitudes and behaviours. An intentional slur or outburst is a conscious decision so an attempt to make the perpetrator aware of the racism in the hope they stop is not likely. Furthermore, those who make racial slurs are usually aggressive so a confrontation would almost lead to retaliation. To protect the safety of the victim, it is best to ignore the remark altogether.

*the coffee and throw the
money. Then when she put
down the coffee she splash
the coffee out.*

None of the participants believed that discrimination from store employees or those in customer service positions should be accepted, evident from their responses to actual experiences. When they were discriminated against by customer service workers they either confronted the person directly or brought the issue up with higher authorities and usually got an apology or some other desirable outcome. G1:6 explained how she proceeded to confront the waitress.

*I just standing up and say,
'excuse me what your
name?' and I write down
and the supervisor came to
see me straight away… they
starting to apologise to me
and offer me the coffee and
not pay but I say 'look she
spoil my feeling and I can't
stay at this place anymore'
but at least I talk with the
supervisor…let him know
that this shouldn't be going
on. You need to stop it.*

Similarly, G1:4 recalled a story where a customs officer at an airport was suspicious of his reasons for a business trip. While other passengers were screened with ease, the officer questioned him in regards to all aspects of his trip. He replied "Didn't I put all the information on the form? Read the form and I am here on a business trip". He stated that the officer had no right to pry into his personal information and that they would not have singled him out if he was not Vietnamese. However, as stated by G1:2, the racism in these scenarios is often elusive, making it difficult to detect. Therefore, as suggested by G1:6, it is important to document what in the context makes the behaviour racist, such as how they were being treated relative to others.

School Environment. Table 3 has two forms of racism at school: bullying from other children and perceived discrimination

from a teacher. In both cases, the participants suggested proceeding with caution and report their experiences that an aggressive or accusatory confrontation is unlikely to resolve issues and can exacerbate it. G1:7 described an incident where she was racially bullied at school by a fellow student. She recalls being reluctant to take action and therefore endured the bullying for years. It was not until another classmate informed the principal that the harassment ceased. According to the participant, personal confrontation of the parents or the student would have caused "more conflicts" because of the sensitive nature of the issue. Parents are usually extremely defensive of their children and accusations of racism would usually not be well received. Accordingly, after the resolution of the incident, "she didn't dare display that behaviour anymore… sort of just walked pass and staring at you instead of calling you names". According to G1:12, who was approached by concerned parents about their children being discriminated against by a teacher, she advised the parents to seek help from the school counsellor before making accusations against the teacher. Accusing a teacher of racism, especially when it is not true, can be extremely damaging to their career and requires further investigation. While remaining silent about the issue resolves nothing, any action must be undertaken with extreme caution and evidence needs to be collected to support the claims before the case is pursued further.

Racism from Groups. Numerous participants gave examples of incidences where they were racially harassed by groups and their retaliation resulted in physical attacks. In such cases, participants acknowledged that a passive approach would be best: by "pretending like you didn't hear it and walk[ing] away" (G1:5). Participants acknowledged that there will be aversive consequences when confronting a group. Therefore "when it's a group onto one… then there is nothing much you can do" (G2:1). Further, "when anything is a group then it's a lot more out of hand… let's just say that" (G2:9).

Joking. Participants suggested that responding to racial jokes should be judged by the severity in context. Since studies have shown that not all racism is intentional, jokes, stereotypes and misunderstandings should be treated differently to intentional and malicious racial slurs and outbursts although equally serious (Guerin, 2003). According to participants, jokes were usually not made by strangers but by acquaintances, and an accusatory confrontation is likely to damage the relationship. In dealing with jokes, participants felt it was best to "laugh it off" (G2:1) or "say something humorous in return" (G2:4). However, if the jokes become too serious then letting the other person know this is generally all that is needed. "Once they know you're offended… they generally stop" (G2:1).

Stereotyping. Similarly, participants felt that stereotyping was often just an "easy way to categorise people, attitudes and behaviours that are normally not detrimental to anyone" (G2:10). The participants believed that when dealing with stereotypes it is important to change the mentality. This can be accomplished in a similar manner to misunderstandings. Participants acknowledged that stereotypes and are generally harmless in themselves and only become problematic when manifested as racism.

Interestingly, one participant argued that generalising and stereotyping can also have positive effects. G2:4 stated that in his line of work, he is often preferred over Caucasian workers because of stereotypes:

> *You would get your typical people who really dislike Asians and say that we are inferior to them but generally we would also get those who think that we are superior. In the sense that, in my line of work being in real estate, we would see a lot of clients and they told me that they would prefer someone with an ethnic background …simply because we have better*

work ethics.

Misunderstandings. Similar to joking and stereotyping, participants felt that misunderstandings of different cultural customs were often a form of unintentional racism. When dealing with misunderstandings participants felt that being proactive and trying to educate by providing accurate information would eliminate the misunderstanding. When approached by a co-worker and asked to stop speaking Vietnamese, G1:6 confronted the issue in a non-aggressive manner and chose to explain to the co-worker the reasons why she was speaking Vietnamese. She further said in an attempt to rectify the situation she told her co-worker:

> *Okay I will speak English… but in sometime when I speak Vietnamese please accept that because I have no choice but I do not talking anything behind you. This is not personal between us.*

Racial slurs. Racial slurs are different to unintentional forms of racism and although participants believed that racial slurs were a conscious decision to display racism, they similarly believed that any response would simply be "a waste of time" (G2:9). G2:3 stated that he rarely responded to racist remarks because he did not want to give the perpetrator the satisfaction of a confrontation because it would just "stir them on more". Similarly, G2:8 believed that:

> *If they are to the point where they are calling you names, making remarks then they are not likely to change their opinion so easily… it's always going to be at the back of their heads so… I just walk away*
> (G2:8)

If responding to the incident could not achieve a desirable outcome then participants felt it was best left. Furthermore, since those who make outburst are likely to be aggressive in nature, confrontation would usually warrant further aggression on the part

of the perpetrator.

Summary. As evident from the results of this study, participants certainly did not adopt passive responses to racism, as was expected from some of the literature. Even G1 participants, who were expected to engage in forbearance because of their stronger ethnic identification with Asian culture, did not passively accept the racism. However, confrontation was mediated by the social contexts of the relationships involved (strangers, work colleagues, employers) because confrontation was seen as more effective in some environments than others. Despite this trend of confronting racism, G1:8 stated that he would not respond to racism unless it was life threatening. This is why:

> *We escaped Vietnam to come to Australia…for our safety. And just because someone pushing in front of us, it's not a life or death matter so if they want to go in front of us, that's okay.*

Many participants saw the value in standing up for themselves and their rights, and felt that they could not only effect change on their current environment but also for others in the same situations. G1:7 felt obliged to confront a racial incident that she witnessed occurring in a supermarket because the victim was unable to speak English. She retold the story of an incident she witnessed at Woolworths where an elderly Vietnamese lady was being mocked when she tried to tell the cashier that she had left her groceries behind. Her motivated response to this was:

> *I feel at the time, if they could do this with this one lady then they could do it with many others because there are majority of people who shops around there don't speak English… imagine if she did this to my mum*

In contradiction with the literature (Noh et al. 1999), none of the participants reported that the fear of being seen as weak or breaking cultural norms would have prevented them from confronting a racial incident, and actually reported being happy to do so when appropriate.

Conclusion

Overall, many important results are seen in the participants' interviews, and this study makes two major advances. First, the historical context for racism towards this group is not like that presented in some current theories, and we found no simple division between old and new racisms. There were strong historical changes but they were contextualised through particular events and people. Of most importance for this group, initially racism was seen as low, and Australians were keen to support the Vietnamese, but then racism become stronger partly through public figures but all of this was probably contextualised through (a) problems assimilating into mainstream society, (b) the behaviour of a minority of Vietnamese people, and (c) the misconception of 'job stealing'. Thus the political and social contexts played a major role in changing the individual responding to racism in context for these participants.

These results of historical context will not necessarily apply to other groups but the main point is still that detailed contextual analyses show how even the historical context changes in unexpected ways—there is no static environment of racism. To understand what racisms are current, how these affect the recipients, and how these bring about the recipients' behaviour, we need to do more carefully documented analyses (Guerin, 2005b).

The second main advance from this research is to show the huge diversity in how different generations, and different people, respond to racisms in different contexts. There were older people who were more confrontational in one context towards perpetrators of racism, while in another context (particularly when comments were made about the use of English), the younger generation were much more confrontational. The idea that fixed or standard methods of recommended responding can be developed is probably not going to work.

There were some similarities, however, and in particular almost everyone reported that if approached by a group when alone they would not confront the racism. But that was one of the very few common responses to a context of racism. This result means that both research and intervention are going to need to examine the whole field in much more detail than has been done in the past. Even the categories borrowed from Guerin (2005b), used here to loosely categorise the contexts, produced very different responses between people when other parts of the contexts were changed. Almost all of the responding was strategically negotiated by participants according to the social relationships involved, and this also needs to be seen as a major context for confronting racism. People need to be trained in contextual process rather than fixed or standard procedural responses to racism.

Overall, racism and responding to racism have been treated as too monolithic. They vary in an assortment of contexts and we need to set about describing those changes in context with different groups. The examples found here might not apply to other groups and settings, and so interventions need to encompass the hugely context-dependent nature of complex real life situations. Hopefully once more evidence is accrued some more general patterns might be found, but we must not assume this. For the group here, Vietnamese-Australians, there were large historical changes that were not simple, and responding to racisms was very strategic in relation to the contexts in which they occurred.

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The ethics of eMental health in Australia's Western Murray Darling Basin

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eHealth for people in rural and remote Australia living with a mental illness is increasingly being recommended for treatment and support options. In a study of mental health service users and practitioners, the authors found that many of those encouraged to take up eMental health options were unable to afford the technologies required. Additionally, service users interviewed resided in areas poorly serviced by Internet networks, and often travelled long distances to access face-to-face treatment, rather than endure long waiting lists and the challenges of eHealth technologies. In this artcle, the authors use Wadhwa and Wright (2013), and Fisk and Rudel's (2013) frameworks for the ethical treatment of people with mental illness, in order to explore the challenges and benefits of using eMental Health in Australia's Western Murray Darling Basin.

There has been a mixed response to eHealth treatment for people with mental illness globally. Globally, telepsychiatry has been found to be useful in providing information and follow-up in conjunction with face-to-face treatment (Dijksman, Dinant & Spigt, 2013; Ennis et al., 2011; Jones & Ashurst, 2013). What little has been done in the context of rural and remote Australia similarly tends to focus on telepsychiatry (D'Souza 2000; Griffith & Christensen, 2007; Hawker et al. 1998). Some argue that eHealth is a reasonable approach to treatment for mental illness (Hawker et al., 1998; Rajkumar & Hoolahan, 2004). However, Judd et al. (2002) argued against the use of eHealth for treating people with mental illnesses.

Those who find that online eHealth is an appropriate way of approaching treatment for regional service users with mental health suggest it is worthwhile due to the difficulties implicated in travelling large distances (Burmeister, Islam, Dayhew, & Crichton, 2015; Griffiths & Christensen, 2007; Lessing & Blignault, 2001), follow-up and monitoring service user's once they are no longer in an acute state of illness (Jones & Ashurst, 2013), and where health practitioners are proactive about engaging with eHealth technologies (Wade, Eliott & Hiller, 2014). Still others only advocate for

eHealth in order to keep accurate service user's records and only where such data bases can be monitored and managed by service users themselves (Ennis et al., 2011). Global research about eHealth in the mental health context has explored a range of areas. eHealth has been shown to break initial barriers of social inclusion for people with mental illnesses (Ryan, Clark & Dixon, 2013). However, it has also been argued that the unreliability of Internet connections and telephone networks makes eHealth a hindrance to becoming well (Wood et al., 2012). Thus, the general consensus is that forms of eHealth (including telepsychiatry and online treatment programs) in the treatment of mental health should not be used as an all-encompassing form of treatment in absentia of face-to-face therapy and support.

The measurements of the ethics of eHealth tend to be directed at the affordability, accessibility, service user's management and privacy of eHealth data, and service user's information (Wadhwa & Wright, 2013). While these models of ethical use of eHealth tend to be focussed on physical illnesses such as cardiac and diabetes monitoring, they are still applicable to the mental health context. Having said that, there is a growing body of literature that questions the nature of, and tries to seek solutions to, ethical problems such as privacy

for service users with mental illness (Burmeister, 2000; Burmeister, 2016; Carlson et al., 2015; Teipel et al., 2016). This literature does question the efficacy of current systems due to affordability and the risk to service user's privacy (Crichton & Burmeister, 2014; Burmeister et al., 2015; Spiranovic, 2015).

This paper argues that while there are some elements of eHealth that are useful in the monitoring of people's mental health in the Western Murray Darling Basin (MDB) region of Australia, the ethical considerations (especially affordability, accessibility, and effectiveness) need to be explored in much more detail. eHealth is arguably useful for monitoring and keeping in touch with people with mental illnesses when a service user's condition has been stabilised. However, our research shows that some service user's still do not find eHealth useful even for this purpose and prefer to travel vast distances for their check-ups and monitoring. Thus, the conundrum of eHealth for mental health in the Western MDB is this: while eHealth seems more reasonable and has had some success, there is still resistance to it amongst practitioners and service user's due to accessibility, affordability, and the effectiveness of face-to-face human contact.

Following on from the work of Wadhwa and Wright (2013), this article questions the ethics of adopting eHealth for mental health given that research about the impact on isolation of people with mental illness is inconclusive, the adequacy of privacy measures, whether eHealth genuinely enables and encourages service user's autonomy, and whether the harm that potentially arises from eHealth outweighs the benefits. Further, there is an ethical question of whether service user agency in access, choice and surveillance (as described by Fisk & Rudel, 2013) is being considered. This article focuses on the dominant ethical issues that arose for our research interviews with service users and mental health practitioners, in particular the issues of access and choice (as outlined by Fisk & Rudel, 2013). In our research, these ideas manifested as questions about the cost of technology, availability of

practitioners, and reliability of Internet services. Wadhwa and Wright's (2013) important question about the extent to which technology becomes a substitute for human contact, and the danger of isolation is also significant to the majority of participants in our research.

Some of these ethical questions have another side. The question of isolation and agency is taken up by some participants as a potential benefit as well as a potential harm. As shown below, our participants did speak of the positive aspects of eHealth in the treatment of and recovery from their illnesses. Similarly, the capacity for knowledge gathering and information sharing was significant and gave service users a sense of community.

This paper therefore draws on Fisk and Rudel (2013), and Wadhwa and Wright's (2013) frameworks of ethical conduct using those as a framework of analysis. In doing so the paper argues that before making eHealth the only treatment and follow-up option available to service users in rural and remote regions of Australia, analysis using ethically aligned frameworks such as those of Fisk and Rudel (2013), and Wadhwa and Wright (2013) need to be considered. Ethical and moral considerations including access, surveillance and affordability are considered below from the point of view of mental health service users and practitioners. We acknowledge that the frameworks chosen for analysis (Fisk & Rudel 2013; Wadhwa & Wright, 2013) are not theoretical frameworks in terms of being "an account of the world which goes beyond what we can see and measure" (Scott & Marshall, 2009, p.760). These frameworks are though ways in which interpretations of existing issues and considerations of appropriate service provision can be measured. Fisk and Rudel (2013), and Wadhwa and Wright (2013), are thus, conceptual tools with the capacity for interpretivist researchers to make assertions about the lived experience of, and ethical application of, eHealth service use in the mental health context. The research reported in this article is qualitative research informed by the interpretivist tradition (Neuman, 2000,

p.158). As indicated in Neuman's (2000, p.71) discussion of interpretivism, the point is to acknowledge and explore the subjective meaning of human behaviour and action. In our research, we have positioned interpretivist social science alongside ethical conceptualisation in order to explore the links between the subjective experience of mental health service users and practitioners, and the ethical implementation of appropriate services. In deference to the importance of the subjective experience in our work, it is important to make a short acknowledgement of the use of language. As part of our research design, we interviewed people who were in out-patient treatment programs for mental illness, people who are using available services to manage their illness regularly and people who use services periodically. Not all the services accessed by these participants or employing the practitioners we interviewed are medical services, and therefore the term "patient" does not apply to all. The authors have, in the interests of confidentiality and accuracy, chosen to refer to this group of participants as "service users."

The ethics of eMental Health and the tyranny of distance: Conceptual framework

The logic of suggesting eHealth for mental health management and treatment seems reasonable given the vast distances our research participants' travel. However, as we argue in the cases presented below, it is not the panacea it first appears. The research undertaken asked participants to indicate how far they travel to visit service users (in the case of practitioners) and to access services (in the case of service users). Many practitioners and service users are travelling up to three hours to provide or receive services. Some communicate with practitioners by email over a distance that would take 4 – 6 hours to travel by car. Some practitioners serviced an area the size of the Island of Bali (Indonesia). The ethics of travelling this far is (as noted below) found in the question of affordability. As Wadhwa and Wright (2013) note, the ethics of eHealth need to take account of affordability and accessibility of services in the physical

health context. Given that similar concerns have been raised by various studies (National Mental Health Commission, 2014; Pakrasi et al., 2015), such ethical parameters appear equally valid for mental health. Fisk and Rudel (2013) add another dimension in their assessment of the agency of service users. They suggest agency is a significant mechanism for enabling mental health, recommending the use of strategies that maximise choice and access, but work with service users about the level of surveillance they require.

Further, the remoteness and distance from major cities has meant slower Internet service upgrades so that many participants were still struggling to receive adequate mobile telephone reception let alone stable or affordable Internet services. The Australian Government services Australia according to population in need (measured by percentage of population). Thus, in rural and remote Australia the population is lower and the percentage of people in need of services is lower. Arguably the expense (travel costs as well as remote living subsidies) of sending someone to the regions prevents what we have found to be adequate face-to-face service provision for mental health in the regions. While eMental Health has been shown to be a useful concept for young people and in cities, older people tend to find that face-to-face treatment is preferable. In our sample, younger participants were happy to have been able to receive a text of support at a crucial time of day during an acute phase of their illness, and some older people were managing their illnesses with the help of their city-based therapists by email. However, most people were more willing to travel vast distances to make contact with a psychiatrist or other mental health professionals when they were becoming unwell or in the midst of an acute episode. Therefore we argue that eHealth has its merits in our sample region, but we are not serviced adequately by either telecommunications technology or face-to-face therapists. As will be seen throughout this paper, it is this inconsistency between availability, affordability, distance and

usefulness that constitutes criteria that should form the basis of ethical service provision for people with mental illness in our region. These issues are not being addressed by current service provision and are only noted superficially by Australian government policy.

Methodology

A qualitative investigation of mental health in the western MDB was undertaken. Utilising the interpretive methodology outlined by Neuman (2000), in which the importance of subjective experience is emphasised, this study used criterion sampling and semi structured interviews. There were two stages to the project. In the first stage, semi structured interviews with 27 mental health practitioners were conducted. In stage two, 13 semi structured interviews with mental health service users were conducted. Sampling in stage one began with Charles Sturt University's School of Psychology and contacts in local mental health service providers, and an invitation sent to potential participants through the University's community newsletter. Potential participants then made contact with the researchers, the participant information sheet was provided and a time for interview was made.

In the second stage a postcard sized information card was circulated amongst general practice medical clinics, posted on bulletin boards in Wagga Wagga and surrounding towns, and an advertisement was placed in the "Community Diary" broadcast by local volunteer run radio station 2AAA FM. Participants were asked to contact the key researcher and eligibility for participation was then judged according to age (all participants were over 18 years old), capacity to provide consent (all participants needed to be able to give informed consent without support), and current mental health status (participants needed to have been well for at least 6 months and be in contact with a mental health practitioner). Participants in this stage were also asked to keep a journal of their experience of use of telehealth services and use of other services. This paper uses only data from the semi structured

interviews because few participants completed the journal task to a degree that provided information that was not also collected in the interviews.

Approval was provided by the Charles Sturt University Human Research Ethics Committee. All interviews were analysed using thematic analysis techniques and voice sheets. In line with interpretive work that focuses on the subjective experience of participants, thematic analysis and voice sheets were used according to protocols described by Morse (2008). In this method of analysis, categories are developed using participants own words and language. Each voice sheet represents one category and includes all parts of the interview transcript from all participants related to that category. Initially service users and service practitioners were analysed separately. It became clear that some categories crossed the experience of both service users and practitioners. In terms of the ethical framework used in this paper, most of the categories in the analysis of the data emerged amongst both service users and service practitioners.

Analysing qualitative data using inductive methods can, once categorised, be further interpreted using existing research and evidence. Spicer (2008) writes of the iterative process in which qualitative analysis uses both inductive and deductive reasoning. This process involves moving from deduction by examining the existing knowledge, and induction using a similar process. The result of such a process is that interpretivist work will include discussions of data in which researchers move between participants subjective experience and researchers interpretation using existing knowledge present in published research. The discussion below makes use of this process.

This paper presents data collected during the course of this project, as well as informal follow-up conversations with some participants conducted in 2015.

The Western Murray Darling Basin: The site of investigation

The investigation that formed the base of the data collection and considerations for

this paper was conducted in a 1,000 km² area known as the Western MDB. This region was chosen due to the (recently phased out) scope of the Australian federal government's free health jurisdiction known as Medicare Local. In this region, two million people are resident. Australia's mental health rates tend to be around 30% of the population (with more known to be resident in rural and regional areas) and thus in this area we expect that (conservatively) around 600,000 people will experience mental ill health at some point in their life-time.

The current services available for face-to-face treatment include one resident psychiatrist (located in the city of Wagga Wagga), two psychiatrists who fly in and out from Sydney once each per week, and a number (no one could accurately tell us) of mental health nurses, private psychologists, and counsellors. Most of the mental health treatment work has been taken up by local general practitioners who act as temporary counsellors and supply referrals to psychologists, counsellors, psychiatrists and other appropriate service providers. There are two Emergency Departments (one in Griffith and one in Wagga Wagga – which are approximately 190 km apart) with facilities to conduct teleconference assessments with psychiatrists in Sydney in the case of service users presenting with mental illness.

In the Western MDB and the region known as the Riverina, the major centre of Wagga Wagga is home to approximately 63,000 residents. Wagga Wagga is located approximately 460 km south west of Sydney, 450 km north of Melbourne and 240 km west of Canberra. Many service users in our study were found to drive to these cities to see psychiatrists or consult with their preferred psychologist. They explained this was because it was more financially affordable and the waiting times shorter than accessing local practitioners, or because they had developed relationships with those practitioners before moving to the Western MDB.

Data Analysis and Discussion

In the analysis of the interviews conducted, there were some clear themes. The first was the expense of face-to-face treatment, as well as the availability of practitioners in the Western MDB. This challenge indicates a need for eHealth as a treatment and post treatment monitoring method. However, our participants were challenged by the expense and reliability of Internet connections and the technology required to access eHealth services, and so were more inclined to travel large distances than to access eHealth options (a second dominant theme throughout the research). Additionally, privacy concerns in the online space as well as the importance of face-to-face contact with other people make eHealth options less viable for people with mental illnesses. The challenges of living rurally and remotely position rural and remote residents at risk of social isolation. When those residents have mental illnesses with symptoms that include isolation and disconnection from other people, there is a greater risk to mental illness and chances of recovery from illness. Thus, eHealth can be a help and a hindrance to people with mental illness. In this paper, the term "recovery" appears many times. In academic research it is a contested term. Burmeister and Marks (2014) contend that to recover requires person centred, directed and appropriate servicing to people with mental illnesses. The outcome of this is a person with a mental illness who is a contributing member of their community who has a sense of self-worth and self-esteem. We do not wish to enter the debate about or engage with the recovery model as many have (see Carling, 1995 and Jacobsen & Greenley, 2001 for an extended discussion), instead it is sufficient to define the term "recovery" in the way that the service user participants did – to no longer be in an acute phase of their illness.

Finally, having established that eHealth is both useful and contains potential harms, we argue for a middle ground of sorts. To ethically mediate the effects of mental illness and take account of the challenges for rural and regional mental health service users and

practitioners, we argue that eHealth be used as a check-in, follow-up, and information distribution method rather than direct treatment.

The Challenges of Mental Health Treatment in the Regions

The expense of mental health practitioners. One ethical limitation is affordable access to health treatment. In Australia, we have systems that minimise the cost of treatment, however, many long term and ongoing illnesses require regular treatment that is not always covered by government rebates. Added to this is the challenge of attracting mental health practitioners to rural and remote areas. With a minimal number of practitioners and a growing number of potential service users, the cost of treatment can preclude service users from seeking the required support from professionals. Some have found face-to-face self-help groups useful (local support groups and online chat networks were some of the online services used by our research participants). However, when a service user needed regular monitoring, they were inclined to travel to major cities rather than pay the fees or endure the waiting list times in their local area. As one service user said:

> It's actually cheaper for me to drive over to Canberra and see him, than to see any of the psychiatrists that are practicing here in Wagga. So ridiculous as it is, it's, yeah that sort of works out best financially. But I mean I drive for 2 ½ hours to get there, I have a 10 minute appointment with him, all he does is look at my bloods, order more blood tests "How are you going, everything okay?" "Good" "Yep see you later" that's it. There's no psychotherapy involved. So what [sic] would be something I could really easily do via video conference or Skype, anything like that you know, but I don't think he's up for that sort of technology… (Female service user, early 40s, ill-defined diagnosis)

As this participant noted, she found it cheaper to travel and more convenient than waiting the time required by the local psychiatrist. This is one occasion where a service like Skype would be useful. However, as Wade, Elliot and Hiller (2014) found, such possibilities are only useful if the practitioner is willing to provide and engage with the service. For the service user above, the idea of video conferencing or Skype would have made a big difference, however the psychiatrist was not willing to use a telepsychiatry service. Later in her interview this participant highlighted a further problem she would have with this option, her rural Internet connections (even ordinary phone and mobile services) were unreliable. Thus, there are two issues here. The first issue is the willingness of practitioners to engage with technology, and the second is the reliability of Internet and phone connections in rural, regional and remote Australia. Another participant found email contact with her psychologist (a four-hour drive away) was useful because both parties (service user and practitioner) were willing to engage and make adequate use of the service, and she had face-to-face support from her local general practitioner. Thus, the non-availability of practitioners made travel necessary for many of our service user participants.

Availability of practitioners. Although there are a number of practitioners in the Western MDB, an interview with the CEO of the local General Practitioners Network indicated that there were many more vacancies than could be filled. In the Western MDB, this problem has delayed the recovery of some service users. As one participant told us:

> It's not perfect at the moment because I can't get in to see a psychiatrist… it's a year waiting list. (Female service user, early 20s, severe anxiety)

Concerns by practitioners were that people would need to move to major cities or better-serviced areas in order to access the necessary treatment.

> I've already got issues where I've got a client who needs a psychiatrist and a clinical psychologist, and I can't

access it here. This person will have to; probably move to Sydney to get help. (Provisional Psychologist)
the more likely you are to lower your inhibitions around accessing services where you think that there may be benefit to you so if you are convinced of the benefit to you of accessing help through video conferencing if that for instance is the only thing that's available or you have to travel 300 kilometres to get the face to face then you may be more likely to do that. (Psychologist)

Part of the ethical management of general health services for Wadhwa and Wright (2013) was the availability of appropriate services. With increasing migration to cities during a recent long and difficult drought (Kettlewell, 2010) the problem was further exacerbated. This migration is in part reasonable when work is hard to find. However, some people are connected to the land (especially families who have strong roots and Australia's Indigenous people whose identity is bound to the land of their ancestors: Ganesharajah, 2009) and this is not an option for all rural, regional and remote residents.

To be able to engage successfully with a practitioner in another town or in a major city without the expense of travel would be useful. However, as iterated in more depth below, this should not and does not preclude the need for appropriate face-to-face treatment. Thus, the availability of face-to-face treatment for mental health is as important as the availability of reliable eHealth technology.

Barriers to appropriate intervention. The primary barriers to appropriate mental health intervention using telehealth technologies have been noted already. In this section the ethics of these barriers are more clearly outlined. In effect, the availability and security of telehealth is still tenuous. To provide appropriate services, governments and relevant agencies need to provide secure services that can be reliably accessed in rural and remote areas. Additionally, the isolation already part of rural, regional and remote

residents' experience needs to be addressed more purposefully and strategically in order to avoid any further exacerbation of mental illness. Isolation is a significant problem for people with illnesses such as depression and anxiety. eHealth has the potential to provide another means for both exacerbating isolation and providing an alternative means for engagement (Dow, et al., 2008; Edwards et.al, 2013). Thus, we have another conundrum – to offer technology at the risk of further isolation (as expressed by many practitioners interviewed for this study) and escalation of mental illness, or provide technology in order to mediate that isolation and provide a potential aid for recovery.

Telecommunications availability and security. Economic disadvantage is another ethical consideration. People with mental illness are frequently in the lowest socio-economic levels of society. In the discussions of availability and security of telecommunications technologies, participants highlighted the issue of the cost of technology. For some people with mental illnesses, work capacity is significantly hampered. Australia's social welfare system allows for some payment for living expenses and some subsidised medical treatment. However, at this stage, the cost of technology (computers, Skype, smart phones, and Internet connectivity costs) is not a subsidised expense for people with mental illness. Some devices are rebated for other health conditions (for example insulin pumps and internal defibrillators), but as yet technology is not rebated for mental health conditions. Therefore, as one service manager noted, some service providers are reluctant to prescribe eHealth options and some services are considering the installation of free access computers.

Skype would be a benefit but I do doubt that many clients would have the facility for that. Not a lot of clients have computers. One of our plans is to provide 2 computers out in the front room so that clients can come in and access those when they need to. (Service Manager)
The privacy of service users using a

computer to communicate with practitioners from a public access computer was not considered useful by service providers or service users interviewed. Participants expressed discomfort with public access devices because they were concerned about people accidentally or purposely seeing written communication or overhearing verbal communications. Thus, while the idea of public access telecommunications systems seems like a good idea, participants were more comfortable with the suggestion that these could be used for information gathering in a relatively private place (for example a booth or kiosk) rather than open access in a public space like a library or service provider's "front room". This may not be a problem for city residents, because of the idea presented by one family counsellor/ social worker below:

There still seems to be a real fear around being able to use not only the technology, but the confidentiality of some of that technology. Rural people and that are – are very much, very private; I find them more private than city people, and they're very concerned with the confidentiality and the privacy of some of the new technologies. (Family Counsellor/Social Worker).

However, the questions of privacy and confidentiality were raised by many participants. Burmeister et al., (2015) show that there is a way to mitigate such privacy concerns through centralised data, managed by a trusted agency. Ethically, the concerns of privacy and accessibility do need to be addressed. Fisk and Rudel (2013) argue that where service users do not have control over the information they share with practitioners, they feel overly surveilled. Similarly, Ennis et al. (2011) argue that service users should have control over their own information in order to be able to mediate some of the power relationships involved in medical interactions, as well as giving service users control over their own circumstances. Ethically, privacy is a very important

component of the potential for humans to exercise agency. Access and privacy therefore need to be considered carefully in the context of the implementation of eHealth.
The importance of human contact. Overwhelmingly, face-to-face, real time human contact was described as part of the process of recovery for the people with mental illnesses interviewed in this study.

In the last 15 months I've started to come out and do things and so I'm in a book club so I've got friends, that I didn't have friends before. So you can talk to them and they'll go, oh yeah I did that too and you're like, really oh good, that's normal then. So which is awesome because I've never had that. So I've you know got a handful of people that I can rely on… the person that I was married to was quite reticent and we were on a farm. (Female service user, 40-49, Personality disorder).

Similarly, a young girl's experience moving from a very small rural town to her family farm shows the strong link between mental ill health and social isolation.

I loved going to school, I didn't pick up a pen until the beginning of year 11. I didn't think I'd live long enough to use the information. I didn't care, I just went because there were people and I can't stress enough how lonely it was moving to the farm from in town and it's not like I saw many people when I lived in town. (Female service user, now 21, Depression/suicidal).

Building trustworthy relationships with other people as well as practitioners was important to those participants who had lived on farms away from towns. While both the participants above were happy to use technology in some circumstances (when the Internet connections were reliable and phone calls unmonitored) they both indicated that recovery began when they started communicating with other people face-to-face in real time.

So people, especially when they're suffering from illness and they've had a lot of difficult circumstances or if

traumas' involved or that face to face contact is often the first step to recovery and building rapport. (Mental health recovery support worker)

All the practitioners interviewed emphasised that face-to-face treatment in initial stages of an illness, and during acute stages of illness were more important than phone or other telecommunication. As Lu et al. (2014) found, face-to-face engagement with other human beings, adequate opportunities for building social capital within community (Bourke, 2003), and growing supportive networks of local people are critical to the recovery of people with mental illness and preventing the acquisition of mental illness.

Conclusion

This paper has covered some contrasting issues for the use of eHealth in the treatment and management of mental illness in the Western MDB. The area of eHealth for the treatment and management of mental illness is still in its fledgling stage. As researchers and scholars, it is important to continue questioning the ethics, politics and roll out of eHealth services. Consideration of technology infrastructure, ethical service treatment, the nature and importance of human face-to-face contact, and the nature of, treatment and management for mental illness in rural, regional and remote areas of Australia are important and ongoing bases for research. Other areas requiring investigation include telecommunications privacy, the uptake of technology by rural, regional and remote residents, as well as cultural implications of and treatment of mental illness in rural, regional and remote areas of Australia and globally.

We have argued above that there are some ethical considerations for the development of infrastructure (reliability and accessibility of technology, and agency of service users among those) that need to be taken into account in the development of mental health services. The participants in this study further outline some of the benefits to their mental health and provision of services by using eHealth. However, we must be aware of the current capacity for appropriate interventions and should not exclude the very real need for accessible and affordable face-to-face contact with practitioners and other people in the treatment, recovery and management of mental health.

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What works in family psychoeducation for depression?
A component analysis of a six-week program for family-carers of people with depression

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There is increasing evidence that Family Psychoeducation (FPE) improves outcomes for the person with depression, as well as improving the mental health of their carers. However, which elements of FPE are most important for carers of people with depression has not been investigated. The aim of this study was to investigate whether the 'big three' FPE components, education, skills and social support, that have been identified as important in FPE for people with schizophrenia, are equally important in FPE for people with depression. The second aim was to identify whether the relative importance of these three components differ for particular demographic groups. Participants comprised 553 family-carers of people with depression who completed the "Partners in Depression" FPE program. Findings showed that improved coping skills (specifically, communication with the depressed person and self-care) and improved social support were the most important program components for reducing carer distress. Women reported greater benefits than men from the social support and communication skills components of the program. Improvement in knowledge of depression was not related to a reduction in psychological distress. This study provides preliminary evidence of the importance of the skills and support components in FPE for people with depression, particularly for women.

Depression affects around one million Australians per year (ABS, 2008), and its impact extends far beyond the person experiencing the disorder. Family and friends usually provide the majority of the daily emotional and practical support to people experiencing depression and there are a large number of studies demonstrating that this caring role takes a toll on the mental well-being of the family-carer. Research has shown that between 40% to 72% of family caregivers experience clinical levels of psychological distress (Coyne et al., 1987; Heru, Ryan, & Madrid, 2005; Jeglic et al., 2005; McGill, Schniering, & Hazell, 2014), with symptoms typically alleviating if the person they are supporting recovers (Coyne et al., 1987; Jeglic et al., 2005). The most frequently reported problems by those caring for a depressed relative are financial difficulties due to the impact on earning ability of both patient and

caregiver as well as the cost of treatment, feelings of isolation, reduction in social activities, relationship distress, feelings of confusion and being overwhelmed by depressive symptoms, worry about stigma, worry about the future, and being able to access treatment (Ahlström, Skärsäter, & Danielson, 2009; Highet, McNair, Davenport, & Hickie, 2004; Jeglic et al., 2005; Lemmens, Eisler, Buysse, Heene, & Demyttenaere, 2009).

There is substantial evidence that family interventions for patients with schizophrenia, bipolar depression and eating disorders lead to improved outcomes for both patient and carer (Henken, Huibers, Churchill, Restifo, & Roelofs, 2007; Jewell, Downing, & McFarlane, 2009; Lucksted, McFarlane, Downing, & Dixon, 2012; McFarlane, Dixon, Lukens, & Lucksted, 2003). In particular, Family Psychoeducation (FPE) is an evidence based practice that is recognised as part of the

recommended treatment for psychotic disorders by the USA Department of Health and Human Services (SAMHSA, 2009), and the UK's NICE guidelines (NICE, 2014). Studies show that while there are both similar and different challenges in supporting a relative with depression compared to schizophrenia, the overall carer burden is just as significant (Anderson et al., 1986; Angermeyer, Kilian, Wilms, & Wittmund, 2006; van Wijngaarden et al., 2009). Despite these findings, and the high prevalence of Major Depressive Disorder (MDD) (ABS, 2008), the quantity and quality of published research on FPE for depression has lagged behind that for other disorders. However, of those studies that have been done on FPE interventions for MDD, most suggest that these programs lead to improved outcomes with regard to both patient recovery and carer well-being (Clarkin et al., 1990; Fiorillo, Del Vecchio, et al., 2011; Fiorillo, Malangone, & Del Vecchio, 2011; Katsuki et al., 2011; Lemmens et al., 2009; Luciano et al., 2012; Sanford et al., 2006; Shimazu et al., 2011). A recent study also demonstrated the cost effectiveness of FPE for MDD (Shimodera et al., 2012). This study showed the savings generated by the increase in patient relapse-free days for patients whose families received FPE, compared to a control group who received treatment as usual (a combination of medication and supportive psychotherapy), significantly outweighed the costs of providing an FPE program.

FPE interventions have a number of core characteristics. They are educationally orientated programs that focus on providing relatives with an understanding of the illness, developing problem solving, communication and coping skills, and on supporting development of social support networks. Based on models originally developed by Andersen, McFarlane and Falloon (Anderson, Hogarty, & Reiss, 1980; Falloon, Boyd, & McGill, 1984; McFarlane, Lukens, & Link, 1995), FPE interventions differ from traditional family therapy in that they do not assume dysfunction in the family (Dixon et al., 2011). Whilst the primary goals of FPE programs have traditionally been improved outcomes for the patient, there is now an increasing focus in these programs on improving carer well-being, recognising that the two are interdependent (Lucksted et al., 2012).

Similarly, while there is increasing evidence that FPE for depression is worthwhile, the questions of why it works, or which elements of the programs are most important, and for which people has yet to be investigated. In contrast, recent reviews by Lucksted et al. (2012) and Jewell et al (2009), spanning three decades of research on FPE for schizophrenia and other psychotic disorders, have identified four elements of successful programs. First, the 'big three' components critical to FPE programs are education (providing knowledge about the illness and treatment), skills (developing the carer's skills for coping with their relative and with their situation) and peer social support (opportunities to meet others in the same situation to reduce feelings of isolation and for shared problem solving). Second, providing family-carers with education, without also providing skills and social support opportunities, is not sufficient for achieving improved outcomes for carer or patient. Third, the education component of FPE is most important at the acute stage of the illness, whilst the support element is the most critical in the longer term. Finally, the most important skills to target appear to be the skills required for communicating effectively with the depressed relative and self-care skills. No previous study has attempted to investigate whether these elements are important in FPE for depression.

Understanding the mechanisms by which FPE for depression works is necessary to inform future delivery and ongoing development of FPE programs. Importantly, despite its demonstrated efficacy and cost effectiveness, FPE for depression is still not widely available (Frank, Rummel-Kluge, Berger, Bitzer, & Hölzel, 2014; Lucksted et al., 2012). Findings from a recent study of the implementation of an Australian FPE program for depression found that 50% of planned groups were cancelled with the overwhelming majority (91%) of group facilitators citing insufficient participant numbers as the primary reason (McGill & Schniering, 2014). Anecdotal feedback from facilitators, as well as

empirical evidence, suggests that practical difficulties in committing to a program over 6-12 sessions, rather than lack of interest, is a key reason why most carers do not attend FPE groups (Shimazu et al., 2011). Another recent Australian study found that organisation factors such as lack of funding and resources, are a key barrier to providing FPE programs for depression (Wirrell, McGill, Kelly, & Bowman, 2014). These findings suggest that factors such as the overall length of FPE programs and alternative models of program delivery need to be considered if these barriers are to be adequately addressed. Understanding which components of FPE for depression are most important and whether this differs according to family-carer characteristics such as gender, age, or relationship to the depressed person, is crucial if program developers and providers are to be able to make informed decisions about program content, format and delivery for future advancements in program development.

The first aim of this study was to investigate whether the 'big three' FPE components, education, skills and support, identified as critical in FPE for schizophrenia (Jewell et al., 2009), are equally important to family-carers supporting a person with depression. The second aim was to identify whether the relative importance of these components differ for particular demographic groups; in particular, gender, employment status and level of baseline distress. This study draws on data from the Australian Partners in Depression (PID) community based program, collected between 2010 and 2012 (Hunter Institute of Mental Health, 2013). The PID program is a six session multi-family FPE program for relatives and carers of people with depression. An efficacy study of the PID program showed very high levels of participant satisfaction with the program as well as significant reductions in levels of participant psychological distress, both at the end of the six week program and at six month follow-up (Hunter Institute of Mental Health, 2013; McGill et al., 2014). However, a component analysis of the program was not part of this study. Importantly, the question of which changes in carer skills, attitudes and behaviours

targeted in the program (the program components) were most strongly related to a reduction in psychological distress was not addressed. Further, whilst the previous study showed that a reduction in psychological distress was moderated by gender and employment status, and that carers with higher baseline distress improved the most, the question of whether these different participant groups benefitted differently from different components of the program was not addressed. Hence, this was investigated in the current study.

Method

Participants

Participants were 553 people who completed the Partners in Depression (PID) program. This represents a subset of all participants who completed the program during its national dissemination between March 2010 and April 2012. A total of 1120 family-carers, friends and professional carers attended the program and completed the baseline questionnaire during this period but for the purpose of this study, 240 non-relatives were excluded. Of the 880 relatives, 553 returned post-program questionnaires that could be matched with baseline responses, representing a 63% response rate.

PID attendees were self-identified family-carers, over the age of sixteen years, who had a family member with depression. They were recruited through health and community settings throughout Australia. Although the program was aimed at carers who were supporting a person who had been diagnosed with MDD, those supporting a person who had not been formally diagnosed or with comorbid conditions were not excluded. Participants were predominantly women (79%) and the average age of the sample was 53 years (SD= 11.9 years).

Intervention

The *PID* program is a group education course for people who "live with, love or support a person with depression", which was developed by Hunter Institute of Mental Health, Newcastle, Australia (Hunter Institute of Mental Health, 2013). It comprises six 2-hour weekly sessions that cover information about depression and its treatments, coping skills and

self-care (see Appendix A). The program aims to improve participants' mental health and resilience by providing them with relevant information about depression and the carer experience, opportunities to discuss and share their experience, and by engaging participants in a range of activities that encourage self-care, help seeking and positive coping. Program content was informed by a literature review of what information and support carers of people with depression reported wanting, a focus group with the target population, and advice from a reference group of stakeholders. The program was developed to be a stand-alone intervention, with the expectation that facilitators would refer group members who needed additional support to relevant services. Group members are provided with session booklets that include the information covered in the session and work pages for the group activities. The program is run by two health or community professionals with mental health knowledge and group experience, who have attended a standardised two day facilitator training program and completed quality assurance measures during implementation of the program. During the national dissemination period, 211 programs were delivered across Australia with an average of 6.31 participants attending each group. Program delivery occurred in settings where the program was delivered independently of and as part of the treatment for the person with depression.

Measures

Program Components. Information about changes in carer behaviours, feelings and attitudes was collected using 11 Likert scale response items and one free text response item collected at baseline and the completion of the program. These items formed part of a larger questionnaire developed for the initial study (McGill et al., 2014).

Details about these items are provided below:

(i) Items from a *Carer Attitudes and Behaviours Questionnaire (CABQ)* assessed the degree to which the program influenced specific mental health promoting attitudes and behaviours such as understanding symptoms and treatment for depression, engaging in self-care and accessing support services. At the

start, and on completion of the program, participants indicated their agreement with statements that measured the attitudes and behaviours specifically targeted by the program on a five point Likert scale (from 1= *strongly disagree*; 5 = *strongly agree*).

(ii) One free text response item was used at the end of the program which asked, "Overall, what would you say were the *main benefits* you got from participating in the *Partners in Depression* program?"

Psychological Distress The primary outcome measure was the Kessler-10 (K10; Andrews & Slade, 2001). The K10 is a measure of psychological distress. Items are rated on a five point scale and participants indicate how much each item applied to them over the past four weeks. For example, "About how often did you feel tired out for no good reason? 1= none of the time to 5= all of the time". The total score reflects a person's level of overall psychological distress. Scores range from 10- 50 and higher scores indicate poorer mental health. Using the ABS (2008) coding system, total scores of 10-19 were classed as low psychological distress, total scores of 20-29 were classed as moderate psychological distress and total scores of 30-50 were classed as high psychological distress. The K10 has been used in a number of Australian population health studies and has good validity and reliability (Andrews & Slade, 2001). It is frequently used to identify risk of mental disorder (ABS, 2001). Cronbach's alpha for this sample was calculated as .90.

Procedure

Facilitators advertised the availability of the program and people interested in attending contacted the local facilitator to register interest and complete the screening process. Local facilitators distributed the information and consent sheets, baseline and post program questionnaires to participants and the project team sent the six-month follow-up questionnaire to participants who had provided consent to be contacted at a later date. The study was approved by Hunter New England Human Research Ethics Committee and the Macquarie University Human Research Ethics Committee.

Data Analysis

Exploratory and Confirmatory Factor

Analysis was used to reduce the 11 CABQ items to a smaller number of 'program components' (carer behaviours, feelings or attitudes targeted by the program). Multivariate regression analysis was conducted to measure the strength of the relationship between the change in program component measures and decrease in psychological distress. A series of 12 mixed measure analysis of variance (ANOVA) calculations were conducted to investigate the extent to which participants experienced change in each of four program component measures (knowledge, communication, self-care, and reduced isolation) from baseline to post-program, and to identify the degree to which change in program component measures was affected by three between-subjects factors (gender, employed/ not employed and baseline distress category). For example, for one of the analyses, a baseline and post-program mean was calculated for the component 'self-care'; an interaction variable was then created to investigate whether the change in the self-care component mean from baseline to post-program was moderated by gender. This analysis was repeated for each combination of the four program components and three demographic variables. Finally, thematic analysis of free text responses to the single question pertaining to main benefits derived from, the PID program was conducted by the first author who reviewed and coded responses based on the primary themes reported by participants.

Results

Participant Characteristics

A total of 553 participants returned post-program questionnaires that could be matched with their baseline responses. Although six month follow up data was collected, the available sample for the six month follow up time point was too small to provide adequate statistical power. Not all participants completed all items on the base-line and post-program questionnaires.

The majority of participants were female (79%), 55% reported that they were in paid work and 67% were aged between 41 and 64 years. The majority of participants were supporting a spouse/partner (40%) or an adult child (28%). Sixty percent of participants reported a medium level of psychological distress at the start of the program and 11% reported a high level of psychological distress according to the Kessler-10 (Andrews & Slade, 2001). Full demographic characteristics are reported in Table 1.

Tests for significant differences in participant characteristics at baseline showed that females ($M = 20.74$, $SD = 6.90$) had a significant 2.71 point higher average K10 score at baseline, 95% CI [1.32, 4.08] than males ($M = 18.03$, $SD = 6.47$), $t(567) = 3.85$, p <.001. Participants who were not employed ($M = 21.35$ $SD = 7.26$) had a significant 2.14 point higher score, 95% CI [1.01, 3.27], than those who were employed ($M = 19.21$, $SD = 6.44$), $t(567) = 3.72$, p <.001. Tests for differences in average K10 score at baseline based on relationship to the person with depression, age group and marital status were not significant. Tests for significant differences in mean baseline level of the four program component variables between each demographic group were also conducted and there was no significant difference in these scores.

Factor Analysis

The data set was first divided into two separate samples using random number allocation so that exploratory and confirmatory factor analysis could be conducted on different data. Sample A contained 279 participants and Sample B contained 274 participants. Independent sample t-tests and ANOVA's confirmed there were no significant differences between the two samples with regard to age, gender, relationship to depressed person and mean level of baseline psychological distress (K10).

Exploratory Factor Analysis (EFA) EFA was performed on the eleven items from the baseline Carer Attitudes and Behaviours Questionnaire (CABQ) using Sample A. A Principal Component Analysis with Oblimin rotation was used, specifying a minimum factor loading of .4 and minimum eigenvalue of one. Prior to running the Principal Component Analysis, tests for normality, linearity and multi-collinearity were conducted and the data indicated that not every variable was normally distributed. Given the robust nature of factor analysis and the large

sample size, these deviations were not considered problematic (Allen & Bennett, 2010). A linear relationship was also identified among the variables.

Four factors were identified and in total these accounted for 67% of the variance. The number of factors was further supported by visual inspection of the scree plot. One factor contained four items, one factor contained three items and two factors contained two items each. The items appeared to be logically clustered and were labelled, Knowledge of Depression and Support Services (4 items), Self-Care (3 items), Communication with Depressed Person (2 items) and Feelings of Isolation (2 Items). Factors and factor loadings are shown in Table 2.

Confirmatory Factor Analysis (CFA) The four factor model was then tested with Confirmatory Factor Analysis on the Post-Program *Carer Attitudes and Behaviours Questionnaire (CABQ),* using data from sample B (n = 306). The model fit statistics showed a reasonable fit with the post program data, CMIN/DF = 2.713, CFI = .918, TLI = .865 and RMSEA = .075. The path diagram for the CFA is shown in Figure 1.

Reality of Scales Based on the factor analysis, the four factor (program components) scales were tested for reliability. The *Communication* scale showed good reliability for both baseline and post-program, r = .87/.87 respectively, and it was therefore decided to retain this composite measure despite it comprising only two items. The *Knowledge and Self-Care* scales showed acceptable reliability on the baseline and post-program data, r = 69/.67 and r = .69/.74 respectively. Whilst loadings for the *Feelings of Isolation* items were strong, the scale showed poor reliability on the baseline and post-program data, r = .53/.42 respectively. However, the CFA model showed poor fit if this scale was excluded, CMIN/DF = 11.384, CFI = .649, TLI = .415 and RMSEA = .185, therefore it was decided to retain this component in the analysis, recognising that results must be interpreted with caution.

Program Components Predicting Change in Psychological Distress

In order to determine the relative predictive value of the four factors (program components) in contributing to a reduction in psychological distress, a hierarchical linear multiple regression analysis was conducted. Prior to conducting the multiple regression analysis, testing for assumptions of normality, linearity and homoscedasticity of residuals was carried out and results showed these assumptions were met. No extreme univariate outliers or significant multivariate outliers were identified and missing data was treated list-wise. Based on identified participant differences at baseline, in order to co-vary for gender and employment status, these variables were entered as step one in a hierarchical regression analysis and the four program component variables were entered in step two.

In step one of the hierarchical regression analysis, gender and employment status accounted for a significant 4% of the total variance in reduction in distress on completion of the program, $R^2 = .044$, $F (2, 453) = 9.53$, $p < .001$. In step two, the four program components accounted for an additional 8% of the variance, $R^2 = .12$, $F (5,449) = 9.85$, $p < .001$, $f^2 = .14$ which is a medium effect size (Cohen, 1988) (See Table 3). Changes in three of the four program components were significantly related to a reduction in psychological distress; reduced *Feelings of Isolation,* improved *Self-Care* and improved ability and confidence in *Communication with depressed person.* Increased *Knowledge of depression and support services* was not a significant predictor of reduction in distress.

Effect of demographic factors on changes in program component measures

Mixed design ANOVA's showed significant main effects between participant baseline and post program measures for three of the four components targeted by the program; Participants' *Communication with depressed person, Knowledge, and Self-care* all showed significant improvements ($p < .01$) from the beginning to the end of the program. Baseline and post-program means, standard deviations and effect sizes are reported in Table 4.

Table 1 *Sample Participant Characteristics (n = 553)*

		n	%
Gender	Male	116	21
	Female	437	79
Age	16-25 years	22	4
	26-40 years	105	19
	41- 64 years	349	63
	65+ years	77	14
Employment	Employed	304	55
	Not Employed	249	45
Relationship to person with depression	Spouse/Partner of person with depression	216	39
	Parent of person with depression	155	28
	Other relative of person with depression (e.g. Child, sibling,)	105	19
	Multiple relatives with depression	67	12
Kessler- 10 (pre-PID)	Low distress (10-15)	160	29
	Moderate distress (16-29)	332	60
	High distress (30-50)	61	11

Tests for interaction effects between changes in each of the four program component variables, baseline to post-program, and three demographic variables (baseline distress (K10), gender and employment status) produced three significant interactions. Improvements in *Communication with depressed person and Self-Care* was moderated by level of baseline distress ($p < .001$), with higher levels of baseline distress related to greater improvements in both these components. Women also showed greater improvements in *Communication with depressed person* compared to men but this result failed to reach significance at $p < .01$ level ($p = .026$). Change in *Feelings of Isolation* showed no significant main effect as only women reported a significant improvement between baseline and post program ($p = .004$). Men showed an increase in *Feelings of Isolation* between baseline and post-program, but this result was not significant ($p = .089$). These interactions are illustrated in Figures 2 and 3 respectively.

Thematic Analysis of Free Text Data

The main benefits of the program most frequently cited by participants in the free-text response question were: sharing experiences with others in a similar situation, for example, "I am not alone" (38%); developing awareness of the importance of self-care and learning coping strategies, including cognitive behavioural therapy (CBT) techniques (33%), acquiring an understanding of depression and how it effects people (30%); learning communication skills and strategies (15%); and obtaining information about support services and resources available (10%). Most participants reported benefits relevant to more than one theme.

Discussion

The first aim of this study was to investigate whether the three components of FPE programs shown to be the most important

Table 2 *Exploratory Factor Analysis: Program Factors and Long Factor Loadings (n = 296)*

	Knowledge of depression and support services (Knowledge)	Self-Care	Comm. with depressed person (Communication)	Feelings of Isolation (Isolation)	Item-Code
I understand causes, symptoms and treatments for depression.	.595				K_Symp
I have a good understanding of the support services available.	.806				K_Spt
I talk with others about the support experience.	.738				K_Talk
I have been able to access the support I need.	.642				K_AcSpt
I feel others don't understand what it is like to support someone with depression				.770	ODU
I feel a strong sense of isolation due to supporting someone with depression.				.837	Isol
I am confident in my ability to communicate with depressed person.			.917		C_Abil
There is good communication between myself and depressed person.			.935		C_Good
I know what helps promote my own mental health.		.697			SC_Know
I believe it is important to take time out and look after myself.		.829			SC_Impt
I make sure I take time out to look after myself and engage in self-care activities regularly.		.785			SC_Do

in reducing psychological distress in family-carers of persons diagnosed with schizophrenia and other psychotic disorders - education, skills and social support - were also the most important in reducing psychological distress in family-carers of persons with MDD. The results from this study indicated that two of these components, improved carer coping skills (communication with depressed person and self-care) and improved social support (reduced feelings of isolation) were predictive of a reduction in psychological distress. However, whilst participants' knowledge of the illness and available support services showed significant improvement during the program, this improvement was not shown to be significantly associated with reducing distress. The importance of reduced feelings of isolation was reiterated in the thematic analysis of free text responses which found that 'connecting with others in the same situation' was the most frequently reported benefit of participation in the program.

The second aim of the study was to investigate whether the relative importance of each program component in reducing carer psychological distress differed by gender and employment status or level of psychological

Figure 1: *Confirmatory factor analysis on four component model*
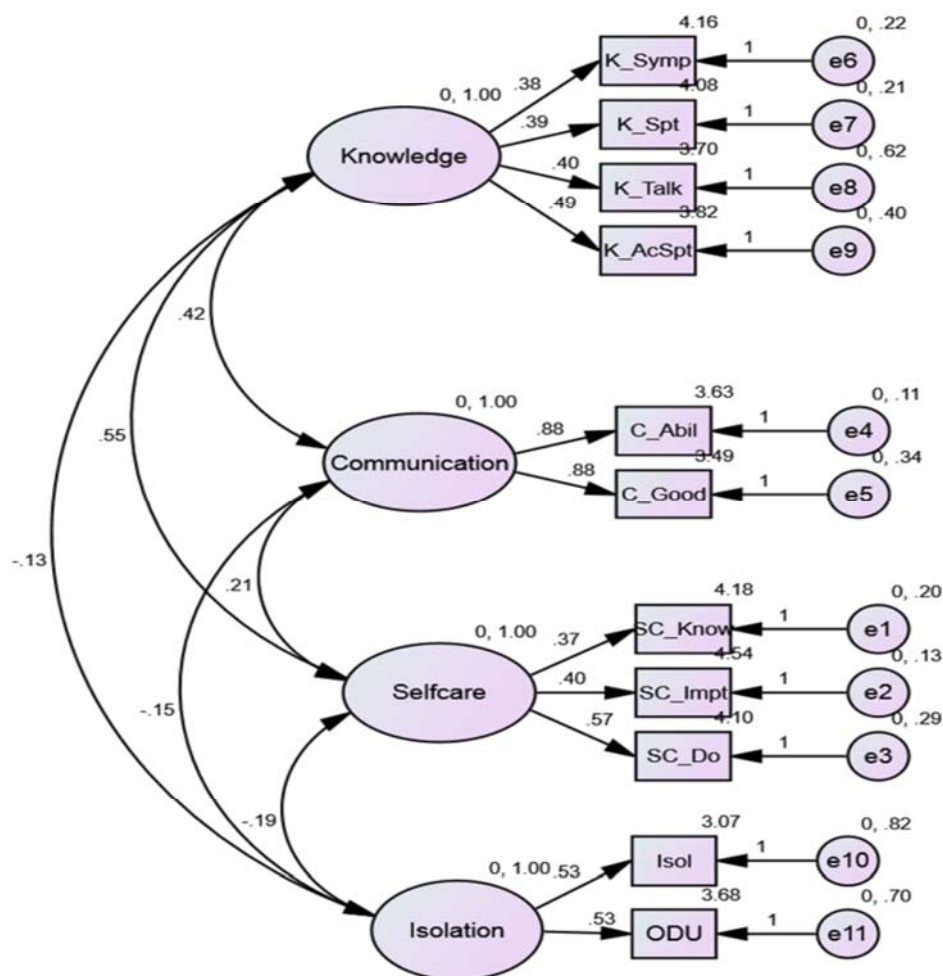
distress reported by the participant prior to commencing the program. A previous study showed that women, people who were not in paid employment benefit, and individuals with higher levels of baseline distress benefitted most from a FPE program (McGill et al., 2014). This study similarly showed that the relative importance of FPE components varied by gender and by the family-carers' baseline level of psychological distress. However, employment status was not found to influence program component outcomes. Women reported more improvement than men in communication skills and those with higher levels of baseline distress reported more

improvement in both communication and self-care skills than those with lower levels of baseline distress. However, only women reported experiencing a reduction in their feelings of isolation through the program.

Overall these results are consistent with the literature about what is important in FPE for schizophrenia and other psychotic disorders; social support and coping skills, particularly around communication with the depressed person and self-care, were both shown to be important in reducing carer psychological distress   However, the finding that improvement in carers' knowledge of depression and the professional support services

Table 3 *Hierarchical Regression Results: Program Components Predicting Change in Carer Psychological Distress*

Program Factor	R^2	B [95% CI]	β	sr^2
Step One	.04**			
Gender		-1.90 [3.00, -.90]**	-.16	.03
Employment Status		-1.17 [-2.95, -.85]**	-.12**	.02
Step Two	.12**			
Gender		-1.55 [-2.57, -.527]**	-.13	.02
Employment Status		-1.29 [-2.14, -.43]**	-.13	.02
Knowledge		.08 [-.09, .25]	.05	0
Communication		.25 [.01, .49]*	.09	.01
Self-Care		.36 [.14, .61]**	.14	.02
Feelings of Isolation		.71 [.30, 1.12]**	.16	.03

*Note: n = 455 due to missing data, CI = confidence interval, *p < .05, **p < .01*

available to them was not related to a reduction in distress was unexpected. This was further supported by the analysis of the free text data which found only 10% of people reporting this information being a key benefit of the program. Previous studies have suggested that the knowledge component of FPE programs is most important at the beginning/acute stage of the illness (Anderson et al., 1986). Accurate data on the length of time the patient had been diagnosed with depression was not available for this study, although it is possible that the majority of people attending the program were beyond the acute stage and were already familiar with this information. It may also be the case, as has been shown in previous studies, that knowledge of depression is a necessary foundation for carer well-being but is not sufficient to lead to improved outcomes on its own (Greenberg, Greenley, & Kim, 1995).

The finding that men did not appear to benefit as much as women from the component of FPE that targeted feelings of isolation and social support was also unexpected; although as noted, results using this measure must be interpreted with caution. However, this result is not inconsistent with the limited research that has evaluated gender specific effects of FPE for mental illness. For example, a study by McWilliams et al. (2007) of 115 caregivers of relatives with schizophrenia on the acquisition of carer skills and knowledge from a six-week FPE program found significant gender differences in acquisition of different skills, with the largest difference being that women gained more understanding of the importance of caregiver social support, whilst men showed no change on this aspect. Another study based on 43 families by Hsiao (2010) found that female carers of relatives with mental illness experienced higher degrees of perceived caregiver burden and that this was related to their perception of less social support compared to male carers. The mechanism by which FPE results in an improvement for women but not men with regard to social support may be similar to that found in comparative studies of single sex and mixed gender therapy groups for substance abuse, which have found that for women, group cohesion is greater in female only groups and that this mediates improved
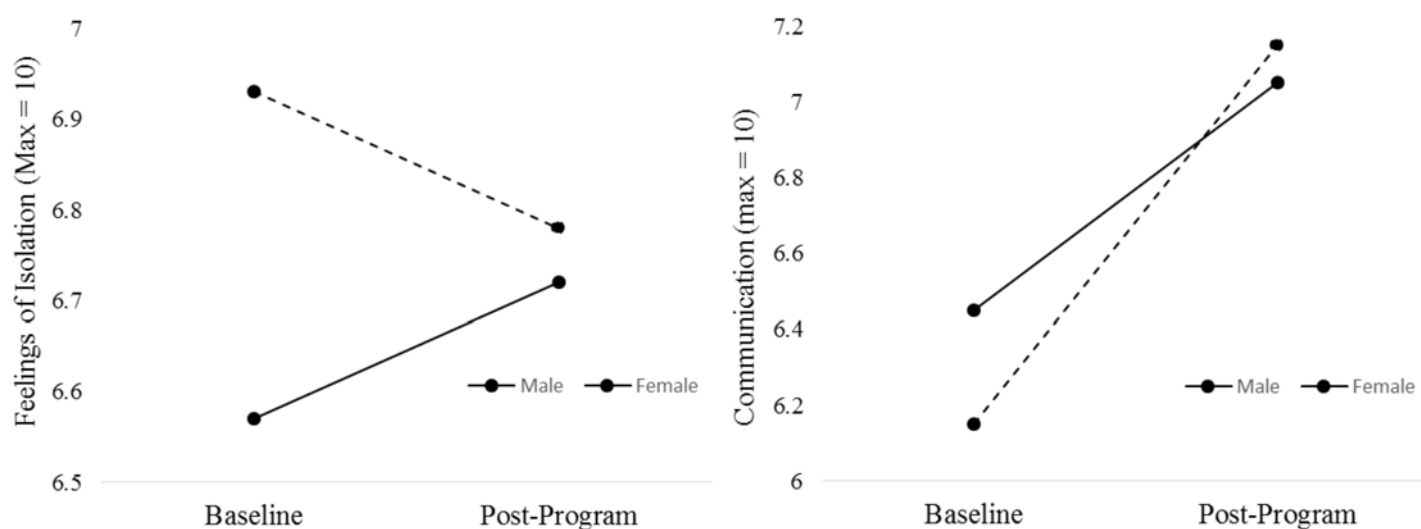
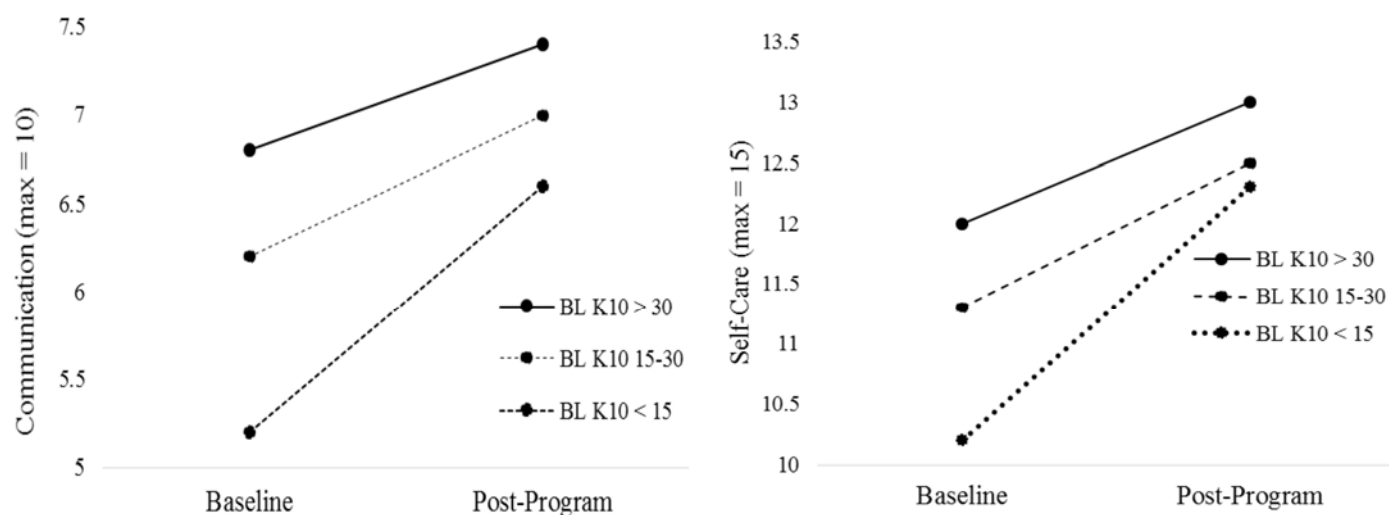*Figure 2*: Change in *Feelings of Isolation* and *Communication* components by gender.

Figure 3: Changes in *Self-Care* and *Communication* components by Baseline Distress (K10).

Table 4 *ain Effects for Change in Program Components Over Time and Interaction Effects with Gender, Employment and Baseline K10*

Variable	Baseline mean(SD)	Post-Program Mean(SD)	F	p-value	Partial eta²
Self-Care Main Effect	11.37 (1.96)	12.78 (1.58)	F (1, 506) = 229.59	< .001	.312
Self-care x Baseline K10 Category Interaction			F(2, 506) = 10.05	< .001**	.038
Self-care x Gender Interaction			F(1,538) = .673	.412	.001
Self-care x Employed/Not Employed Interaction			F(1, 538) = .496	.482	.001
Communication Main Effect	6.23 (2.18)	7.11 (1.87)	F (1,544) = 124.92	< .001**	.187
Communication x Baseline K10 Category Interaction			F(2, 512) = 5.58	.004**	.021
Communication x Gender Interaction			F(1,544) = 4.956	.026*	.009
Communication x Employed/Not Employed Interaction			F (1, 544) = .726	.394	.001
Knowledge Main Effect	12.77 (2.76)	15.80 (2.00)	F (1,517) = 622.66	< .001**	.546
Knowledge x Baseline K10 Category Interaction			F (2,491) =.64	.527	.003
Knowledge x Gender Interaction			F (1,517) = .85	.357	.002
Knowledge x Employed/Not Employed Interaction			F (1,517) = .765	.382	.001
Isolation Main Effect	6.85 (1.72)	6.77 (1.62)	F (1, 528) =2.964	.086	.006
Isolation x Baseline K10 Category Interaction			F (2, 497) =2.834	.06	.011
Isolation x Gender Interaction			F (1,528) = 8.229	.004**	.015
Isolation x Employed/Not Employed Interaction			F (1, 528) = .242	.623	.000

*NB: **p<.01, *p< .05*

rates of recovery (Greenfield, Cummings, Kuper, Wigderson, & Koro-Ljungberg, 2013; Greenfield, Trucco, McHugh, Lincoln, & Gallop, 2007). It may also be that the large gender imbalance in most of the FPE groups in this study meant that the isolation factor was not addressed for men as much as for women. Similarly, the finding that communication skills improved more for women than for men could be because women felt able to engage more with the communication component in a female dominated group. It is possible that men only groups may have produced different results on both these measures.

The finding that the relative importance of the various program components did not differ by age group or relationship to depressed person requires further investigation. It may be that the perceived care burden itself is comparable across these groups and therefore the information, skills and support needs are also similar. However this finding has not been previously reported and needs replicating with further studies. Winjgaarden (2009) highlighted the different experience of caring for a spouse (which was the most common relationship type amongst these participants) compared to caring for an adult child (which is a more common type of relationship among carers of people with schizophrenia) but there have been no studies looking at comparative outcomes.

The lack of a significant difference in outcomes based on carer employment status was also unexpected, based on the results of the previous efficacy study of the program. In particular, it was expected that unemployed carers would benefit more from the support component of FPE than those who were employed, on the basis that employed people may have felt less socially isolated than persons who were not working. However, as aforementioned, results for this measure must be interpreted with caution and need replicating in future studies.

The finding that carers with higher levels of distress at baseline made greater improvements in their coping skills (communication with their depressed relative and self-care skills) than individuals with lower levels of initial distress does not seem surprising. What is interesting is that level of initial distress did not make a significant difference to improvements in the support component. However, if it is the case, as indicated above, that the majority of participants were supporting someone beyond the acute stage of the illness when knowledge is a critical component of FPE, this finding is consistent with research which highlights the importance of the peer support component of FPE in the longer term.

Implications for Practice and Research

This study adds to the increasing evidence base on the efficacy of FPE for depression. The results provide preliminary evidence for the mechanisms by which FPE for depression may reduce psychological distress in family-carers as well as adding to our understanding of which program components of FPE programs appear to be most beneficial As noted, despite evidence of its efficacy and cost-effectiveness, FPE for depression is not routinely offered, with organisational resources and insufficient participant numbers the most frequently cited reasons for this. Thus, there is a need to develop models of FPE which can provide carers with the information, skills and support they need at the time it is most needed, but which can be delivered within the resource constraints consistently faced by providers. The results of this study provide some preliminary information about which aspects of FPE programs are most important for which people and several findings have implications for future development and implementation of FPE.

The finding that having the opportunity to share with others in similar situations is a particularly important component of FPE for depression, particularly for women, is relevant if considering development of alternative delivery formats for FPE for depression, such as on-line psychoeducation programs (Stjernswärd, 2012). Whilst interactive programs that provide information about the illness and help develop coping skills may contribute to addressing the knowledge and skills requirements of FPE, the findings from this study suggest that the importance of the support component must not be minimised and that programs that address social support and connection are likely to be more effective that those which ignore these components. Future

research is needed to investigate both the acceptability and efficacy of FPE models which combine the cost effectiveness and timeliness of providing on-line psychoeducation with the need to share with others; for example, models of FPE which combine some face to face sessions and some on-line sessions, or which include on-line forums, as these formats may be one way to address program aims and accessibility within resource constraints.

The finding that the support component of FPE was of greater importance to women than men, and that women gained more from the communication skills component also suggests that FPE for depression may need to be adapted for male family-carers. Initially, further studies are needed to examine whether women and men may need slightly different things from FPE for depression; strategies for developing skills around communication with their partner and their own self-care may need a different emphasis or approach for the different genders.

In contrast, the finding that carers' age and relationship to depressed person did not make a difference to the relative importance of program components suggests that FPE for depression can address core issues that are common across carer life span and irrespective of how a person is related to the depressed person. The need to customise programs for specific groups or deliver them separately adds to the cost and complexity so this finding is of practical relevance. Nevertheless, replicating this finding in future studies is needed to ensure that such customisation is unnecessary. In particular, given the aging population, studies that investigate whether older carers have specific needs is warranted.

Finally, the finding that family-carers experiencing the highest levels of distress at the start of the program were found to benefit most from the communication skills and self-care components, suggests that interventions targeting skill deficiencies is particularly important for this group of carers and highlights that these elements should be focused on when family-carers present with a high level of distress.

Limitations and Future Directions

In the absence of previously validated measures, this study used specifically designed measures to capture program impact. Future studies of FPE programs need to develop more reliable and standardised measures of program components in order to replicate and validate these conclusions, and to enable outcomes to be compared across different FPE programs. A further limitation of this study was the lack of sufficient data to allow measurement of family-carer wellbeing beyond the end of the program. Future studies that measure participant behaviours, feelings and attitudes targeted by FPE programs over longer time p eriods are needed. Furthermore, the findings from this study were based on participants' self-reported improvements. Future studies that measure actual changes in behaviour (e.g. around self-care or help seeking), would provide further validation of the efficacy of FPE for depression. Finally, information on the stage and length of the illness of the person being supported would allow us to draw firmer conclusions about the relative importance of FPE components at different time points.

In conclusion, notwithstanding the study limitations, the current findings suggest that providing information about depression, its symptoms and treatments, may be necessary but not sufficient to establish an improvement in wellbeing for those caring for a person with depression. Providing training in skills, notably how to effectively communicate with the depressed person and how to look after oneself, as well as providing opportunities for peer support are important components for improving carer wellbeing. The peer support component of FPE appears to be particularly important for women and should be considered when developing programs, including those that may look to deliver FPE using an on-line format. It also seems that there may be differences in what men require from FPE for depression and more research is needed to investigate male carers' needs for support. By investing in caring for our carers, we can both improve their well-being while also ensuring that those they care for have the best possible chance of recovery.

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Appendix A: Content of *Partners in Depression*
Family Psychoeducation Program

Session No.	Content
1	Introductions and orientation to the program.
2	Developing an insight into the care and support role and the symptoms and treatments for depression.
3	Validating the care and support experience.
4	Introduction to cognitive behaviour therapy and the support role.
5	Suicidality and strategies for communicating with the person living with depression.
6	Help-seeking, support and future planning.

(Hunter Institute of Mental Health, 2013)

Psychological growth in young adult refugees: Integration of personal and cultural resources to promote wellbeing

Anja Copelj
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This study explored the Psychological Growth (PG) process in six young adults from a refugee background living in Victoria, Australia. An Interpretive Phenomenological Approach was used as the basis for the interviews and analysis. Four superordinate and eight sub-ordinate themes were identified: (1) appreciation of life opportunities ("hope and optimism" and "determination and ambition"); (2) increase in self-belief ("identification of personal strengths" and "development of positive bi-cultural identity"); (3) strengthening of cultural/social connectedness ("importance of social support" and "prioritising life values"); and, (4) pro-activity ("engaging with meaningful life activities/careers" and "acceptance"). The findings suggest that resettlement experiences as well as the initial trauma represent both a source of ongoing psychological disruption and an opportunity for psychological growth. The study also discusses the importance of proactive behaviour as being a catalyst for PG.

While the impact of forced migration on individuals is probably best understood as a broad, complex and multifaceted issue (Shakespeare-Finch, Schweitzer, King, & Brough, 2014), psychological research has generally focused on the pre-migration persecution or war experiences as sources of potential trauma and mental illness that might affect post-migration adaptation (Copping, Shakespeare-Finch & Patton, 2010; Ryan, Dooley, & Benson, 2008). As a result, psychological research and practice has focused on the outcomes (most often negative) of the forced migration experience more so than the post-resettlement adjustments and processes themselves that promote successful adaptation (Miller, Kulkani, & Kushner, 2006). As such our current perspective on this phenomenon may benefit from a broadening in contextual understanding. For example, up to 60 percent of refugees do not present with clinically significant distress during resettlement, signifying that different pathways, not all negative, are possible in the psychosocial transition of refugees (Berger & Weiss, 2006; Klasen, Oettingen, Daniels, Post, & Hoyer, 2010).

Theorists from community and humanistic psychology fields have broadened the focus and promotion of wellbeing in refugees by conceptualising the adaptation and wellbeing of refugees within relational, familial and socio-cultural contexts (Joseph & Murphy, 2013; Miller, Kulkarni, & Kushner, 2006; Miller & Rasco, 2004; Ryan, Dooley, & Benson, 2008). Psychosocial wellbeing in refugees can be defined with respect to three core domains: individual/psychological resources, social ecology, and culture and values (Earnest, 2005/2006). Accordingly, these Resource-Based models (Ryan, Dooley & Benson, 2008) emphasise the importance of psychological resources (i.e., adaptive coping strategies) as well as social and cultural resources (i.e., interpersonal, community and familial support) for promoting wellbeing in refugees. Papadapolous (2007) devised a Refugee Trauma Grid framework for mental health workers to evaluate refugee clients' functioning. This grid consists of different levels of factors (i.e., individual, family, community and society/culture) to facilitate a more holistic understanding of the multilevel nature of the refugee experience. Proponents of the framework also emphasise the importance of assessing refugee clients'

strengths and resiliency at each of the different levels and to incorporate them into treatment planning and the therapeutic relationship. These interventions do not deny, but rather complement, traditional approaches by identifying and promoting individuals' strengths and adaptive coping resources for dealing with their negative and traumatic experiences.

Ascertaining positive changes and growth in refugee populations

In line with adopting a more holistic perspective on the psychosocial wellbeing of refugees, researchers have also found evidence to support the notion of positive psychological changes in survivors following adverse life events (e.g., Joseph, Linley & Harris, 2005; Papadopoulos, 2007; Tedeschi & Calhoun, 1996). Despite variations in terminology, positive outcomes have been identified in the domains of relationship enhancement, new self-perceptions, and changes in life philosophy (Joseph et al., 2005). For the purpose of the current research the term Psychological Growth (PG) will be used to denote positive change following adversity.

Several cognitive models of PG following adversity have been developed and whilst there is insufficient room to review them all, three general observations can be made. Firstly, all the models share common ground with the psychosocial framework of posttraumatic stress reaction which describes the engagement of cognitive-emotional processes to deal with distressing emotional states following trauma (see Rubin, Berntsen, & Bohni, 2008 for a comprehensive review). According to this theory, the symptoms of Posttraumatic Stress Disorder (PTSD) (re-experiencing, hyper arousal and avoidance) represent the need to undertake cognitive-emotional processing of trauma-related information. Secondly, the psychosocial theory of stress response also recognises that cognitive-emotional processing can produce changes in individuals' personality and assumptive worlds as a result of coping and posttraumatic adjustment (Janoff-Bulman, 1989). Finally, PG theorists broaden the trauma framework by rejecting an exclusively deficit-focused paradigm and acknowledging the complex emotional reactions, both positive and negative, to trauma. The advantage of theories of PG is that they provide a more detailed theoretical account of how processing trauma-related information can result in different posttraumatic adjustment outcomes.

A key difference between growth theorists is how they conceptualise and measure PG. Quantitative methods employed in studies of post-war survivors indicate that researchers conceptualised PG as the result of cognitive-emotional processing arising from the traumatic experience and embedded in the survivor's meaning-making search and cognitive coping capacity (Tedeschi & Calhoun, 1996). Consequently, PG has been assumed to occur after coping with and overcoming the trauma. A more dynamic framework postulated by Joseph and Linley (2005) and Papadopoulos (2007) has conceptualised PG as a process which continues throughout an individual's life span and denotes the characteristics that humanistic psychologists would describe as "a fully functioning person" (Joseph & Linley, 2005, p.270). These PG development models assume that refugees could experience positive changes whilst still experiencing adverse conditions during the process of relocation and resettlement (Shakespeare-Finch, Schweitzer, King, & Brough, 2014). The person is also presumed to be able to integrate these complex experiences into his/her continually developing worldview and self-structure, and to develop characteristics that enable him/her to transcend, and overcome, future traumatic and stressful experiences. As individuals reconstruct their sense of self, and understanding of the world following adversity, goals and priorities are re-evaluated in a way that aligns them more realistically to new circumstances, meaning and purpose in life (Joseph & Linley, 2005). Consequently, qualitative enquiries have investigated the adaptive significance of PG in helping refugees with post-migration resettlement and ongoing decision-making in terms of their life choices (e.g., Sutton,

Robbins, Senior, & Gordon, 2006).

The process and adaptive significance of PG in refugees

Research investigating the developmental process and adaptive significance of PG in refugees is limited. Qualitative studies have investigated how young refugees constructed their experiences of trauma and how that impacted the resettlement process (e.g., Copping, Shakespeare-Finch & Paton, 2010; Schweitzer, Greenslade, & Kagee, 2007; Sutton et al., 2006). The key outcomes of these studies have broadened the focus of PG by highlighting the importance of behavioural actions as well as cognitive and environmental factors in precipitating the PG process. Sutton et al. (2006) explored how unaccompanied refugee minors' experience of trauma led to positive changes and feelings of growth during their resettlement to the UK. Positive resources such as community and family support, religion and comparing oneself with others less fortunate enabled young Sudanese to cope better with resettlement to Brisbane, Australia (Schweitzer et al., 2007). Copping et al. (2010) used a grounded theory approach and replicated the finding that community support and religion enabled young Sudanese refugees to deal with initial negative feelings, intrusions and flashbacks of traumatic experiences. However, it was PG (in the form of identification of strengths and appreciation of new possibilities) that enabled the participants to move forward and capitalise on new experiences following resettlement in Australia.

These findings align with Rogers' (1959) concept of positive human growth which predisposes people to search for meaning and to incorporate experiences into a cohesive sense of self. Joseph (2004) described this concept as an "innate motivational directional force in humans toward the development of autonomous determination, expansion and effectiveness, and constructive social behaviour" (p.103). From this perspective, while traumatic experiences such as war and forced relocation can overwhelm the subject and create denial strategies and anxiety, there is potential for positive change within appropriately supportive contexts. Furthering the understanding of how cognitive, emotional, behavioural and environmental factors precipitate the growth process will potentially help us understand how to assist people overcome adverse events.

Cross-cultural variation in PG

Whilst PG has been reported across cultures, the way that growth is expressed and perceived has been found to vary between people from different cultural backgrounds (Shakespeare-Finch & Copping, 2006). For example, as noted earlier, the domains of positive outcomes assessed by quantitative measures, such as the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996), include changes in spirituality, relationships with others, appreciation of life, personal strength and new possibilities. Yet, as reported by Copping et al. (2010), Sudanese refugees expressed these changes as values that were strengthened as a result of suffering and displacement rather than necessarily having changed as result of their experience. Similarly, factor-structure studies using the PTGI have only been replicated in Western societies, suggesting that PTG might manifest differently in refugees coming from non-Western countries (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003). These societies focus more on familial and social systems in their identity constructions and it is these aspects that can be strengthened and changed positively in the aftermath of trauma (Berger & Weiss, 2009). Consequently, for refugees coming from collectivist (e.g., African countries) and familial-oriented societies (e.g., former Yugoslavian and Middle Eastern countries), social and spiritual factors and values might become further strengthened as they are utilised as coping resources at times of struggle during war and adjustment following resettlement to Australia.

Rationale for the current research

Currently, there is an identified need to broaden our understanding of the stressfulness of forced migration and the

processes and opportunities for growth. There is also a need to investigate perceptions and interpretations of war experiences and of coping by refugees from different cultural backgrounds. Further qualitative investigation is needed to facilitate understanding of how PG might manifest in different refugee communities and help inform therapeutic practices. The major limitation of previous studies is that their samples were comprised of recently arrived refugees whose level of success and adaptation to the host society was not known. There is evidence to suggest that a protracted period of time is needed to detect PG in refugees (Morris, Shakespeare-Finch, Riek, & Newbery, 2005). As such, established former refugees might be able to provide a more nuanced account of their pre-migration and trauma experiences, and the processes undertaken to deal with these and successfully settle into Australian society. Importantly, given that over 64% of Humanitarian Entrances to Australia are under the age of 30 (Department of Immigration and Citizenship, 2013), there is great benefit in understanding the perceived difficulties, coping and resettlement experiences, and possible positive outcomes for young adult refugees.

Children and young adults arriving as refugees are exposed to a unique set of challenges. Pre-migration experiences of dislocation, disruption, deprivation and loss can exacerbate psychological crises including mistrust, doubt, guilt and inferiority that occur during normal development (Erikson, 1982 as cited in Eisenbruch, 1998). Most refugees have experienced disrupted schooling and limited English skills. Children arriving prior to the age of 16 are placed in classrooms with chronologically aged peers and are expected to adjust socially, emotionally and academically (Earnest, 2005/2006). At home they often take on more of the parenting responsibilities to support their family, and as a result are exposed to significant family stressors and intergenerational conflict as they navigate parents' cultural expectation as well as the expectations of their peers and the wider

community in order form their identity. These issues are further exacerbated in refugees arriving in Australia after compulsory schooling ends (older than 16 years of age) where they are exposed to more significant disruptive schooling and less opportunity to transition into desired post-secondary education. This group have also been found to struggle to develop English language proficiency due to higher family responsibility, limited resources to support post-compulsory training and education, and potentially more significant stressors arising from their pre-migration experiences (Abkhezr, McMahon &Rossouw, 2015).

Aims of the study

The aim was to build on existing literature and offer further insight into how young adults from a refugee background interpreted and identified with their experiences, and coped with resettlement in Australia. The three main objectives were:

1) To investigate the adjustment and resettlement process of young adults from refugee backgrounds, which included understanding the sources of their initial distress and the sources which aided in their resettlement to Australia.

2) To explore the manifestation of PG processes in refugees that occurred as a result of life events and enabled them to think differently about the world and act differently as a consequence.

3) Based on the above, to gain insight into the lived refugee experience that potentially can inform mental health support services of ways to promote PG.

Method

Design

Interpretive Phenomenological Analysis (IPA; Smith, 1996) was considered the most useful method for exploring refugees' coping, perception, and interpretation of their life experience. IPA seeks to understand meaning of events and experiences through an individual's perceptions and interpretations. Further to this, IPA also allows researchers to interpret the findings based on their own experience and knowledge (Smith, Jarman, & Osborne, 1999). The principal researcher's approach to

this study was motivated by two related factors: firstly, her own experience as a young refugee resettling to Australia and her own dissatisfaction with current research and clinical practice guiding refugee mental health; secondly, the principal researcher's own interest in understanding and informing mental health practice. Given the central role of the researcher in the process, the researcher's reflexivity and self-awareness of her own influence was crucial at each step of research design. The process that the researcher has undertaken to reflect on this process is discussed in greater detail in the procedure and analysis section.

Consideration was given to the use of IPA within a pre-existing theoretical framework and how this may impact information provided by the participants. According to Storey (2007), researchers using IPA and wishing to make use of existing psychological theories and knowledge must avoid violating a person's meaning making and interpretation of life events. One suggestion offered is to invoke the theory when discussing the findings arising from an analysis of participants' meaning-making. Sutton et al. (2006) adopted this perspective when investigating PG and positive changes in refugee minors using IPA. The current study takes a similar stance on the use of theoretical framework and literature and further details are described in the analysis section.

Sample

A purposive, self-selected sample of six participants contributed to the current study. Smith (1996) has stated that purposive sampling is able to provide in-depth insight into the research question. Three organisations working with refugees in Melbourne, Victoria were approached by the principal researcher and were informed that the researcher was interested in interviewing people who had shown positive changes and had adjusted well since re-settling in Australia. They were also informed of the inclusion criteria for the current study including: being between the ages of 24 and 34, arriving as refugees to Australia, and living in Australia for over five years . All

participants were expected to have sufficient English language skills to be able to take part in the study without an interpreter. Additionally, participants reported experiencing at least one traumatic event (based on the Life Events Checklist; Blake et al., 1990) prior to their forced migration (see Table 1). The representatives from the organisation sent out information to suitable individuals including an explanatory statement about the study and whether they might be interested in taking part in the study. Interested individual's provided consent for their contact details to be passed onto the researcher. The researcher emailed the potential participants and provided information about the study and asked for their willingness to participate. Six people agreed to participate and three people did not respond. The participants were relatively similar in age, education level, and had experienced significant pre-migration stressors and traumatic experiences (Table 1).

Data collection

Ethics approval for this study was granted by the Federation University Ethics Committee. Participants were provided with an Explanatory Statement and asked to sign a consent form. The researcher conducted, and digitally recorded, six semi-structured interviews which ranged from 60 minutes to 2.5 hours. Semi-structured interviews were constructed following guidelines outlined by Smith et al. (1999). An interview schedule comprised of general questions was designed to ask participants about: their pre- and post-migration experiences, how they have coped with challenges and whether they have changed as result of their life experiences. Prompts were prepared for each question. Neutral questions were selected to allow participants the freedom to respond with narratives which may confirm or deny PG and allow the PG discourse to emerge from respondents' narrative spontaneously. An example of questions included: Can you tell me about your experience of arriving in Australia? What were some of the initial difficulties and concerns that you had experienced after arriving in Australia? What

Table 1 *Demographic Information of Participants*

Partic- ipant	Sex	Age	Length of stay in Australia (years)	Country of birth	Highest education Level	Marital Status	Pre-migration stressors, losses, traumas [a]
1	M	30	5	Togo	Bachelor	Engaged	Yes
2	M	30	8	Sudan	Postgraduate	Married	Yes
3	F	31	14	Afghanistan	Bachelor	Married	Yes
4	F	27	18	Bosnia & Herzegovina	Postgraduate	De-facto	Yes
5	F	26	17	Bosnia & Herzegovina	Bachelor	Married	Yes
6	M	30	17	Bosnia & Herzegovina	Postgraduate	De-facto	Yes

Note. [a] *experiencing at least one pre-migration stressor, loss or trauma as reported during the interview included being physically injured, witnessing someone else being killed or injured, fearing your life or someone else's life was in danger, and feeling terrified and helpless.*

are some ways you have dealt with some of the challenges?

Data analysis

The interview transcripts were analysed using the principals of IPA as outlined by Smith et al. (1999). The steps for analysis of each of the interview transcripts are outlined below:

1. First author re-read through each transcript individually, and used the left hand margin to highlight individual thoughts and observations in response to what was expressed by the participant.
2. The emerging themes that capture the essential quality of the expressed meaning of the participant were documented on the right hand margin of the transcript.
3. Emerging themes were listed on a separate piece of paper and examined to see if any of the themes were related, or connected, to each other. Common themes were grouped together under a broader subordinate theme.
4. Themes and subordinate themes, as well as relevant quotes, were listed in a separate table. Tracing the themes and subordinate themes to relevant quotes ensured that the researchers own bias did not distort the selection process. Themes that were not supported by rich evidence from the transcript were omitted from the table.

This four step process was completed for each of the transcripts. The next stage of analysis involved searching for themes reflecting shared aspects of experiences for all of the participants. To search for shared themes, themes from all of the participants were collated to ascertain if broader themes could be developed that were relevant to all of the participants. Following this analysis four broader superordinate themes and eight subordinate themes were identified across the participants. The themes were then consolidated into a conceptualised model of PG in refugees. The second author monitored

the data analysis process throughout each step of analysis, which provided an opportunity for verification of identified themes.

Findings and Interpretation

The six participants were all able to provide insight into how they were able to initially cope with resettlement in Australia. Moreover, they were able to identify positive outcomes as a result of their experiences pre- and post-migration. As summarised in Table 2, four key themes reflecting the PG process have been identified. The themes, as identified across the case studies, have been organised as a nascent model of the PG process (see Figure 1).Table 2, below, provides a summary of the four superordinate and eight subordinate themes identified across the cases.

The themes were arranged around the participant's central concern: coping and overcoming his/her pre- and post-migration life experiences. The inter-relational model in Figure 1 depicts the process of how they coped with, and made meaning of, their life experiences and the identified positive outcomes.

Brief summary of the psychological growth cycle model in refugees

As conceptualised in Figure 1, the PG cycle for refugees was simplified to four key stages (commensurate with the four superordinate themes) and sub-stages (commensurate with subordinate themes). Pre-existing and ongoing trauma underpinned the refugees' ongoing efforts towards goal fulfilment and personal development following resettlement. Across participants' stories the experience of trauma was not confined to an isolated event (despite identification of primary traumatic events such as war and displacement); rather, it manifested throughout pre- and post-migration experiences. *Appreciation of new life opportunities* being presented in Australia helped the participants to cope with these stressors. Through coping with, and overcoming various life challenges, all six participants reported an *increase in self-awareness*. The recognition of innate resources and coping strategies *(identification of personal strengths)* that they had gained throughout their lives enabled them to cope with ongoing life stressors. All participants described initial difficulty in adjusting to Australia and feeling different because of their accents and cultural backgrounds. Also, they described how they were able to identify multiple strengths and benefits of coming from a different background and establish a more *positive bi-cultural identity.* It is through this positive bi-cultural identity that all six participants reported recognising the importance of various resources and cultural values that they had brought with them and how these enabled them to cope with various life challenges *(strengthening of cultural and social connectedness).* For example, both Daniel and Michael emphasised the importance of community support that enabled them to survive the impact of war and prolonged years in refugee camps. For the other four participants it was the strengthening of family support that enabled them to overcome many of their life stressors. Inner strength and social support provided the individuals with a direction in pursuit of meaningful goals and careers *(proactivity)*. A detailed description of each of the stages is described below.

Stage 1: Appreciation of life opportunities. A central tenet expressed by all of the participants was the appreciation of life opportunities that helped all the participants make sense and cope with pre- and post-migration difficulties and stressors. In line with developmental models of PG (Joseph & Linley, 2005; Papadopoulos, 2007) all participants described ongoing reflection and active engagement in meaning making and focusing on future life opportunities to help them cope with both present and future challenges.

Michael and Daniel experienced severe disruptions from early childhood up until early adulthood. Michael spent the majority of his adolescent years in refugee camps whilst Daniel had to move through different regions before arriving at a refugee camp at 17 years of age. For Michael, whilst he acknowledged the "limited opportunities and conditions of the refugee camp" he continued

Table 2 *Key Themes Identified Describing the Process and Structure of Psychological Growth*

Superordinate theme:	**Appreciation of life opportunities**
	1. Hope and optimism
	2. Determination and ambition
Superordinate theme:	**Increase in self- belief**
	3. Identification of personal strengths
	4. Development of positive bi-cultural identity
Superordinate theme:	**Strengthening of cultural and social connectedness**
	5. Importance of social support
	6. Prioritising of important life values
Superordinate theme:	**Proactivity**
	7. Engagement with meaningful careers
	8. Acceptance

Note. Numbered themes denote sub-ordinate themes

to pursue education and complete his secondary studies in English in the hope that he would be able to be granted a visa to another country. It was this optimism that helped buffer against the ongoing challenges that he faced during his time in the refugee camp: "we were approved and we were very happy because we thought we were given a new opportunity in life". For Daniel, despite significant educational disruptions and separation from his family, his persistence to recommence secondary school when arriving in the refugee camp provided him with the will and optimism to make the most of this opportunity.

> *I was busy supporting myself and it became really tough...so this is when I dropped out of school because my dad was not paying for me and my mum was not around either. I stopped school for a while and started reading books and I discovered that I had to go back and work a little bit to put some money together and enrol myself... since I started developing myself and reading books, such as those on positive thinking, I came across the importance of education...so I always dream and wish to have a chance to study*

> *overseas and have the opportunity to be in a big library...*

For both Michael and Daniel, they were able to reflect on and appreciate the potential life opportunities in Australia while still in their home countries. Specifically, their strong desire to maximise their academic and learning potential which was formed prior to migration helped them deal with the significant challenges they reported upon arriving in Australia. Whist refugees arriving as older adolescents and young adults may have to delay their own personal goals (educational and career achievements) in order to gain financial and independent security and provide support to their family (Abkhezr, McMahon & Rossouw, 2015; Earnest, 2005/2006), they may also be more predisposed to dealing with this than school aged refugees due to their maturity to reflect on future opportunities while waiting to migrate. All participants described how unique opportunities available in Australia enabled them to cope with post-resettlement difficulties, however the realisation and acknowledgement of these opportunities was expressed at different timeframes for refugees depending at what age they arrived.

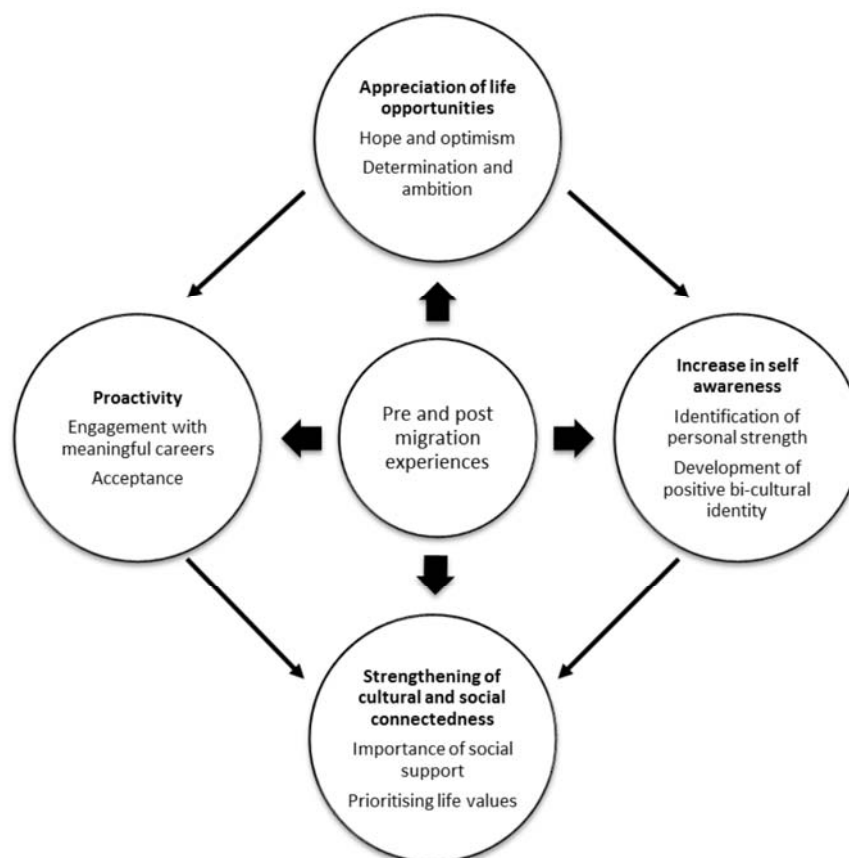> *There was a systematic discrimination in the way that*

*Figure 1.*A conceptualised model of psychological growth (PG) cycle in refugees. The conceptualised PG cycle has been simplified to four key stages: Appreciation of Life Opportunities; Increase in Self-belief; Strengthening of Cultural and Social Connectedness and Proactivity

refugees are perceived as not knowing English and that you are dumb and poor...even though my Year 12 certificate I completed in Kenya was in English they were telling me to translate it...It was a nightmare and I saw that I did not have a chance to go to university. Also because I was turning 22 I was being told that no one would accept me in high school so only opportunity I had was to go to TAFE....This was tough and challenging...the first semester I tried working all night and going to class all day and not sleeping and drugging myself with coffee...so eventually with persistence and keeping my part-time job, and aiming high academically, I was able to manage studying full time and working...The fact that you could see your friends working and earning money and were driving cars and had

laptops was tempting...they were telling me that I could wait and keep on waiting, go to University and never get the job and have these stuff... (Michael)

Michael and Daniel demonstrate a cohesive sense of identity and a realisation of opportunity that was formed through ongoing reflection and maturity prior to arriving to Australia. In contrast, refugees arriving at a younger age may not have had the maturity and also the opportunity to compare current living conditions to their homeland, and may have needed a longer time to fully appreciate the opportunities available to them (Schweitzer et al., 2007). In line with the Eisenbruch's (1998) interpretation of Erickson's developmental theory, adolescence is an especially critical time when refugee children are faced with additional challenges of resolving normal psychological crises to help them transition into adulthood. Certainly for the refugees

coming from former Yugoslavia, arriving in Australia as children entering adolescent years, it was only after coping and resolving many of the crises related to their identity, values, and feeling different to their peers that they were able to fully appreciate the opportunities that were made available to them.

> *In school they could not understand why you speak another language at home and why you have these gatherings at homes...It helps you become a better person and stronger character...as I started maturing I realised that it was OK to be a little different... (Mary)*
> *Whilst I was upset initially that I had to worry about all these things, when I wanted to be an adolescent having fun and enjoying life, I think I can see how it has impacted me in a positive direction...it made me realise what is important in life...(Sophia)*

For the three refugees who came from the former Yugoslavia (Mary, Peter and Sophia) it was only after living in Australia for several years, and comparing their living standards to those of their family overseas, that they began to fully appreciate the opportunities and freedom available to them in Australia which enabled them to remain hopeful and optimistic about their future.

Lily also described how the realisation of opportunities and freedom in Australia, along with the determination to succeed, enabled her family to cope with language difficulties and deal with initial settlement issues and challenges.

> *There were times that we would get lost... There were times where I just wanted to give up. I did not because I was thinking that if we gave up where would we go? I do not want to go back to Afghanistan...The thing which kept me going was the opportunities that were available here. I knew that I could do whatever I wanted. I could do so much here and every door I open would be full of opportunities so that is what kept me going. (Lily)*

The importance of identifying strengths

and adaptive thoughts and feelings to promote PG and psychosocial wellbeing has been strongly supported in the current study. These participants did not perceive themselves as hopeless victims, but rather described themselves as being mature for their age, having the coping resources and life experiences that better equip them to overcome difficult situations in comparison to their peers. This maturity was also highlighted through the narratives of the participants who exhibited insight, which to the researcher was felt to be beyond their years.

Stage 2: Increase in self-belief. All of the participants described how dealing with, and overcoming, various life difficulties enabled them to reflect on their own strengths and innate resources to enable them to cope. In line with Rogers' (1959) concept of positive human growth and Joseph's (2004) concept of "innate motivational directional force" all participants engaged in deliberate self-reflection and desire to learn and grow from their experience to help them develop a stronger sense of self. In the current research, recognition of individual strengths and innate resources was expressed through two of the sub stage themes: identification of personal strengths and development of positive bi-cultural identity.

Identification of personal strengths and the development of bi-cultural identity

Both Daniel and Michael described how the harsh and dangerous life experiences in Africa enabled them to approach challenges in Australia with a positive frame of mind.

> *On the contrary I had some friends who were short sighted and when they crossed all those obstacles they went into the workforce and were doing labouring duties and they were telling me to forget about school... So eventually with persistence and keeping my part-time jobs and aiming high to succeed academically I was able to find time myself to juggle both studying full-time and working part-time to earn some income. (Michael)*

Daniel also described how his strengths

and resilience set him apart from his peers in being able to remain focused on his career goals, despite facing financial difficulties. Lily and Sophia discussed how taking on extra responsibility at a young age, once resettling in Australia, forced them to become more mature which enabled them to cope and manage life difficulties.

> *Whilst I was upset initially that I had to worry about all these things, when I just wanted to be an adolescent having fun and enjoying life, I think now I can see that it has impacted me in a positive direction. For start, I realised that I am capable to deal with a lot of challenges and it has perhaps shown me how strong and supportive I can be. (Sophia)*

Peter and Mary described how continuous disruption and constant moving between different countries and schools made them feel different and unaccepted. However, eventually they were able to accept and identify unique strengths and individual qualities.

> *It helps make you a better person and have a stronger character...as I started maturing I realised that it was OK to be a little different...I feel that I can understand people from different backgrounds. You can be compassionate and a little bit emotive and understand that it is not easy; you have been through it yourself. (Mary)*
>
> *You end up almost with your own inner toolbox for different situations... I think it made me more of a stronger person ....it gets you a thicker skin in a way. Ok some people might say that you speak funny, you do not know what you are doing, they are going to have a different misconception of who you are, where are you coming from… you can take that and feel sorry for yourself or you can take it and say - yes I am different, but that is what makes me interesting. (Peter)*

As suggested by Joseph and Linley (2005) it is often not until people find themselves in a challenging situation that

they are able to draw on and recognise personal strengths and abilities. The participants were able draw on their own psychological resources (Ryan, Dooley & Benson, 2008) to negotiate settlement challenges. A difficulty reported by all participants was that associated with trying to adhere to one's cultural and familial values, as well as trying to adjust and conform to the wider Australian society. Daniel and Michael described the perceived discrimination they experienced.

> *People think of the refugees in terms of people that want to take away from the community without giving anything back – which is not true... there are people that thinks that they will spend tax payers' money... . (Daniel)*
>
> *You know when you hear in media, in the news, getting refugees getting nasty comments obviously when you are in certain places in trains you get people getting out of the seats and leaving you in your own seat in the train.... No doubt those are my roots and if for one part people want to make a living of tarnishing that part than it damages you as a person. Most often it's your dignity and reputation that makes you an individual and if someone strips you of it you are a naked person and you often can't restore it. (Michael)*

All participants described how they eventually realised the strengths and benefits of integrating both of their cultural identities and their refugee experience. Two main strengths were identified: providing a better focus and resources to cope and think about life difficulties; and, the ability to relate to others.

> *I could never understand how someone can judge someone based on the groups they belong to. I also have seen many people who were doctors and lawyers overseas but came here and became cleaners and factory workers. I have learned to appreciate people, no matter what their background is, and to judge people on not what they do or have, but rather on*

their values and goodwill. (Sophia)

These findings also support the need to broaden the focus of attention on sources of distress for refugee clients and to tailor psychological services to address the variety of needs that may be expressed (Miller, Kulkarni, & Kushner, 2006). All of the participants described ongoing stressors following resettlement which extend well beyond the pre-migration trauma proposed by the medical model. Post-migration familial and social stressors, such as limited social support, difficulty adjusting to a new environment, initial language and educational difficulties, and greater family responsibilities, were key concerns emphasised in participant narratives. Similar findings have been reported by other qualitative studies indicating that post-migration stressors were the priority concern for young adult refugees in comparison to pre-migration traumas (Copping et al., 2010; Schweitzer et al., 2007; Sutton et al., 2006).

Stage 3: Strengthening of cultural and social connectedness. All six participants described the importance of both innate and environmental resources to assist in coping with distress and also with pursuing own growth enhancing fulfilments. This is commensurate with the Resource-Based models of wellbeing that emphasises the importance of integrating an individual's psychological, social and cultural resources for personal growth (Ryan, Dooley & Benson, 2008).

Daniel and Michael described the importance of the support from their community in enabling them to cope whilst living in Africa and after resettling to Australia. Feelings of connectedness and community provided them with a sense of belonging and empowerment to deal with, and overcome, difficult situations. This is similar to from Copping and colleagues (2010) who discuss strengthening of community and cultural resources for collectivist societies as an adaptive coping strategy and a catalyst for growth. Michael described the disintegration of African families and community ties in Australia as being the central cause for many young African youth engaging in risk-taking behaviour such as careless driving and drug-taking. For him, valuing and appreciating community support was strengthened following his resettlement to Australia.

I thought to myself that I will take this opportunity to make a new family and that is when I joined the association and got to know people from Africa, from different parts…I've tried to get to know them and to build my community around them. (Michael)

Family was described as the main coping resource and support network utilised by Lily, Peter, and Sophia in overcoming resettlement issues.

The experience that we have been through has brought us closer…we always talk about these experiences – they are no longer traumatising but rewarding. (Lily)

I also think that I was able to maintain best aspect of my Bosnian heritage and the Australian society which has helped provide focus and direction in life. For example, I know the importance of family and friends, has always been emphasised in my culture and something perhaps I realised the real value of…I appreciate the importance of family as I think family can overcome many of the life challenges. ..I know other families which have divorced of the family fell apart once moving to Australia. I think it was the string family support that in a way was strengthened throughout life which made us realise how important we are to each other
(Sophia)

We stick with the Bosnian community. Once you are together it is a lot easier at least there is someone feeling what you are feeling. (Lily)

Peter did not directly state the strengthening or importance of family, although throughout his narrative he disclosed how his brother and his parents were the main people who helped him, and on whom he depended. This appeared to help

him deal with continuous disruptions to his education and difficulty in fitting in during high school years.

All participants described how their experiences of surviving war and overcoming resettlement difficulties provided them with greater insight into what was really important in their lives.

Firstly, it made me appreciate about what is really important in life. For example, I really appreciate the importance of family as I think with family you can overcome many of life challenges. I have seen that my parent's marriage had enabled them to cope and really overcome events that most people would not even witness through Hollywood movies. (Sophia)

Additionally, participants described how the experiences gave them a more optimistic view of the world and enabled them to accept and appreciate the simplest things they have in life.

...has given me a positive outlook on life that I have to appreciate whatever little that I've got and not so much for something that is not there... In other words, I do not whine about meaningless things and it has also taught me to embrace human life – appreciate what I have and not what I don't (Daniel).

... I look at the world very differently than if I was a 30-year-old brought up in Australia. I would have wanted all the luxuries in Australia, now I make the luxury out of the smallest things. Even on a Sunday if I spend time with my mum and my family, I think that is better than anything else for me. It's so special. So it has made me appreciate how much they mean to me and I look at the world very positively. I try to find happiness in everything that I do. (Lily)

In line with the underlying assumptions of positive psychology, the findings from the current study support the need to conceptualise the adjustment and wellbeing of refugees within individual and socio-

cultural contexts (Miller et al., 2006). Consequently, the term psychosocial wellbeing is an effective choice for characterising the adjustment process of refugees (Earnest, 2005/2006; Miller, & Rasco, 2004). As postulated in the Resource Based Model, the wellbeing of refugees could be defined as the ability to satisfy personal needs and demands, as well as those relating to adjusting to a new socio-cultural setting (Ryan et al., 2008).

These findings also suggest that a cultural collectivist-familial dimension can influence the expression of PG (Copping et al., 2010; Powell et al., 2003; Shakespeare-Finch & Copping, 2006). The two participants from Africa came from collectivist societies and described the importance of their community support, whilst other participants described the importance of family support. As suggested by Berger and Weiss (2009), these cultural values are further strengthened when utilised as coping resources in difficult times, such as during war and in subsequent adjustment following resettlement.

Stage 4: Proactivity The combination of positive change and outcomes resulting from recognition of opportunities, identification of personal strengths and social support, in conjunction with coping, engendered a more overall *proactive* approach to dealing with situations. This is in line with Hobfoll and colleagues' (2007) behavioural expressions of PG, where moving forward and engaging in meaningful activities helps individuals make sense and fully appreciate their experience, and maximise their growth. The importance of incorporating behavioural components of growth (Hobfoll et al., 2007) was further supported by the findings. For the participants, pursuing their educational as well as career aspirations enabled them to cope and overcome various pre-migration traumas and post-migration stressors. For example, both of the African participants described how it was their desire to complete their educational studies which enabled them to cope with living under harsh conditions in refugee camps. It was also their persistence

to achieve academic success and empower the African community in Australia which enabled them to deal with various post-displacement stressors. This line of findings supports other qualitative studies that have suggested the importance of encouraging behavioural actions to promote positive psychological and social changes (Hobfoll et al., 2007; Sutton et al., 2006).

Five participants disclosed how reflecting on the positive outcomes of their experience (including their ability to relate to people and recognise life priorities and values) made them want to engage in careers which would enable them to help other people overcome similar difficulties.

So I started working there and realising how little English people speak and how helpful I can be to them. Communicate to them the basic things such as have you gone to the toilet? Have you eaten? Do you understand what operation you are having? Just being able to translate for them sort of tells them that I know what you are going through made me realise that was a good thing. (Mary)

It is through this knowledge and experience that I wanted to do something meaningful and get involved in doing something which will help people and make a difference. (Sophia)

Four of the participants described how they wished they could help people in their homeland who are still struggling with war and poverty. However, they were realistic in knowing what was within their control and what they are unable to change. They were all able to accept that war and poverty in their homeland was something that might be unchangeable as it has been a re-occurring theme through history.

I do know that I do not have to have a very idealistic approach to life as research and common knowledge have taught us that is how it has been since the beginning and probably that is how it is going to be. Also looking from a realistic point of view, I have enough knowledge and strengths to know of

what can be changed and what can't be changed, and, you know, direct the image in a positive way instead of making useless noise. (Daniel)

However, both Daniel and Michael were hopeful that with their careers they would be able to make a significant contribution to Africa in the future.

Right now it is quite dangerous to engage in and we do tend to observe those things quite closely...if the country thrives and is ready to receive some advocacy on human rights and good governance no doubt that some of us would be interested to do some work and at some point down the track. (Michael)

Application of research to theory and practice

The current findings provide insight into the adjustment and resettlement processes of young adults of refugee backgrounds including sources of distress and the resources which assisted them. The findings also highlight the need to broaden the focus of mental health services for refugee clients following resettlement. From the data, a model of the process of PG following adversity was derived and includes four key interconnected stages. The successful migration experiences reported here appeared to be based on having an openness to new opportunities, the realisation of inner strengths through facing challenges, connectedness to social and family structures, and a proactive action orientation.

The domains of PG process in the current sample are in accord with quantitative measures, such as the PTGI (Tedeschi & Calhoun, 1996). There were however, noteworthy differences in the way these factors were identified and expressed. The three common domains assessed by quantitative measures: enhancement of relationships (current sample: strengthening of socio-cultural support), new self-perceptions (current study: increase in self-awareness) and changes in life philosophy and purpose in life (current study: proactivity) were supported in the current

findings. Following the participants' traumatic experiences, they were strengthened or developed through dealing and coping with post pre-migration and post-settlement stressors. It was also through their life experiences that the participants were able to develop an understanding of their purpose in life.

The findings also highlighted additional components of PG which are not currently captured by popular quantitative measures. For the current participants, strengthening of social and cultural supports and proactivity were additional socio-cultural as well as behavioural components described in the PG model that currently are not captured or assessed by the quantitative measures (Tedeschi & Calhoun, 1996). These findings provide support for the recently revised PG models that move beyond the cognitive models of PG, and towards acknowledging how relational, familial and community systems can be strengthened and changed in the aftermath of trauma (Berger & Weiss, 2009).

Limitations of the current study

Firstly, a central tenet of the growth process is that the traumatic events experienced by individuals are severe enough to shatter basic assumptions and schemas relating to self and the world (Janoff-Bulman, 1989; Tedeschi & Calhoun, 1996). Whilst all the participants in the current study described experiencing severe levels of distress and negative life experiences, the magnitude of distress (e.g., such as presence of PTSD or depressive symptoms) was not explicitly assessed. However, the post-traumatic growth reported by participants in this study can also be seen as an indication of post-traumatic stress given the U-shaped relationship between stress and growth reported in previous research (Joseph, Murphy, & Regel, 2012). The authors argue that a moderate level of post-trauma stress is experienced but the individual is still able to cope and cognitively process the event. Secondly, all of the participants described using various coping processes, as well as positive cognitive appraisals, from a young age to deal with traumatic experiences. However,

for refugees resettling to Australia, who do not have the educational strengths or social support to manage their pre- and post-migration stressors, the current PG model might not be as relevant. Additionally, participants were all younger refugees who had the necessary English language skills to undertake the interview and this might not be an accurate reflection of the wider refugee community. Consequently, the coping resources, adjustment journey and PG process might vary. Finally, future studies could also investigate how factors such as gender and family structure influence the PG process.

Therapeutic implications for mental health professionals working with refugees

Underpinning the practice and research of mental health matters is usually a medical model which has been criticised as providing a narrow understanding of the refugee experience by focusing solely on the impact of individual pre-migration trauma (Miller & Rasco, 2004; Ryan et al., 2008). We argue that the use of person-centred principles and techniques would be of therapeutic benefit and could be integrated into other existing approaches to therapy with refugee clients (Joseph & Murphy, 2013).

There has been some debate as to whether one therapeutic approach can both treat trauma symptoms and facilitate growth (Joseph et al., 2012). We argue that a holistic approach, guided by person-centred principals, is best suited to working with refugees to facilitate positive outcomes and growth. The participants in this study exemplified the positive outcomes possible after forced resettlement following extremely stressful experiences. They also embodied the human actualising tendency. All of the participants demonstrated strong motivation to evolve and hence improved their overall wellbeing. They were able to do this by drawing on a wide variety of supports available to them, most notably familial support and enacting inner resources. The participants described their ongoing trauma as a burden but also as a source of growth and transformation. There was also evidence of the psychological tension between holding

on to the pre-trauma self-structure and the integration of new meaning (Joseph, 2004). The traumas experienced by the participants gave them an awareness of the fragility and uncertainty of life that necessitated a significant change in their self-structure. It is noteworthy that these traumas were a continual presence that required ongoing negotiation and could not be simply left behind as the participants began new lives in their adopted country. It follows then that a therapeutic relationship can provide a safe environment to assist the client in moving toward positive outcomes and PG: this journey may be an effortful endeavour involving deliberate coping efforts and conscious emotional processing in order to search for positive outcomes and contemplate the broader context (Janoff-Bulman, 1989).

If we accept that self-actualisation is innate, then the role of the therapist is to assist the individual to release that potential and direct it towards life activities. The fundamental elements for this to occur, according to the participants, were a sense of hope and of opportunity. While the client's environmental context will be a significant factor, the therapist can assist in recognising and bringing into awareness the unique opportunities in the client's present and future. The next phase of therapy should focus on the building of client self-confidence and the strengthening of support networks. According to the participants, by identifying personal strengths and by valuing their bi-cultural identities they were able to engage in meaningful activities. Success in these pursuits further strengthened their self-confidence and began a positive feedback and growth cycle. Post-trauma self-acceptance appeared to be the pinnacle so far of this growth process. When applying the current PG model to trauma therapy, exposure to the trauma would not be initiated or avoided within the therapeutic relationship but would be dealt with as it arises throughout the growth cycles. This would mean that the trauma would be introduced to therapy by the client and would function as a barrier or challenge to the growth process. This is a point of difference to most exposure-based

therapies where trauma exposure is encouraged or introduced by the therapist (Elliott et al., 2013). It must be noted however that the model developed here is based on a small qualitative study and requires further application and evaluation.

In order to provide services that promote a person-centred framework and cultural competence it is paramount in psychological practice to assess the perceived goals and life priorities of the refugee client. The importance of trauma counselling should not be dismissed, and should be a priority for some clients. However, the findings suggest that for some refugees this might not need to be the primary focus. Assisting the refugee client to recognise the opportunities available to them, to encourage determination and hope might be an important initial role for mental health professionals. For other refugee clients, helping them recognise their own strengths as well as discussing adaptive coping mechanisms might form an important part of therapy.

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Coping and preventing lateral violence in the Aboriginal[1] community in Adelaide

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Lateral violence describes how members of oppressed groups direct their dissatisfaction inward. This inward deflection has been associated with the Aboriginal community in Adelaide, South Australia and has shown to be destructive. Interviews with 30 Aboriginal participants examining their ways of dealing with and strategising to prevent lateral violence in the community have been presented in a thematic analysis. Overall seven major interpretive themes emerged from these interviews: education is central; support provides unity; champions and role models are essential; culture and identity are empowering; avoidance of Aboriginal spaces by Aboriginal people can be protective; lateral violence can be challenged; and positively reinterpreted. Given that many participants drew on a number of coping strategies to deal with lateral violence, it is hoped that such information will benefit individuals, community, governments and funding agencies to support future research, education and services within communities in order for Aboriginal people to heal and prevent lateral violence.

Lateral Violence and Disempowerment

Definitions of lateral violence (LV) reveal that LV is a form of overt and covert dissatisfaction and disruption amid members of oppressed groups (Native Counselling Services of Alberta (NCSA), 2008). Within Indigenous groups, overt physical violence coupled with covert behaviours such as bullying, harassment, gossiping and sabotage have been found (Australian Human Rights Commission (AHRC), 2011; Derrick, 2006) along with stripping away of each other's Aboriginal identity (Clark, Augoustinos & Malin, 2016). Lateral violence with Aboriginal communities in Australia is linked to intergenerational and collective trauma that has its roots in colonialism. From colonisation Aboriginal people's lives were undermined and controlled through racism and oppression. Appeals and resistance were met with further disempowerment that has become multigenerational and continues to be evident today (Milroy, Dudgeon & Walker, 2014).

Feelings of powerlessness and dependency have been further linked to poor health and life outcomes (Milroy et al., 2014). The effects of powerlessness in relation to LV have reportedly contributed to a blame mentality, lack of trust in others' judgment (Derrick, 2006), jealousy over possessions (Coffin, Larson & Cross, 2010) as well as physiological signs such as sleep disorders, weight loss or gain, depression (Native Women's Association of Canada (NWAC), 2015), and more recently potential links to high stress levels and wellbeing in Adelaide (Clark et al., 2016). In contrast, having a sense of control over one's life has been linked to better health and life outcomes, wellbeing and prosperity in many areas of Aboriginal life (Milroy et al., 2014).

Healing, Training and Empowerment

Disempowerment has meant that many

Aboriginal people are in a continual state of healing, which has been described as a holistic process of physical, cultural, psychological and/or spiritual renewal (Mackean, 2009). According to Milroy et al. (2014) healing and redress for Aboriginal people needs to include processes of empowerment, community governance, resilience, restoration and reconnection with community life. Importantly, reclaiming the history, ancestry and community stories of family and country help to restore a sense of cultural continuity. One such example of cultural renewal in Adelaide is the cultural and language reclamation of the Kaurna language, which has enabled the Kaurna people to define themselves and transform their society in their own way rather than be defined by others (Amery, 2016).

Healing and empowerment can occur at various levels; starting with individuals clarifying and/or redefining their values and norms which permeates to the community for collective healing and goal setting (Dudgeon et al., 2014). Furthermore, empowerment needs to be strength based and on the premise that strength and tools lie within communities. Thus, training and information on LV appear to be increasing within Indigenous communities by Aboriginal people in Canada and Australia and appearing on websites. Examples of which include: *Chameleon strategies (2016)*; *kweykwayconsulting*, (2016); *Aboriginal cultural workshops* (Ryan, 2015); *Koorreen enterprises* (2015); *Kornar Winmil Yunti* (2016); and *Lateral Love* (2014).

Coping, Resilience and Support
Collective vs individualistic coping
Incidence of high psychological distress (ABS, 2016), racism (Stolper & Hammond, 2010) and poor mental health (AIHW, 2015) in Aboriginal communities means that coping is fundamental to survival. Much of the coping research and literature has been dominated by individualistic Western cultural paradigms (Kuo, 2011; Yeh, Arora, & Wu, 2006) with four broad coping styles: active or problem focused (i.e. confronting problems); denial-disengagement or emotion focused (i.e. withdrawal); social support seeking; and positive reinterpretation (Mellor, 2004). Some researchers also suggest forgiveness of a perpetrator as a coping mechanism (i.e., Strelan & Covic, 2006). Research on collective coping emphasises "cultural" and "social" mechanisms as underlying the stress and coping process (Kuo, 2011). Collective coping responses or strategies can be: value-driven (e.g. forbearance and fatalism); interpersonal (e.g. family and social support); culturally conditioned emotional/ cognitive (e.g. acceptance and avoidance); religion and spiritually grounded (Fischer, Ai, Aydin, Frey, & Haslam, 2010); respecting authority figures; and relational universality such as belonging, sharing and identifying with others (Yeh, et al., 2006).

Individualistic cultures value independence and autonomy, where the focus of change is the external environment. Collectivist cultures emphasise group cohesion, interdependence, connection, harmony and conforming to group norms. Thus individuals in a collectivist society aim to change themselves (their minds, emotions or behaviours) to fit the environment and to protect it (Kuo, 2011). Individuals will generally use a range of collective and individualistic coping strategies in their daily lives, whether they are from an individualist or collectivist society. Some forms of coping are deemed more functional than others. For example, Yeh et al. (2006) indicate that active and internal coping (i.e., seeking support, taking concrete action or reflecting on possible solutions) is deemed as functional resulting in positive consequences. In contrast, dysfunctional coping (i.e., withdrawal, denial or repression, controlling feelings and having a fatalistic attitude), can result in negative consequences. However, Yeh et al. (2006) point out a cultural bias towards problem-focused coping and personal agency, which are concepts highly valued in individualistic cultures.
Coping and resilience within Aboriginal communities Australian Aboriginal people are regarded as a collective culture where individuals are held

together through kinship systems involving a shared sense of identity, responsibility, care and control (Milroy et al., 2014). Examples of coping and resilience in relation to Aboriginal people in Australia have primarily been in response to racism (Mellor, 2004) and psychological stress (Kelly, Dudgeon, Glee, & Gaskin, 2009). Mellor (2004) indicated three broad themes of coping behaviours to deal with racism in his research which are *defensive*, *controlled* and *attacking*. Defensive (defend or protect the self) includes: passive (resignation of the situation); active (avoiding future encounters or individuals, venues or situations); reinterpretation of the event (to lessen the impact of racism); social support; and strengthening children (to help them cope with racism in the future). Controlled (control the self) is primarily about ignoring (which is a choice to not respond). Finally attacking (control the environment/perpetrator) is about contesting racist behaviours, confrontation of some kind (i.e., educating the perpetrators through factual information), asserting identity and pride, or seeking external controls (i.e. calling on those in authority).Yet, Mellor (2004), indicates that the Indigenous people in his study were reluctant to use regulatory or legislative bodies as they were seen as ineffective.

Coping in relation to psychological distress for Aboriginal people has been to identify risk and protective factors whereby protective factors shield against the effects of risk. Those who are psychologically overwhelmed or struggling to cope with multiple stressors are likely to effectively exhibit higher psychological distress (Kelly et al., 2009). Some of these risk factors include unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage. Protective factors include connection to land, culture, spirituality, ancestry and family and community (Social Health Reference Group, 2004). These factors can serve as a source of resilience and can moderate the impact of

stress on social and emotional wellbeing (SEWB) of an individual, family and community. Merritt (2007), amongst others, has argued that exceptional resilience has enabled many Aboriginal people to survive and be shielded against the devastating effects of colonisation and intergenerational trauma.

Social support Coping in the form of social support is via bonded and bridging support. Bonded relationships are between intimate associates who are often from homogenous backgrounds; and bridging relationships are between less intimate associates usually from heterogeneous backgrounds. Both bonded and bridging relationships contribute to a well-developed social network (Gottleib & Bergen, 2010).

Research on social support within an urban Aboriginal community in Perth has reaffirmed the importance of bonded relationships which provide many protective resources for wellbeing and positive health outcomes (Waterworth, Rosenberg, Braham, Pescud, & Dimmock, 2014). Furthermore, bonded relationships similar to kinship relationships promote connectedness, identity, and a sense of belonging and empowerment (Waterworth, Pescud, Braham, Dimmock, & Rosenberg, 2015). However, in some circumstances, bonded relationships can have a negative effect and be psychologically stressful. For example, Aboriginal people can withdraw from bonded connections to protect themselves and immediate family, as the influences of extended family members and obligations can cause them physical or emotional harm. This withdrawal can contribute to fragmented kinship affiliations, isolation and reduced opportunity to develop new bonded relationships. Bridging relationships with non-Aboriginal people can also have positive effects, particularly if the interactions are with non-Aboriginal representatives from organisations that provide support, encouragement and information. Bridging contact with non-Aboriginal members are deemed less important within the Aboriginal community and rarely incorporated due to exposure to cultural distinctiveness,

discrimination and racism, which may prevent Aboriginal people from accessing this type of social support (Waterworth et al., 2014, 2015).

Lumby (2010) indicates that another form of support is social networking on Facebook. Facebook is becoming a popular vehicle amongst urban Indigenous young people in order to build, display and perform Indigenous identities. Facebook acts as a modern site for kinship activity of continuity connectedness and cultural belonging (Montgomery 2014). Facebook provides a means for both confirming Indigeneity by embracing some users but at the same time, denying Indigeneity by imposing penalties on others for 'faking' or being perceived as 'faking' (Lumby, 2010). Thus Facebook can be a tool of scrutiny and surveillance and can also be a platform for racial vilification external to communities (i.e., racism), and abusive and hateful messages from within (i.e. LV) Indigenous communities (Montgomery, 2014).

Therapeutic interventions and counselling In order to cope and heal, Aboriginal people may seek counselling and therapy for a variety of SEWB issues with the five most common during the 2012 to 2014 period being: depression, anxiety and stress, grief and loss, family or relationship problems, and family and community violence (AIHW, 2015). Various types of therapies and techniques are utilised to engage Aboriginal people in counselling. Some recommended therapies include: narrative therapy which enables a process of storytelling (Fredericks, 2006); an adapted form of cognitive behaviour therapy (CBT) (Bennett-Levy et al., 2014) where its suitability is still being reviewed and monitored (Dudgeon & Kelly, 2014); art therapy (Cameron, 2010); and Aboriginal traditional healing. In a Western Australian context traditional healers work with the ngarlu (spiritual life force located in the stomach) (Roe, 2010). In a South Australian context, traditional healers (Ngangkaris) provide similar healing in remote, rural and urban areas (in Adelaide) via a "two way"

health care model (with Ngangkari and the health professional) (Panzironi, 2013).

Other national examples of healing and educational initiatives by Aboriginal and Torres Strait Islander people include: the *We-Al-Li* program (Atkinson, 2012) to heal trauma; the *Seven Phases to Healing* targeting grief and loss, anger and violence (Wanganeen, 2014); Aboriginal men's healing such as *Red Dust* (Powell, Ross, Kickett, & Donnelly, 2014) and *Mibbinbah Spirit* (Bulman & Hayes, 2011) to address issues of racism, trans-generational trauma, and loss of culture and identity; and Women's healing initiatives include Aboriginal family violence programs that aim to safeguard, empower and to heal such as the *Nunga Mi:Minar* service in SA (Snell, 2009).

There is a lack of specific and tailored resources for Aboriginal people's healing, and often reliance on mainstream health and mental health services which fail to understand and address many Aboriginal healing issues. Aboriginal people have continually identified that what they need and want in order to heal themselves and their communities are preventative and holistic healing processes that promote strong, resilient communities focusing on restoring SEWB (Dudgeon et al., 2014). The success of therapeutic services also depends on cultural competency, cultural safety and relationship building. Cultural safety means that services must be culturally sanctioned so that everyone has the right to feel good about themselves and their identities (Frankland, Lewis, &Trotter, 2010).

Policy and Legislative Solutions
Lateral violence as a concept does not appear to have legal standing. However, bullying, which is considered part of LV, has a number of avenues for complaints and redress under various legislations and laws. The creation of the *Fair Work (FW) Anti Bullying* jurisdiction, for example, provides readily accessible external intervention into workplace bullying without applicants having to exhaust internal organisational processes. However, defining and stopping bullying, whether in law, policy or research

remains a challenge despite good intentions (Worth & Squelch, 2015). Online bullying and cyber-safety is a growing concern, particularly for young people. For example, the most common form of communication between youth aged over 13 is social media. And around half of all youth between 8-11 years access and use some form of social media (Radoll, 2014). Now under the *Enhancing Online Safety Act, 2015,* the Children's e-Safety Commissioner was established as a complaints system for cyberbullying targeted at children and can direct large social media companies to remove offensive material (Young et al., 2016).

The Current Study

Lateral violence has been an under researched area within the Aboriginal context in Australia. Although there is increasing information and research on related concepts, such as racism, trauma, violence, family violence and SEWB, very few Indigenous people have been consulted about LV. Thus, this study aims to provide a voice about LV from local Aboriginal community members in Adelaide. Lateral violence may fit within the holistic healing and wellbeing framework for Aboriginal people, as it is a source of significant stress and can be destructive to one's identity and wellbeing. Therefore it is important to identify ways of dealing and coping with LV in order for Aboriginal people to gain a better understanding, be empowered and protect themselves from further distress.

Research Approach

Indigenous Framework

This research is informed by an overarching Indigenous framework which advocates for cultural safety, respect, relevance and Indigenous world views (Rigney, 2001). An Indigenous methodology also considers Indigenous people's ontology; epistemologies; axiology (Smith, 2003); diversity; relationality and connectedness; and acknowledging Indigeneity (of participants and authors and the principle researcher) (Wilson, 2008). Moreover, an "insider" approach based on acknowledgement and experiences of

Indigeneity will be used in interpretations and analysis. At the same time "outsider" input via supervisory and collegial support is vital and will assist in further rigor.

Method

Participants

Thirty Aboriginal participants consented to take part in the study. Inclusion criteria were identification as Aboriginal and/ or Torres Strait Islander, 18+ years of age, and residing in Adelaide. The majority of participants were female (63%). Ages ranged from early 20s to mid-60s with about 13% in the younger age bracket (30 years and under) and 10% in their late 50s to mid-60s. Furthermore, almost half (47%) of the participants in the study had a university level education.

Procedure and analysis.

Ethical approval for the research was gained by both the Aboriginal Health Research Ethics Committee and the University of Adelaide Human Research Ethics Committee. A recruitment flyer, with an invitation to "chat" about LV, was disseminated via various email networks with a request to circulate further. An information sheet was then distributed to interested people which provided background details of the researchers, the research, rights, responsibilities, risks, and incentives (i.e. $,50 gift voucher). Prior to the interviews, brief demographic information, such as gender, age and educational background, was collated. Information was provided about counselling services with assurance of support upon any distress.

The interviews included broad questions such as: "Have you heard about LV?", "What do you know/understand about LV?", "Can you tell me about some of your experiences of LV?"; "How has it affected you?", "What have you done to stop or curb LV in the past?"; and "What would you like to see happen to make changes in the community?" The interviews ranged from 15 minutes to an hour, and were tape-recorded and transcribed verbatim. All participants were asked if they wanted to view the transcripts prior to analysis and

only one participant requested to do so. The transcripts were then de-identified and pseudonyms were assigned to all names mentioned in transcripts to maintain anonymity and confidentiality of participants. The data were coded using NVivo10 qualitative software and analysed using a thematic approach (Braun & Clarke, 2013).

Findings

Overview

Many participants were aware of LV before the interviews and reflected on a range of strategies to cope and prevent LV at both individual and community level from both Western and collectivist perspectives. A common value was strength in unity. This is not surprising, as LV is a segregating phenomenon that can isolate individuals, families and groups from each other.

Education

The most prevalent strategy discussed by participants was education and raising awareness. The participants learned about LV both formally and informally through training, workshops, work colleagues, the internet and research papers. Participants were eager to build on their knowledge of LV as well as to ensure others understood the damaging effects of LV.

Formal training Participants indicated that formal training, in the form of educational workshops can assist people to better understand LV, its effects on individuals, families and communities, and to work towards strategies for prevention. The extracts below exemplify the need for LV training.

> *Lila (age category 56-60): I think the lateral violence training that we did has helped me understand it more. [If]I see somebody who behaves really badly, well that's lateral violence. I see somebody else and I say that's jealousy. I see somebody else and that's incompetence. I can now separate it. That lateral violence training we did...it really did make a difference to a lot of people who came to the training. People talk*

> *about lateral violence more often than not…I have a lot of respect for the lateral violence training. It was like a breath of fresh air that came in. It's a way we can make changes' cos if we don't work together we are never gonna improve. No matter what amount of funds they give us, no matter what fantastic technology they give an Aboriginal organisation, no matter… if we don't work together we are never gonna make the changes… People were talking to communities and they were saying we need to do it [LV training] here... I was just sad that it just wasn't ongoing. I know you didn't have the money and stuff.*
> *Rose (age category 41-45): It would be good to learn a bit more about lateral violence… If you ever run a lateral violence workshop let me know, I will love to go.*

These narratives identify that formal training is a feasible option for better understanding LV. Reference was made to the "Preventing Lateral Violence" PLV workshops (Clark, Glover & Butler, 2015) which Lila had previously attended and Rose had heard about and was keen to attend. The workshop helped Lila distinguish LV behaviours from others, enabled conversations and better unity within the workplace. Both the narratives reiterate the need for workshops within the community as an education tool. Other workshops on LV appear to be increasing around Australia (see for example Koorreen Enterprises, 2015; Korner Winmil Yunti, 2016; Ryan, 2015) which appears to be a reflection of workshop necessity.

Understanding and awareness It would seem that once participants understood LV, it enabled a process of self-awareness of values, behaviours and roles for preventing LV within the community. The narratives below exemplify this process.

> *Eve (age category 31-35): I think we are all probably a little bit guilty of being perpetrators and exacerbating that [LV], but for me personally I think with the name of it actually*

created an awareness … of my own actions, how I may talk about people, how I might even think about my community. So for me it really created a self-awareness, which I think you've got to have that before you can create community or any other sort of awareness…taking responsibility for our actions..

Kelly (age category 41-45): Accept people for who they are, really, I think, they should really look at themselves inside, you know and really look at their values and… you know, what do they believe in and, you know… they say they like to be respected and this is how they like to be treated themselves, but if you've got a connection it can be really hard…it prevents you from moving ahead… Own it…and you know, if you own it, then…it needs to be clearly defined what it is and why you're doing it. Why are you doing it?

Both Eve and Kelly indicated the importance of critical reflection of one's values, thoughts, beliefs, actions and accountability. For Eve this assists her to "create community" and for Kelly reflection meant that one can "move ahead" and "own it". Thus these participants hypothesised that such reflection allowed self-awareness, ownership of one's actions, and improved community connections that assisted with fair treatment and respect amongst community.

This process begins with awareness and naming LV (Clark & Augoustinos, 2015) through education, which can set in motion a process of self-reflection about ones' own experiences and responsibility in acknowledging LV and accountability. This realisation process begins at the individual level to accommodate the collective community level. This is supported in the literature that indicates that individual change leads to community change (i.e. Dudgeon et al., 2014).

A LV campaign Participants realised

that education for the broader Aboriginal community and general population was needed to drive the message about prevention of LV as shown in the extracts below.

Russell (age category 36-40): I think the media and NITV…maybe do a commercial but …it has to be hard hitting, like see some of these drunk [sic] driving commercials…People need to understand what could come of lateral violence like suicide and all these other things… It needs to be put in their face. There needs to be some kind of shock value, shock education. Because if we sugar coat things people aren't going to, it's not gonna sink in. You need something that they'll talk about in the community. "Oh, did you see that commercial?" or "Did you see that show on this and what happened."

Rachel (age category 31-35): I can see a campaign, it would be great but I can see little kids saying, "Oh I'm naming it now' cos there's a name to it"…Yeah need someone to get out and do a lot more workshops around it in community…I'd love to see more like a stall at NAIDOC and Reconciliation Week and stuff like lateral love, lateral violence, learn, something like that. You know that Quit Smoking campaign and all that, it would be good to see. I know it costs a lot of money but it's so good for community and not just Aboriginal workers but Aboriginal community young, old, talking about lateral violence "Let's stop it!"….Yeah and have posters of local Aboriginal mob, it's got to be credible, it's hard' cos we've all had our frustrations where we will all have fights with our family and that and you don't want someone going "Oh hypocrite!"

Both Russell and Rachel supported a visual educational campaign including television, film, posters and visual displays at community events. They acknowledged the

success of other campaigns on sensitive topics. Rachel, in particular, stressed the importance that the campaign be credible and foster community participation and ownership, be culturally safe and model respectful practices.

Targeted LV education Participants suggested that LV needs to be targeted to both the Aboriginal and non-Aboriginal communities. However, the future of Aboriginal communities lies with the next generation and therefore a focus on prevention and unity needs to start with young Aboriginal people, as suggested in the extracts below.

> *Eve (age category 31-35): I think it would be very hard for a non-Aboriginal person managing Aboriginal people in a team to sit down and name that [LV]. I guess it has to be promoted and talked about and spread about within the Aboriginal community, but I think you need non-Aboriginal people … be aware of this because also it would stop non- Aboriginal people from perpetrating lateral violence as well, and you know they could do it quite innocently or non-intentionally, but that can happen …*

> *Maggie (age category 46-50): … How do Aboriginal people do that [pull themselves up]…Because the next generation shouldn't have to wear lateral violence and shame… You know but now they've got a whole new ball game...they've got technology…Facebook and through the mobile phone.*

> *Russell (age category 36-40): It needs to start with the young, 'cos they need to educate their parents. That's kind of ironic. It's supposed to be the other way around, but the young ones need to go back into their community and educate their parents…*

In these extracts Eve highlights the value of LV education for both Aboriginal and non-Aboriginal people, especially in the workplace where non-Aboriginal colleagues and supervisors can inadvertently become involved or perpetrate LV. Both Maggie and Russell have concerns about the normalisation of the younger members of the Aboriginal community embracing LV. Thus participants highlighted the importance of LV education for all people, Aboriginal and non-Aboriginal, young and old, in the workplace and the community as well as in schools (as identified in other extracts).

Facebook and the mobile phone were mentioned by Maggie, and it was a concern in many of the extracts given its utilisation by young people (Radoll, 2014) and can be an avenue for both affirming and questioning authenticity of Aboriginal identity (Lumby, 2010). The literature indicates that practices of non-affirming identity can affect a young person's self-esteem and contribute to adjustment problems (Phinney & Chavira, 1992). Hence, by targeting education towards the young, the intergenerational cycle of trauma and violence can be prevented and in turn, an avenue for accountability for parents to stop modelling LV for their children.

Support

Four types of support were recognised by participants as central to coping for LV: social and family; workplace; legal; and counselling support. Such support can assist to promote unity and work together towards common goals within Aboriginal communities.

Family and social support Support from family and community was salient, even though it can also be the most likely place where LV occurs. The extracts below indicate the importance participants place on support within families and communities in response to LV.

> *Peter (age category 26-30): Um try and support each other. I mean like if someone's got a problem, try and help them out in the community and try not make it harder for them so they think about, you know, these people and their families as well… Um maybe try to explain to them the importance of sticking together.*

There's a lot of bigger problems out there.

Russell (age category 36-40): And I feel that by then putting lateral violence on their siblings of all people they should be supporting… And I tell them that. They should be supporting each other… Not running each other down.

The participants alluded to the desire for family and community support consistent with the literature that indicates that bonded (kinship) support is more common than bridging support within the Aboriginal community (see Waterworth et al., 2014). Peter reiterated the need to "stick together" for support as the absent but implicit message is that the community is divisive. Russell indicated support rather than "running each other down". Being put down and division are two aspects of LV, and thus family and community support is vital to alleviate problems and strive for improved outcomes.

Workplace support Many participants worked within an Aboriginal organisation or service where LV was an issue and discussions about workplace support featured prominently in interviews. The two extracts below exemplify the importance of workplace support for improved outcomes.

Beau (age category 36-40): I mean personally here we're pretty supportive of one another and I think we stand sort of united and I think should be within reason without…Yeah we all stick up and support one another and we can debrief.

Kelly (age category 41-45): What makes it work here is that everyone talks about it, you know, if they notice something they are on [to] it pretty quick and its open and … [Non-Aboriginal] manager is really good with support in that way… And she's really at the forefront with supporting Aboriginal workers here...it's really good. And we have our own set

groups and its specific for us to do, to work with the community … clients that we work [with] here...it's flexible but you can sort of like feel confident in working...

These extracts exemplified positive support within the workplace. Beau reiterates that when there is support there is unity amongst colleagues. Kelly indicates that an open and communicative environment with the support from a non-Aboriginal supervisor helped with unity, confidence and service provision. Thus these findings show that a supportive working environment is necessary and can utilise both bonded and bridging support (see Waterworth et al., 2014, 2015).

Legal support Many participants advocated for legal support avenues which could be via legislation, workplace policy or guidelines pivotal for combating LV in the workplace.

Eve (age category 31-35): … so I mean there probably has to be some guidelines around I don't know…I think it would be good to have some guidelines around [lateral violence in] workplaces.

Brett (age category 51-55): …You know, where I give the example of how the young girl was treating her mother [perpetrating LV]. Even legislate against it as well…really it becomes a bit of a criminal offence.

Beau (age category 36-40): To me, we've just sort of gone through as an organisation, gone through a lot of our policies and still are continuing as part of our …quality improvement stuff in making them more user friendly… So it's pretty clear….approaching managers and following their bullying and harassment policy and stuff, so…

All three participants reiterated the need for legal avenues for LV. For example, Beau indicated that his workplace has recently undergone a review of many policies and procedures for clarity. There ought to be potential avenues within a

workplace for policy development, guidelines and codes of conduct to enable people to feel culturally safe and not be oppressed by the system, supervisors or other Aboriginal colleagues. Franklin et al. (2009) advocates for the alignment of cultural safety processes with workplace policy and practice.

It seems that LV education needs to be inclusive of information on legal support, such as the FW anti-bullying jurisdiction, and through the children's e-safety commissioner for cyberbullying. Yet it is difficult to know how many Aboriginal people will use these external sources and as discussed in the literature Mellor (2004) indicated that participants in his study felt that regulatory or legislative bodies were ineffective.

Counselling support Many participants indicated that support from a culturally responsive counsellor or psychologist was important to alleviate distress associated with LV.

> *Kelly (age category 41-45): ...I have experienced lateral violence...you need to have someone you can talk with and someone that will listen, someone that understands it, so you know, like you're not having to explain about it ... someone, you know, you go in there to their professional help to...that they can understand what you're saying and how you experience, and if they have no concept of what you're saying and you've got to explain it to them, you're hitting a wall... and they need to understand the cultural...and they need to be sensitive about that, and [if] they don't have it... They're only going by textbook...They haven't lived it, they haven't breathed it, and they... don't understand it, and so, how can they really call themselves a counsellor if they're not appropriate for what you're saying?*

> *Paul (age category 41-45): I got two actually; I got a psychologist through mental health... Now I get*

psychologists and getting it out. Dreaming about it. I saw people get shot but I was 19 years' old when I saw them die but it seemed real, like it just happened... Counselling but not everyone will want to do that or even if it's available. If you can't do all that, go out for a nice walk or fish, have a good breather...

Kelly highlighted the importance of cultural competence for counsellors. Paul's counselling was via an Aboriginal community controlled service which presumably includes cultural aspects. Without cultural competency and appropriate practices, counselling may be of little value to Aboriginal people. Many Aboriginal people in Adelaide pursue counselling services in the Aboriginal primary health care sector (AIHW, 2015). Within Aboriginal services, traditional healers (Ngangkari) may also be accessed. However, the scope of this article does not allow for a report on other counselling options utilised by Aboriginal people in Adelaide such as private, government or Employer Assistance Programs (EAP).

Avoidance of Aboriginal spaces

According to many participants avoiding or disengaging with family, community or Aboriginal workplaces was a common strategy in dealing with the effects of LV.

> *Belle (age category 31-35): Yeah, I don't want to be around black fellas because they're all like this and .... But yeah, I'm very strong about that sort of stuff. I mean it's easy to get like that when you've just really been slapped in the face by your own people so I can understand that. They're probably just venting, but that's really sad to me when they're like that.... Whilst I totally understood what they were saying and where they kept coming from, but I just thought I don't want it to be like that. You should be able to be proud and you shouldn't have to say that everyone's like that and you don't want to be around your own people*

or your own family.

Russell (age category 36-40): I've removed myself from family that sit around the kitchen table and gossip about people... it's about removing myself from the mob and being surrounded by good people.

Leanne (age category 51-55): ...My uncle always told me "never work for a nunga [Aboriginal] organisation Leanne". I said I will just try and keep on hearing that all over the years. I thought I would just try this job anyway then about three months ago it all started happening. God I should have listened to him. I am thinking it's good being up there but you have to treat people how you expect to be treated yourself. It would be a happy place if we all work together. I don't like [it] when people don't work together, especially nungas [Aboriginal people]. All want the same outcome.

These examples illustrate the active avoidance of people and places such as family, community and Aboriginal organisations. These extracts reveal that Belle avoids other Aboriginal community people in order to cope with LV as excessive contact might mean taking on others' detrimental behaviours. Russell has disengaged with family when they perpetrate LV and tries to engage with positive people. Leanne was warned by her uncle and others to avoid working in Aboriginal organisations because of LV, even though she enjoys working in an Aboriginal service. The literature indicates that LV is an issue within some Aboriginal organisations contributing to its demise (Office of the Registrar of Indigenous Corporations, 2010). This aligns also with research in Perth, whereby some participants removed or disengaged themselves from community in order to protect themselves. This consequently fragmented relationships, isolating people (Waterworth et al., 2014, 2015).

Become proud and strong in identity and culture

Cultural maintenance, connections and identity for participants appeared essential and this was linked to empowerment and pride as can be perceived from the extracts below.

Beau (age category 36-40): ...My mum was Aboriginal and sadly not with us anymore but my father, he was Swedish, so anyhow growing up with mum she struggled with alcoholism but she was still very passionate about her people and that we should stand up for our rights and be counted and all this type of stuff, so even though I was sort of unhappy with how I grew up around alcohol, violence, drugs and stuff like that I still absorbed her passion around Aboriginal rights, so from that like I still draw on that to this day to inspire [me] ...

Dianne (age category 26-30): I guess my real cling to my culture, it probably stems from, I lost my grandmother in 2008, and she was the one who I got all the culture from, and everyone went to her house, and she was sort of the matriarch of the family. So, I always looked up to her and if I had any questions, or if I was confused, or...I'd sit down and listen to her stories. And then she passed away, so I was kind of a bit lost for a little bit, and...I guess my strength comes from her, because I know that she would want me to be strong. So, I try and be true to her, and what she taught me, and try and use her strength...because she was a very strong Aboriginal woman, and I would be lucky to be like her. So, I guess that's my push...I want to be a strong Aboriginal woman, and I want to give young girls someone to look up to, too. So, I want to be strong like my grandmother, and then when my kids come along, I want them to be able to be like me.

Both Beau and Dianne drew cultural strength and inspiration from their Aboriginal ancestry in order to maintain Aboriginal identity while at the same time acknowledging other non-Aboriginal ancestry. Beau "absorbed" his mother's passion and recognised her importance despite her struggles with alcohol. Dianne accessed her culture and strength from her matriarchal grandmother and wants to continue her legacy by passing on culture and strength to the younger generation. Cultural maintenance and reclamation are extremely important to ensure this legacy continues for Aboriginal people as custodians for future generations (see Amery, 2016). When culture becomes lost or fragmented there can be feelings of grief and loss; but on the flip side there can be pride in what is retained and reclaimed, no matter how big or small. The literature indicates the important protective factors of cultural and ancestral renewal (see Kelly et al., 2009).

Role models and champions

Participants also referred to role models and or champions of the cause to assist in preventing LV within the Aboriginal community. These are highlighted in the extracts below.

Eve (age category 31-35): ...when we think about lateral violence I think the work that Brian Butler is doing is fantastic... Like I see his posts that he will put up on Facebook ...loving words...there is always encouragement for our communities, but I think what's the next step...and with him being an elder who's going to be following in his footsteps; who's the next young champion... So for me a lot of the time we do need champions...whether it be wearing the t-shirts; flying the flag; whether someone is going to be vocal...getting the people out there who...I believe we have got such an untapped workforce. We have got many talented Aboriginal people who aren't working for whatever reasons but for them to be able to volunteer, to be in a paid position, to want to

have the kitchen table discussions, to want to have the backyard discussions and let's talk about this and then formalise it...however, that happens in a way that other people can pick it up and go you know this is really great stuff that's happening.

Rachel (age category 31-35): ...But we've got to role model all the elders and people my age and that too, got to role model it for our kids and nieces and nephews and stuff and each other.

Many participants identified Brian Butler[2] as a strong formal advocate for LV and in attempting to improve relations within the community by advocating for love rather than destruction. Eve was particularly concerned about who would step up, speak out and become champions when particular elders no longer do it. Rachel indicated the importance of role modelling positive behaviours and relationships to direct the younger ones in the Aboriginal community to prevent LV. Both formal and informal avenues are needed, which included public forums as well as backyard discussions and role modelling. When there are controversial or sensitive topics, such as LV within the Aboriginal community, silence can maintain the status quo. Yet there are always champions that will speak out regardless of a silent veil, even if it contributes to further stress and unwelcome attention. Gorringe et al. (2009) highlight those who break the silence to speak out against sensitive issues face reprisals.

Challenging lateral violence

Participants indicated that challenging LV was one way to curb it. Challenging behaviours were described in a context of respect rather than confrontation.

Leanne (age category 51-55): Yeah 'cos there are two people in this organisation that use it [LV] a lot. I have pulled one of them up and don't expect to be spoken to like that. I actually put in a report to the manager three times. The first time I went to him and he said maybe she

was having a bad day and I said it doesn't matter. I don't expect to be spoken to like that…It can make you out to be a bitch… I can't help it. I was a mouse right through. But I am an adult now and in my 50s and if I don't like something I will say it and say it nicely. They don't like the boat being rocked, if I don't like something according to my J&P, because my old manager said to use your J&P. I carry it around with me wherever I go and always reflect on it. As well as the work plan. I have a lot of tools to back me up.

Beau (age category 36-40): …there's no greater feeling... when you can put someone back in their spot without sort of bullying them or being really nasty, but with statistical evidence to go well actually did you know that blah, blah, blah...they're quiet.

Rose (age category 41-45): This day I came in and a work colleague said "I have to tell you something. Something happened and I addressed it. …They were talking about you. That's right you are friends with Rose"… She said "Stop I don't want to hear this rah rah rah." Which is good on my part that she shut those people down and she said, "It was inappropriate and you shouldn't be saying that about such and such [Rose]."

In these extracts Leanne asserts her rights when disrespected and uses education by showing her J&P[3]. She has reclaimed her power given that she was previously silent (i.e., "mouse"). However when she challenges others, she is consequently met with reprisals and can be labelled a "bitch". Beau finds a way to challenge people ("put someone back in their spot") by presenting factual information rather than retaliating. Rose gave an example of collegial support from others who defamed her. Challenging is a problem solving skill that is positively evaluated as functional within individualistic societies (Yeh et al., 2006). In this case it is difficult to determine the level of

functionality in relation to other coping skills presented by participants. Challenging was rarely discussed, but it appears to have empowered participants to assert their rights.

Turning a negative into a positive

There were a number of participants who turned a negative into a positive. In other words they reframed negative information into positive information in order to lessen its impact. The narratives below exemplify this positive reinterpretation.

Ralph (age category 31-35): And I've learned stinking thinking and stuff like that …. Like when you're gonna think negative and that you're gonna do negative things… But now I um just take a negative and turn it into a positive. A lot of people want you to fail but you've just gotta, you've gotta keep soldiering on. You know in yourself that you're doing the right thing, especially in the Aboriginal community all over Australia.

Russell (age category 36-40): …I've had blatant lateral violence and there's been times where I just go with it. 'Cos I know that will annoy them more…And if they say something, I just say, "Yeah. Why are you stating the obvious?" That's even lateral violence to myself to a certain degree. Like when somebody says, like, calls you a name [word deleted] … And I said, "Yeah, thanks for stating the obvious, like, as in a smart ass way…You know? They expect for me to get all defensive and blah, blah, blah and I always found that if I go with it, it actually annoys them more and then they're more inclined to pull back. I did it a lot in school. [It is used to] …take the power out of the words…So the power, we're turning that word from a negative into a positive.

In the examples, Ralph relies on "stinking thinking" methods to guide aspects in his life. When people have negatively evaluated Ralph he reinterprets their efforts

into the positive, which helps him to keep "soldiering on". Russell gets called derogatory names and takes "the power out of the words" when he turns the information back on the perpetrators rather than reacting negatively. Positive reinterpretation is a cognitive process and described as one of the major coping skills in the general literature as well as a method used to protect oneself against racism (see Mellor 2004).

Discussion

Overview

This article has drawn on participants' resilience, strengths and abilities to cope and strategise to prevent LV. Education and awareness was empowering and a key strategy and was initiated by self-reflection and understanding the role one plays in sustaining or preventing LV. This self-understanding enabled participants to take responsibility for making changes in their lives. This is indicative of collective cultures where individuals change the self to protect the group or community. It also suggests the bonded and caring nature of Aboriginal people to want to ensure that Aboriginal people unite and heal as a group.

Social support via bonding and bridging modes were reported by participants, with bonding support being more prominent in their daily lives. This support assisted in sustaining culture, identity and unity, which are all important for wellbeing. However, there were instances of stress and LV, which meant participants needed to protect themselves. They often did this by disengaging in various ways. Examples included not working in Aboriginal organisations, staying home, and deliberately staying away from the influences of other Aboriginal people. This appeared to be functional to protect the self and community from further disharmony, or as a form of resilience which propels one to seek out alternative and positive support from like-minded people (both Aboriginal and non-Aboriginal). Yet disengagement or avoidance may be a dilemma because if Aboriginal people disengage from community and culture their ability to maintain and pass on culture may be compromised.

Disengagement could inadvertently add to LV, particularly for the younger generation, where affirmation of identity is important and tested on a regular basis. Disengagement in the workplace could also be a dilemma where Aboriginal recruitment, particularly in Aboriginal services, is needed to ensure appropriate cultural service responses to the community.

Instead of disengagement some participants ensured they were culturally grounded and took inspiration from elders, ancestors, within the family and role models from within the community for empowerment. Aboriginal people have different means to access culture depending on their circumstance. For example, many Aboriginal people were removed from culture and family through policies, and therefore access may be different to those who grew up with family and community. Furthermore there are many instances of language and cultural reclamation of individuals, families and groups to increase identity and pride.

Other ways of coping include standing up against LV. This is done at various levels – as a leader, elder, champion of the cause, a positive role model, or individually to challenge LV in daily life. Challenging is aligned with problem solving and seen as functional from an individualistic standpoint as participants felt empowered by this process. A final way to cope and lessen the impact of LV was to reinterpret a negative into a positive, that is, "take the power" out of the words. This appears a helpful cognitive process, which is about changing the self to fit the environment, which is useful for collective societies.

Participants in this study displayed a range of skills conversant with both individualistic and collective coping styles. Many of their coping strategies appeared to correspond with Indigenous research on racism (Mellor, 2004) in order to protect the self, educate others and assist the younger generation to cope. This is not surprising, given that LV is so divisive and damaging to wellbeing, as is racism. Thus the protective factors in this study serve as tools that

empower and assist in LV prevention. This broader education can ensure participants' positive legacy can spread throughout the community.

Implications for health policy intervention and further research

There are many implications from his broad-based research which constituted a first attempt to have in-depth dialogue with some of the Aboriginal community in Adelaide who were primarily female, in the mid-age bracket (41-50 years) and well educated. Firstly, it needs to be recognised and respected that Aboriginal participants volunteered to educate the broader population about LV. As part of the overall study these participants have assisted in endorsing the label of LV (Clark & Augoustinos, 2015), and in setting LV in a broader and holistic healing framework along with racism, trauma and wellbeing (Clark et al., 2016). Participants have now revealed their coping skills, ideas and strategies which are part of healing and as an enabler to empower others. The message about LV has been proliferating slowly within communities (Clark & Augoustinos, 2015); however a broad educational process has not been undertaken in many parts of Australia. The participants advocated for a broader educational campaign with resource materials and educational and healing workshops to nurture the strengths within. Perhaps further research, exploration, replication is needed and further documented discussion on the topic of LV could serve to encourage conversations, attract resources, and empower Aboriginal people to develop additional resources to contribute to the prevention of LV within their families, workplace and the community.

There are currently laws, policies and processes for complaints and restitution for bullying for both adults and children. However, protection from LV as a whole concept is lacking. It appears that many organisations and government departments have policies, procedures and strategic frameworks but lack cultural frameworks. In the workplace, in particular, LV prevention could be included within a cultural safety or respect framework Franklin et al. (2010) suggest organisational realignment of current policies and processes with a cultural safety framework in order to ensure resilience, empowerment, and greater wellbeing for Aboriginal people. Such a framework would also rekindle Aboriginal values of cultural renewal, and sanction cultural competency training for non-Aboriginal staff. Thus, in the workplace, guidelines and processes aligned with cultural safety that include an understanding of and mechanisms for prevention of LV can ensure unity, resilience and wellbeing, which in turn can greatly add to an increased service to the community.

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Notes
[1]The term 'Aboriginal' is used as the research is about Aboriginal people in Adelaide. This will be interchanged with the word 'Indigenous' when quoted and at a national or international level.

[2]William Brian Butler and Nicola Butler are the individuals behind the Lateral Love and Spirit of Care for all Humankind 2012-2022 process. See https://laterallloveaustralia.com/

[3] A J&P is the Job and Person Specification which is a description of the duties, qualifications, skills, experiences, knowledge and other attributes which a person must possess to perform the job.

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Specific Formatting Requirements
Language
All manuscripts must be in English. Australian English is preferred.

Paper Size, Margins, Alignment
A4 page, ALL margins 2.5cm, all text left aligned (not justified) unless otherwise specified.

Spacing
All text must be double-spaced and left aligned (not justified) unless otherwise specified.

Font & Size
Times New Roman, 12pt unless otherwise specified.

Paper Title
14pt, bold, centred, sentence case.

Abstract and Keywords
The heading Abstract should be centred and in italics.
The text should be left aligned.
Place one blank line after the abstract.
The abstract must be no more than 200 words.
Place up to 6 (six) keywords.

Normal Text
12pt, Times New Roman double line-spacing, left aligned (not justified)
Do not leave line spaces between paragraphs but indent the first line of each paragraph.

Long Quotes (roughly, quotes of 30 words or more):
Indented 1 cm left and right

1st Level Heading
Main words capitalised, bold, centred, not italics.

1st Level of Subheading
Italics, main words capitalised, left aligned. Do not number headings or subheadings.

2nd Level of Subheading
Italics, sentence case, left aligned. Text should continue on the same line.

Tables, Figures, and Diagrams
Captions should be typed above tables and below figures. These should be black and white and inserted in the correct place within the body of the text. Do not allow a figure or table to be split over two pages or to be separated from its label or caption.

Diagrams, illustrations, graphs, and so on, must be 'screen readable'. This means fully legible and readable on screen when displayed at widths that ideally do not exceed about 750 pixels and certainly should not exceed 1000 pixels.

Page Numbers
Insert page numbers at the top of the page, right aligned, beginning with the title page.

Footnotes
Avoid using footnotes. If used, please number them sequentially.
References
Use the reference style of the Publication Manual of the American Psychological Association (6th ed.). List references under the 1st level heading.

Example journal article:
Fryer, D., & Laing, A. (2008). Community psychologies: What are they? What could they be? Why does it matter? A critical community psychology approach. *The*

Australian Community Psychologist, 20
(2), 7-15.

Example book:
Montero, M., & Sonn, C. C. (2010).
    Psychology of liberation: Theory and
    applications. New York: Springer.

Example book chapter:
Fielder, J., Roberts, J., & Abdullah, J. (2000).
    Research with Indigenous communities.
    In P. Dudgeon, D. Garvey & H. Pickett
    (Eds.), *Working with Indigenous*
    Australians: A handbook for
    psychologists (pp. 349-356). Perth,
    Australia: Gunada Press.

Example electronic source:
Cummins, R. A., Hughes, J., Tomyn, A.,
    Gibson, A., Woerner, J., & Lai, L.
    (2007). *The wellbeing of Australians –*
    Carer health and wellbeing. Melbourne,
    Australia: Australian Centre on Quality
    of Life, Deakin University. Accessed 27th
    September 2011 from http://
    www.deakin.edu.au/research/acqol/
    auwbi/survey-reports/survey-017-1-
    report.pdf

The Australian Community Psychologist