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The papers presented here came from two symposia held at the 1992 Australian Psychological Society's Armidale conference, with the exception of Meg Smith's paper which she was unable to deliver. The theme of the conference was to indicate the "specialist-generalist" nature of community psychology. These papers certainly have diversity in common, if nothing else.

The fourth biennial joint community psychology conference organised by the APsS Board of Community Psychologists and the New Zealand Division of Community Psychology and Applied Social Psychology was held at Rotarua last year. The Conference organisers were David Thomas and Linda .... The venue was Apumoana, a Maori marae. The conference was not organised on traditional lines, but was more in keeping with a sixties happening. While there was a schedule of events, these revolved around experiencing maori culture.

There were many highlights. Probably the most impressive cultural learning experience was a Maori school concert. While the outing had been planned as a recreational event, we stumbled into a most impressive display. The concert was a re-run of the final inter-school competition of Maori dance. There is a great resurgence of Maori identity and these competitions are extremely competitive. For the naive onlooker, they are also extremely sophisticated.

Another highlight (or low-light, depending upon your perspective) was an exercise on discrimination. The participants were asked to work in small groups to list the aspects of oppression of racial minorities. After this, each group was asked to get a bedsheat from the marae. One of the maori women participants volunteered to sit in the middle of the group. A representative from each small group was than asked to lay a sheet on the woman to symbolise how maoris are oppressed. In doing so, the representative had to state what aspect of oppression the sheet symbolised. The impact of this process was devastating for all involved. The process indicated the enormity of oppression. All of us felt that we were powerless to intervene in any way. While there were feeble attempts to address oppression, the exercise left an indelible impression (and some scars) of what it must be like for those who are experiencing discrimination.
This year Art Veno is organising a community psychological workshop as a satellite to the Gold Coast APsS conference. The workshop will run from the 2nd of October until the 6th. The theme of the workshop is "community empowerment and enablement". The main issues revolve around reconciliation between White and Black Australians. The workshop includes a one and a half day train trip to Cairns, with keynote speakers and other information exchange, two days in the Yarrabah Aboriginal settlement, with a period of reflection in Cairns. I expect that this should be as successful as previous workshops, such as those at Roturua and Marralinga.

More information can be obtained from the conference organisers who are:

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COMMUNITY DEVELOPMENT AND SELF HELP GROUPS FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

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Community psychology has its roots in the deinstitutionalisation of people with mental illness. The early community psychologists took on the task of developing psychological techniques to work with people disabled by mental illness who were living in the community. The rapid development of effective drugs to alleviate the symptoms of both affective disorders and schizophrenia has meant that in recent years the role of the psychologist as community worker has often been pushed aside in favour of an outpatient medication monitoring role.

The development of support, self help and social action groups by people disabled by mental illness has been a significant development over the past ten years. This paper will examine the social and community factors prompting the development of self help groups for people disabled by serious mental illness and the role that psychologists and other health and welfare workers can play in developing such groups and empowering their members. Implications for recent social policy initiatives in the area of mental health such as the implementation of a national mental health policy and anti discrimination legislation will be discussed.

Self help groups and support networks

Self help and support groups for people with who have experienced serious mental illness have become widespread in the past twenty years. Support groups carry out a number of functions for members - sometimes filling in gaps in professional services, sometimes offering a unique service no professional service could supply.

Better community acceptance of psychiatric illness has made it easier for people to come out in public and admit that they have had a mental illness. Dissatisfaction with existing treatment facilities has prompted people to seek other information about coping techniques, medication options and information about the course of the illness. Mutual support groups can offer more support than medical facilities are able to provide, particularly after a person is discharged from hospital, or can offer support that professionals cannot. In some cases, mutual support groups

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challenge the medical construction of illness and disability and provide an opportunity for participants to critique the definition and consequent treatment of what has happened to them.

Self help groups for other physically and emotionally disabling conditions such as alcoholism and multiple sclerosis have been established for a number of years (Pittman, 1988; Katz and Bender, 1976). Such groups provided a change in role relationships for participants: instead of being dependent on a therapist and defined by the pathology of the disorder, participants in these groups were encouraged to explore their strengths and to take responsibility for helping themselves and others in the groups.

The GROW organisation, a mutual help group formed in Sydney in 1957, is one organisation which is based on help giving and mutual help rather than assumptions that people with serious psychopathology cannot help others or themselves (Linney, 1990; Rappaport, Seidman, Toro, McFadden, Reischl, Roberts, Salem, Stein and Zimmerman 1985). Young (1990) in an evaluation of GROW found that people attending GROW groups felt they had benefited from the group experience on a number of dimensions. These included a reduction in distress from bodily symptoms, improved mood, feeling better about their lives as a whole and feeling that they had more control over their lives. However, the emphasis in the GROW philosophy on personal responsibility and the assumption that medication is a last resort can be counterproductive for people who take medication in order to prevent episodes of biochemical disorders such as schizophrenia or manic depressive disorder.

Some support groups for people with emotional problems were set up in Sydney by the early 1970s. One such group was an informal group of people who had experienced anxiety and panic attacks and met in one woman's home in North Sydney. The group had some links with the emerging community psychology group led by Robin Winkler at the University of New South Wales and provided a forum for discussion about psychiatric care in general. Some of the issues raised in the group were: lack of advocacy for people who were involuntary patients in psychiatric hospitals; no complaints mechanisms for good medical treatment; overuse of major tranquilliser drugs; and lack of information about treatment programs and education about one's illness. Some of these issues were investigated by the Royal Commission into Deep Sleep Therapy (Slattery, 1991).

Development of support groups for people with manic depressive illness

The encounter group movement and the development of therapy groups during the late 1960s and early 1970s in the United States, Britain and Australia fostered the
idea of group therapy but many groups quickly excluded people with manic depressive illness - one writer noted that the presence of a manic depressive in a heterogeneous outpatient group was “one of the worst calamities that can befall a therapy group” (Yalom, 1975).

It was not until the late 1970s that self help groups for people with serious mental illness began to be formed. Support groups for relatives and friends often tended to be formed before groups for sufferers. Torrey (1983) noted that family support groups were the single biggest advance in coping with schizophrenia since the introduction of antipsychotic drugs (Torrey, 1983, p.179).

No support groups appear to have been formed specifically for people with affective disorders before 1975. Winokur, Clayton and Reich (1969), in their comprehensive account of manic depressive illness never mention the role of support groups. Their study of 71 people diagnosed as manic depressive did, however, find that there were significant social, occupational and emotional problems following the episodes of illness.

The concept of self help groups in health care had been applied to other health problems in Australia such as women's health care, alcoholism, and multiple sclerosis by the early 1970s. Support groups for people with bipolar disorder emerged in the mid 1970s with one group beginning in San Francisco and a later group starting in Chicago in 1978. The groups became nationally organised in 1986. Such groups were encouraged by clinicians who recognised that compliance with lithium prophylactic treatment might be enhanced by group discussion and that role modelling of people who had mood swings but who had stabilised on lithium and were successfully employed might be helpful (Shakir, Volkmar, Bacon and Pfefferbaum, 1979; Goodwin and Jamison, 1990). Specialised clinics such as lithium clinics made it possible for people who had experienced manic depressive mood swings to get in touch with each other and form a group.

Australian groups

The author set up a consumer support group in 1981 for people who had been diagnosed as manic depressive or who wished to find out more about the illness. The general aims were education and mutual support without stigma or patronage. The original stimulus event was the 1981 Festival of Madness organised by Pala, an organisation promoting non medical treatment of mental disorder and questioning the way people with mental illness were treated. The discussion prompted a further meeting at the author's house and the concept of a support group for people with manic depressive disorder was discussed. At the time the group began to meet, none of the group members had heard of any other support
groups for people with mood disorders, although many group participants had attended support groups for other problems such as alcohol and drug problems, weight problems or had attended a GROW group.

The Sydney Manic Depressive Self Help group began to be contacted by community care professionals who wanted to set up support groups for clients diagnosed as manic depressive. By November, 1986 there were five support groups specifically for people who had been treated for severe moodswings in Australia: Sydney, Newcastle, Darwin, Adelaide, and Perth. Some of these groups formed independently of the Sydney group such as Wendy Wise’s Even Keel group in Western Australia and Richard Woon’s Self Help Mood Disturbance Prevention MDP in Adelaide. The Darwin group was formed by an ex member of the Sydney group. Following a segment on manic depressive illness on a national television current affairs show in November 1986, more groups were started - Canberra, Bondi Junction, Canterbury and Wollongong. The group changed its name to the Depressive and Manic Depressive Association of NSW and now has over 400 members who receive its quarterly newsletter MANDA.

Many people who attended support groups run by the Depressive and Manic Depressive Association of NSW had already attended GROW, Alcoholics Anonymous (A.A), or Al Anon meetings. Some had attended for emotional support but others commented that they attended because such groups were less stigmatising than seeking support for psychiatric illness.

Functions of self help and support groups for people with affective disorder

Groups can perform a number of functions: emotional support may be only one of them. One function of a group outside the medical setting may be as a stepping stone away from complete dependence upon medical treatment. Groups, like individuals, can go through stages in their functioning and development. They can provide an opportunity to regain the dignity and self worth lost in an episode of serious mental illness by providing opportunities to help others and share experiences. Functions identified by people attending support groups for mood disorders include:

1. information gathering about the illness, medication and treatments;
2. affirmation of positive aspects of having a mood disorder and reassurance of normalcy after recovery;
3. communication with other people diagnosed with the disorder;
4. liaison with medical and health care facilities;
5. critical evaluation of medical treatment facilities and opportunity to campaign and lobby for better care;

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6. opportunities to develop personal skills in social interaction, group leadership, community organising and social action.

Information gathering

People whose lives are dramatically affected by a potentially serious disorder such as manic depressive illness are usually very motivated to find out as much information as they can to minimise the effects of the disorder on their lives. Even conscientious and well meaning professionals may not be able to gather and disseminate the amount of information demanded by people whose lives and the lives of their families are affected by manic depressive illness.

One example of this is the information on the dental effects of antidepressant medication which appeared in the newsletter of the South Australian group, Self Help MDP. Such information had not previously appeared even in comprehensive drug texts and few dentists were aware of the extra dental care needed by people on psychotropic medication with anticholinergic side effects.

Information gathering is particularly important since, at the time of attending meetings, many people were well and had limited contact with health care agencies. As one person explained it, the group was educational not therapeutic; she went to her doctor for prescriptions but found the time too short to explore wider issues about the disorder.

Affirmation of being normal

Being hospitalised for a mood disorder was often the first contact many people had with other people who were mentally ill. For many, this was a frightening experience, particularly if the hospitalisation was in an acute psychiatric admission ward as an involuntary patient in the company of a mixed group of acutely disoriented people (e.g. suffering a range of disorders from the schizophrenias to the organic psychoses). Well people tend to get discharged early so few people learnt that others had experienced similar symptoms of illness and recovered. In contrast, the experience of going to a support group meeting was a positive experience although some people were fearful that it would be similar to the psychiatric group in hospital.

Support groups also offered an avenue for people who worked in health services to talk about their own personal experience with mental illness and to offer their personal and professional resources to the support group. The Depressive and Manic Depressive Association of NSW ran a number of successful support groups between 1983 and 1991 with the assistance of community nurses, social workers
and psychologists who had originally contacted the group to talk about their personal experience of mood disorder and who then took a leading role in organising and facilitating support groups. Shapiro and George (1989) have raised some issues about the distinction between users of mental health services and professionals who work in such services and comment that there is much peer pressure amongst health professionals to keep personal experiences of mental illness out of one's work. They suggest that one way to dissipate stigma is to reduce the distinction between patient and therapist and to encourage all people affected by mental illness to talk openly about it so that mental ill health is included as a positive learning experience for the professional rather than an economic and professional liability (Shapiro and George, 1989).

Communication and sharing of experiences

Support groups provide an opportunity to share experiences with others similarly affected by moodswings. For many people, the desire to share information and meet others was particularly strong after the first severe moodswing.

Forming and maintaining relationships with medical facilities

Comments about treatment were often followed up with articles about ideal or desirable treatment. Most groups engaged in active dialogue with service providers and used the expertise of service providers to prepare information for newsletters and information leaflets. Many groups invited speakers from medical and paramedical professions to groups. Others participate in planning for health care services by offering consumer representatives to health planning committees.

Comments and criticism of treatment

One function of support groups which has had some impact on improving the quality of services for people with mood disorders is that of informed and active critic. People who had received treatment for mood disorders found a ready outlet for opinions about treatment in local newsletters:

"...Me with my illness
Kept in the dark by doctors
Even Keel lets in some light
Me with our illness..."

(Even Keel, S.H.G. for M.D. Mundaring, W.A. Newsletter, July, 1985.)
Lobbying for better services and policy changes and advocacy for people in medical care

People who are acutely ill are often not able to advocate on their own behalf if hospital and medical care is not appropriate or of a high standard. The final report of the Royal Commission into Deep Sleep Therapy and the former Chelmsford private hospital illustrates the inadequacy of monitoring systems in psychiatric care and the difficulties experienced by former patients in bringing attention to poor treatment practice in psychiatric care (Slattery, 1991). Voluntary mental health organisations have in some cases taken up the role of advocate. The Citizens Commission on Human Rights, Committee on Mental Health Advocacy, NSW Association for Mental Health and the Association of Relatives and Friends of the Mentally Ill (ARAFMI) have all been involved in advocacy for people who had experienced inadequate or dangerous mental health care. Community mental health groups were instrumental in lobbying to revitalise the official visitor system in New South Wales. The official visiting system in NSW has existed since last century as a monitoring system in state psychiatric hospitals in NSW but had become ineffective through lack of funds, non appointment of new visitors when existing ones retired and lack of any publicity of the advocacy role. Few people knew of the existence of official visitors in large psychiatric hospitals and the program was largely ineffective during the late 1970s until early 1983 when a number of new official visitors were appointed and mechanisms for effective reporting of conditions inside psychiatric hospitals were instituted.

Benefits of support group membership

Noble, Hétu, Getty and Waugh (1990), in a discussion of recruitment into rehabilitation programs for people with noise induced hearing loss, note that simply offering a rehabilitation program for a particular disability will not guarantee participation: people will defend themselves against an undesired status by avoiding a program that is seen to confer such a status (deaf, mad) and they may not see that the problems they are experiencing are related to the disability as defined by the rehabilitation program. Support groups can offer role models: people see others who have recovered, who are leading valuable, productive lives and who can talk about the benefits as well as the costs of treatment and rehabilitation.

"I watched your program on the Willessee Show and it moved me to write to you because I am 'manic depressive' and was diagnosed about three years ago. Since then I have been taking lithium carbonate and have remained quite stable on this medication. Since my illness I have found it difficult to mix with other 'normal' people as one might say because I feel that I
always have this deep dark secret that I cannot disclose for fear of rejection....” (R.R. Tas)

Similar experiences have been related about groups in other countries:

“...I finally took the plunge and joined a self help group. I was made very welcome, but for three quarters of the evening tear drops pressed against the back of my eyes. I was aghast that everyone was talking so freely about ‘you-know-what’. ... My second meeting? Well, we were still all there, plus a young pregnant lady. I was not so apprehensive but I still felt strange. Then it happened. The pregnant lady started talking and as I looked at her I said to myself - but how could she have manic depression? She's so lovely, so pretty, so nice to be with and then the penny dropped and I said to myself, yes, Debbie and so are you.” (Debbie in Pendulum, vol 5 No 2 Summer 1989, p.10)

Support for relatives and friends

Relatives and friends often bear the brunt of the aftermath of manic and depressive episodes. Parents are usually the ones left with the problem of caring for an adult impaired by schizophrenia (Pakenham and Dadds, 1987; Leggat, 1990) but since manic depressive illness is more likely to occur in a person’s late twenties, many people with bipolar disorder have formed relationships and started families. Spouses and children are then the ones to cope with the legacy of the illness. Relatives and friends often feel helpless.

Rosen (1988), in a pamphlet circulated by the National Depressive and Manic Depressive Association (USA), lists a number of problems faced by both families and persons with bipolar disorder. The person with the disorder often faces residual problems following an episode. These can include lack of confidence, perfectionism, alienation, fears of regression or repetition of acute symptoms of illness, rigidity and fragility, side effects of medication and ambivalence about medication compliance.

The stressors for family members are different. The issues for families revolve around the time and energy spent by family members in caring for the needs of ill family members. Families are often the ones who contact health and community resources for help and face the professionals’ judgments about who is ill and who is not. Spouses and partners are often the ones who pick up the pieces after episodes and who suffer the financial stresses caused by long illnesses, loss of employment, manic spending or expensive medical care. Close family members can suffer stress, anxiety and depression syndromes as a consequence which are
often undiagnosed or trivialised by health workers involved: family members have complained that they have been told that they are "overinvolved", "too emotional" or "intrusive" when they have mentioned their own distress at the behaviour or ramifications of a serious episode of mental illness in a family member.

Support for relatives and friends: Association of Relatives and Friends of the Mentally Ill (ARAFMI)

ARAFMI was formed in 1975 by a social worker, Margaret Lukes, at the NSW Association for Mental Health and was the first support group for relatives of people with mental illness to be organised by a voluntary association. ARAFMI uncovered a tremendous need: many relatives had not been included in treatment plans for family members who were being treated for mental illness. Health workers in hospitals often attributed episodes of illness to relatives, and relatives felt angry, scapegoated and excluded from the treatment process of a family member. The development of support groups for relatives was rapid: ARAFMI now has a number of groups meeting throughout New South Wales. The 24 hour telephone contact provides much information and support to relatives faced with a seriously mentally ill family member.

Caplan (1974) identified a number of factors that can be provided by "significant others": sharing tasks, supplies of extra money, materials, tools, skills and cognitive guidance. For people who suffer repeated episodes of mental illness, close emotional relationships are often one of the first casualties. Support groups composed of people who share a similar disorder can replace family supports and other social networks destroyed by episodes of illness (Katz and Bender, 1976).

Psychologists and the facilitation of self help and support groups

Psychologists and other health workers can play an important role in the development of self help and support groups. To prescribe a role for any participant is to take away the autonomy of the group: those not personally affected by the issue need to be sensitive to the particular needs of the group and the current circumstances of the group. Some people need to break away completely from professional influence in order to determine their own analysis of issues. Professional health workers must recognise and respect the wishes of group members to determine their own course of group development.

Since health workers are usually part of a large bureaucracy and have access to resources, there are a number of ways in which they can work with self help groups:
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- **referral to groups** Health workers who know individuals who may benefit from a support group can be an important referral source. Few groups have the resources to advertise their group activities.
- **link with health care services** Health workers can provide an important link with health services and advocate for better treatment, resources and services; more sympathetic treatment; and changes in attitude towards particular groups.
- **information about medication and treatment** Health workers are more likely to have access to professional journals and books which can provide up to date information about current treatment practices, social policy initiatives and resources available for specific problems. Workers can offer to be guest speakers, write articles for newsletters, or be available as a consultant to group members. Most importantly, they can make information available to members of self help organisations which can enable group members to do their own analysis of professional information about diagnosis, treatment and social policy. The language and style of many professional articles about medical illness, disability, and treatment programs often says much about the attitudes of professional workers towards client groups.

**Social policy and legislative changes**

Self help groups have played a role in recent changes to mental health and guardianship legislation and in developing policies to reform mental health services. Consumer and self help groups have argued for outcomes to be considered in the development of social policy which affects people who have episodes of mental illness. This has been particularly important in the community mental health movement, which is concerned with moving the emphasis away from custodial treatment in institutions dominated by medical and pharmacological treatment to community based services which encompass family support, vocational retraining and the maintenance of social networks.

The National Disability Discrimination legislation which came into effect this year is a significant step forward for people disabled by mental illness. While some states do cover discrimination on the grounds of mental illness (e.g. Western Australia) others like New South Wales do not. Discrimination against people who have had a major episode of mood disorder is one of the main issues concerning members of self help groups. At a recent group meeting fourteen of the twenty people attending claimed that they had been sacked, denied promotion or asked to leave accommodation following an episode of mania or depression.

Self help and support groups give previously powerless and stigmatised people a voice. Since many people have recovered from a severe episode and have returned to social, educational, and employment networks in the community, the groups...
provide a forum for debate and action about current community experiences such as discrimination, unemployment, lack of community resources for daytime activities, and current social policy. Many groups are keen to work with professionals in the health care field, provided the freedom to debate and act is facilitated and the dignity of the members is respected.

References


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Most humanistic theorists subscribe to the view that individuals, at least potentially or by nature, are self-realising autonomous beings. A growth principle or actualising tendency is generally seen in these perspectives as the core propulsive force in development and motivation. As illustration, let me quote my own summing-up, in another place, of Carl Rogers' position in its later form:

A central idea is that an inherent and active directional tendency is present generally in complex organic life forms, needing only a tolerant environment and essential nutrients for each organism to hasten on its developmental path--pushed by imperatives of its species, guided by its individual code, drawn by its own unique experience and, in the case of humans, moving by the intentionality of evolving consciousness and meaning (Barrett-Lennard, 1991--see also Rogers 1963 and 1978).

This quote states much that I agree with, but makes no reference to the relational-social context of life. The perspective I will advance here significantly qualifies the idea or meaning of personal autonomy. It does hold strongly to the view that personal consciousness and well-being are ultimate reference points even when the focus is on collective or social life. When people are at the centre of our interest, when we try to understand ourselves in our worlds, or when we work for self and social change, then the person is the reference point we need to keep coming back to.

In a word, my perspective is both system oriented and person-centred, which I see as two faces of one whole. It seems to me that life is essentially relational, that it is lived within our systems of relation. In describing what this view leads to, I will start with a way of thinking about the human and life systems that appear fundamental in our world.

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1Presented Oct. 1, 1992, at the Armidale conference of the Australian Psychological Society. This paper is closely related to the author’s manuscript article "A person-centred systemic model of change"--offered for an edited book in preparation by D. Brazier. All versions remain under personal copyright by the author.

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Relational systems: Structure and spectrum
In visualizing multi-level systems the most inclusive unit traditionally is placed first or at the top with the major constituent subsystems following next, then somewhat smaller sub-units and so on down to the individual member level. Teams, departments, divisions, whole organisations are examples of the more inclusive, "higher" level system units. Team leaders report to department heads and they to division chiefs, etc. The rank and file worker or member is conceived as having least or narrowest responsibility, which then builds rapidly to a different order as one goes "up" the hierarchy.

This traditional way of thinking has a certain utility in its own terms but would not have arisen from a philosophy centred on persons and human experience; an approach, for example, which views "the unique, subjective inner person as the honoured and valued core of human life" (Rogers, 1974, p. 9). This 'person-centred' approach emphasises the very large and often untapped potential of human beings, in the context of an openly egalitarian and democratic ethic (Rogers, 1974, 1977). Such an orientation runs against the grain of any model that stresses vertical positioning of individuals, which views persons as subunits of their immediate groups, or which regards the groups as existing just to serve the larger system.

Traditional models of organisational structure and functioning evolved and came to make use of and be associated with systems thinking, although in service of much the same values as before. Associations of this sort may be part of the reason that systems theory has not been attractive to humanistic and person-centred contributors. They and, for that matter, most psychologists have scarcely drawn on a systems approach to illuminate issues of primary theoretical and/or practical interest. This seems to me a matter for serious concern because of the power of a well-applied systems paradigm to illuminate complex interactive and change processes. The familiar, linear models of relationship and influence are ineffective and unconvincing by comparison. This is especially true in seeking to envision the multiple levels of human association and interplay that constitute so great a part of our living.

My own evolving perspective is a systems-sensitive one in which the individual experiencing person is represented not at the base but as the apex of a comprehensive scheme of systems and relations. In this sense, the usual hierarchy is inverted and opened out from different starting points, yielding another kind of illumination to the sphere of person-system relations. Altogether, nine levels of system in which almost all of us have membership are distinguished, as follows:

1. The individual person—or person/self system.
2. *The person's main dyadic systems*—or twosome relationships.
3. *Family relational systems*—including actual nuclear family units (of >2 persons) and other familial or intimate mini-systems.
4. *Small face to face groups*—in which everyone is visible to and in some actual contact or communication with each of the others.
5. *Large groups and organisations*—where members, typically, are not all in first-hand contact, although each person has a part in the total system and is affected by this membership.
6. *Communities* of association and belonging.
7. *States, nations and transnational systems*.
8. *Humankind/the human race system*.
9. *The planetary life system*.

I will briefly comment on each of these system levels, starting with the first listed. In the present context, I mostly treat the person as a unitary whole. As an aside, however, I think it can be illuminating to think of a single person as a system, clearly with sub-systems on many levels. Indeed we are such multi-sided beings that the wonder is that we hold together as one whole. Perhaps this wholeness is over-stated. Are we all that singular or, for example, is it in our nature to have different inner voices, multiple self-systems? Aren’t we incorrigible self-communicators, engaged in inner dialogue, debate, argument? These are interesting issues but to one side of my main topic.

From my standpoint, the dyad is not more inclusive than the individual system, but less so. Sentient/reflective consciousness in advanced organisms, particularly humans, plausibly is the highest integrative centre or apex of system. The dyad does not embrace the totality of the individual persons whose relationship and interplay it makes up. (Deviant instances of engulfment of an individual in a relationship may come closest to total containment of person within dyad). However, dyad relations plausibly have greatest direct influence on our personal or psychic well-being as compared with the other systems I will distinguish. Reciprocally, individuals tend to have a larger role in fashioning relationships with one other person, as compared with their direct part in fashioning multi-person systems.

Experience within our family systems, and in other strong personal groupings of nuclear family size, competes with one-to-one relations in the strength of its influence. Families typically include, besides dyads, overlapping and interwoven subsystems of three, four and more members. Family-like relations include close knit and lasting, special friend mini-groups. Particularly close, relationship mini-systems that can form within a much larger membership system may be considered family-like, too. Intense, lasting microgroups of negative valence are also possible,
outside as well as within literal families. (My perspective in the family sphere, blending phenomenological and systems thinking, is much more fully spelled out elsewhere--see Barrett-Lennard, 1984).²

Small groups of a face-to-face nature, become important from the time (if not before) a child enters play school or kindergarten. Such groups have clear boundaries; and are deemed for present purposes to range upwards of 7 persons to 25 or 30. Besides developmental or learning groups of many possible kinds there are, of course, a diversity of groups organised around task and team functions; others that form in response to intrinsic needs and interests of members, and additional broad categories. Accompanying the huge spectrum of composition and function of such groups is enormous variation in their qualitative nature and dynamics.

Organisations play a pervasive, often largely unnoticed, part in our lives. Depending on one's position and responsibilities in an organisation, it may be part of the "taken-for-granted" ground of one's life or a sharply discriminated 'figure' in this ground³. Other relationship entities that are important in their own right to the members involved in them. These smaller systems affect and are affected by qualities of the 'host' organisation.

Organisations of similar dimension and function tend to have much in common, particularly, within the same larger culture. Organisations of dissimilar function, such as universities, public service systems, financial and business organisations, can have disconcertingly similar qualities. It is almost a truism that a person's sense of personal identity and worth is often bound up significantly with

² One element in this further thought is that family systems >2 persons are still dyad-like in the sense of broadly having the form of an A-B relation, one in which A and/or B consist of more than one person. For a particular member, 'A' is taken to represent 'I/me' or 'we/us' within the relationship. 'B' represents the 'you' (singular or plural) side of the relationship system (Barrett-Lennard, 1984).

³ Individuals usually have considerable consciousness of their employing organisation but may only have dim awareness, for example, of service, commercial and regulatory organisations in which they participate as client members or constituents. As consumers, even as medical and other professionals, we are in constant transactional relation with large organisations (drug companies, publishers, banks, insurers, etc.), often with only the vaguest knowledge of their system qualities and wider impact.

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Barrett-Lennard

membership and role in a work organisation.

Communities obviously are of many kinds: growing, for example, out of tribal or ethnic affiliation, common residence and/or interests, and shared religious or other belief. Of their nature, communities tend to be more diffuse and variable in their working and impact than organisations. Externally, we are more locked into our organisations. Internally, our bonds with communities of association and belonging tend to run deeper (Barrett-Lennard, in press). An organisation, especially a person's work/career setting (a university, say), may have the qualities of a primary community for many of its members. This overlap extends the range of needs served by the system, but at some risk to the individual due to the very large impact of loss or change in membership.

Membership of nation states or other big political, ideological or economic groupings has a more subtle, perhaps indirect influence on an individual's sense of identity and other qualities than is the case with literal communities. Its importance and impact on the individual may be more evident when we look carefully from the outside at national societies or regional cultures different from our own. A large part of this influence would be mediated through the component smaller systems in which we have membership. Chains of interactive influence may run from level to level between the person and the nation/international system.

Being members of the human race and world community affects us differentially according to our consciousness of this whole as one single fabric of interwoven, interdependent lives, communities and states; a fabric which grows, changes and has life--a life at risk from itself. Much the same thing is true in respect to our more ultimate membership in the total life system of our planet. Persons, for instance, with highly developed ecological consciousness would be distinctly engaged with this system level.

Probably most effects of our membership in the total life system are mediated through other systems already mentioned. I say 'most' because often we have particular animal friends, a wider sense of kinship with some other species in the spectrum of life, and a direct sense of connection, enjoyment, even of embrace, in certain natural surroundings. It appears to me that a comprehensive view of sources of interconnection and influence should recognise the life system as a whole. Not to appreciate this level of connection is to put ourselves collectively at risk; to appreciate it positively is to be more respecting and regardful of life, both in its diversity and commonality.

This now completed outline of the levels of human/life system that comprise our contextual world, is also shown in visual summary in Figure 1. The small
enclosures and print in the figure illustrate the range of systems potentially encompassed at that particular level. For example, at Level 3 the systems may include the person's original family, their own (next generation) nuclear family, the person and their grandparents, a closely bonded group of three (say) intimate friends of the same sex, and/or a quartet of two couples in long-standing, close relation. At levels 8 and 9, the smaller print simply shows alternative ways of viewing or denoting the same overall system. Let's now look at the basic nature and lines of person-system interconnection somewhat more closely.

The person<->system nexus

In the perspective advanced here, it is taken as axiomatic that individual consciousness and outer living is interwoven with the consciousness and living of others. This 'interweaving' takes place through our many systems of relation, the interaction at each level involving communication or information exchange in some form. The relation in principle is one of interdependence. The person is both recipient and exerciser of influence in these relations. He/she contributes to the qualities of the membership systems and, equally, is affected by the nature and working of these multi-person systems.

This said, let me at once acknowledge that in practice individuals often have very limited impact, for example, on their mid-range and larger systems. These can be organised in a way that includes no provision and little opportunity for rank and file members to exercise modifying influence. Since many such systems are highly resistant to change, and members may be functionaries serving the system as it is, properties of individual members can change without this translating directly into altered properties of their system. However, the system is not necessarily static in the sense of being at rest. More likely, there are inner tensions and an uneasy balance between forces which would produce change and those which act to inhibit such change.

As already implied, relational systems on various levels can have vital effects not only on how we are but also on our sense of who we are. Human systems nearly all come to have implicit, if not overt, codes of conduct. They contribute fundamentally to the ways in which we are under approving and disapproving judgement, to the general ambience of normative codes and values, to our sense of safety or of being endangered, and to the personal relationships that are open to us.

One way of looking at positive and negative effects is in terms of health, on both personal and system levels. Systems can work in ways that are growthful or health-promoting for individual members, or can stress, distort or damage people in them. Societal and other systems that are organised to promote competition, as
so many are in Western cultures, may have high tolerance for resulting damage to particular individual members and sub-groups. This is not to start suggesting, however, that the influence is entirely one way, as though the system existed independently of its members. The relation is interactive and, in large or limited degree, the well-being or 'health' of members also impacts on the functioning of their system. Systems damaging to their members are likely to suffer from return effects of this damage. Equally, positive system qualities can be impaired by characteristics and actions of members, who are then on the receiving end of this impairment.4

A main implication of the perspective presented here is that in order for individual healing to be sustained, the healed person's active life systems, especially their immediate family and other continuing, close personal relationships, need to be or to become reasonably healthy. Additionally, any groups that the person is, and remains deeply involved with, need to be well-functioning. Organisations that continue to be a major part of the person's world cannot be distinctly unhealthy without adverse effect on the individual. Communities the person lives and participates in should at least be relatively benign and free of qualities which adversely affect their constituent smaller systems.

National and cross-national systems can have great bearing on the nature and/or health of small relationship systems. Illustrations of sharply varied nature include the Nazi German state, the Catholic Church, UNICEF, and the interwoven national and ethnic communities of Europe and of the former Soviet Union. The tortured conflict in the former Yugoslavia surely reflects a disorder of relations between the peoples involved; a disorder partly fuelled, historically and in the present, by personal attitudes affecting larger membership systems; systems which in turn have been taking shocking toll of family and community systems and individual lives,

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4 Sometimes there are constituents who are not active members but external supporters or beneficiaries of a system. Organisations with shareholders or distant owners are a case in point. System health would then have another side, involving the relation of outside owners and beneficiaries to the interior working members of the system. The aspect of quality of information exchange and mutual awareness between the main body of organisational members and the owner-investors then becomes an important further issue in the functional health or otherwise of the system.
Figure 1: The P-System

- Level 1
- Level 2
- Level 3
- Level 4
- Level 5
- Level 6
- Level 7
- Level 8
- Level 9

Note: Systems shown in small letters (levels 2-7) are illustrative.
GTB-L Systemic Model of Change

--System Pyramid

S ANTIONS

NITIES

MILIEU & SYSTEMS
Crossnational systems: political, commercial, ethnic / relig, other

COMMUNITY

ETM AND HABITAT

etary life system

Ecology of living systems

ot exclusive. Similarly, for the lines denoting connection & influence.
thus also perpetuating the disorder.5

As summed up in Figure 1, the overall, dynamic framework advanced consists not only of the various levels of system but, also, the many intersystem linkages. The connections cannot all be visualised in a single diagram but, in principle, the person has, as it were, a direct line to every system level and as well, the relations between levels affect the person indirectly. The relationships generally are interactive, so that influences are reciprocal or work in a recursive chain. Interest can be focused on the way individuals are affected, or on the ways they act upon their systems, or the flow in both directions. Involved altogether are the interactive dynamics of person and system, and of system with (sub)system.

Generally, the impact of person on system is viewed as depending on the latter's size and 'distance' (number of levels away) in the total scheme. Other factors, such as how open or closed the system is, and the person's discrimination of it and of interconnecting channels are, of course, relevant too. Systems in their turn act on the person partly according to their size and distance, their own properties and the individual's discrimination. Self-knowing or health on one level generally has favourable effects on another, which then acts back on the first, or on a third level. Likewise, lack of awareness or 'ill-health' on any level acts adversely on others, which may then reinforce it and mediate its spread to additional levels. To take this view seriously alters one's perspective on personal therapy and most other helping interventions.

Concluding implications

I will end with fairly brief comment on where the perspective advanced is leading in my own work. Its potentially radical implications are yet to have full impact in my practice; and I would be greatly interested to hear from any readers about the implications they perceive.

* I know that I think much more about the kinds of worlds my therapy clients...
live in, and am more attentive and attuned to what they tell me on this level, than used to be the case. I do not feel any inner demand for them to be literally self-exploring, or working out interpersonal issues, all the time. I quite often wish I could be present with them in their families, their work place, or another part of their relational-communal world. On occasion, I have gone to an appointment with a client, or couple, in their own home setting, and would like to find practical ways of seeing clients in situ more often. I am more patient than formerly with some clients seeming to advance very unevenly, taking a long time, using the relationship with me as a supportive lifeline as well as a literally therapeutic medium.

* I now appreciate more than I used to why many people in difficulty in their lives do not turn to personal therapy. Why should they, if they have the idea that therapy will focus on their own personality and self but they are in agony over their relational or communal life systems. For a person tortured in their systems, or profoundly cut off and alone, it requires enormous confidence in the potential power of individual capacity to see psychotherapy as a route to a new quality of life. Thus it seems to me extremely important to maintain and develop modes of therapeutic helping that are strongly attuned to context and systems—with no lessening of sensitivity and concern for the inner person. A further development, touched on next, could be of even wider value.

* I think more about meanings of 'prevention' than I used to. Developing greater sensitivity to and concern for the health and well-being of human systems at all levels is in my view basic to any worthwhile approach to reducing conditions conducive to personal and interpersonal disorder. It is difficult to avoid the view, given the scale of human stress, division and conflict, dislocation, addiction and other personal-social problems, that societies in our world are deeply flawed. One glaring example among many is in the field of crime and corrections. As nations have developed crime rates generally have risen steeply. The 'correctional' systems put in place, in their overall effect, reinforce the patterns that have lead to imprisonment and, in effect, promote crime—especially in the context of a diminished sense of connection in the wider community. Developments desirable in themselves, say, in health, educational and welfare fields tend to be introduced piecemeal, without taking account of interactive effects with the other system

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6 While writing this end section, I thought again of an older paper with the ambitious title "Prevention, healing and change on personal & system levels: An approach to integration" (Barrett-Lennard, 1977). This earlier, more free-wheeling account in some ways complements the present work. Copies, in manuscript print-out, remain available from me.
influences at work. My own shifting perspective encourages me to think, however, that we could become much wiser in seeing pattern and connections; and inventively applying this growing wisdom to the healing and betterment of encompassing systems in our world.

* While desiring to contribute to the wisdom mentioned, I also want to go on working with individuals, couples and small helping groups, and believe that when personal healing change can and does occur it tends to have repercussions throughout the relational systems in which most of a person’s living happens. Note my qualification that this effect results if personal change actually occurs. Looked at in finer grain, an increment in self-integration (say) will be reflected in an interactive life context which might now work in an affirming way or, alternatively, may make the shift very difficult to sustain or harder to follow with similar shifts. Thus, self change may build on itself in association with movement in system qualities, or may not build but bog down in the context of strongly counteractive systems.7

* It impresses me that individuals in unhealthy, dissociated, suffering or predatory systems can in practice be powerless to transform their systems into life-enhancing ones. Indeed they may have no belief, or no hope, even no concept of changing themselves, still less their worlds. In such instances, directly addressing their systems, small and large, in some way may be an essential starting point to reaching and aiding individuals. My experience and knowledge of what this can mean in practice is quite limited. I hope to inquire and learn more, reaching outside familiar territory of practice and theory, especially in clinical psychology and psychotherapy.

Implied in what I have said in this paper is the belief that we tend to be less powerless the more deeply we see into the workings of the larger wholes we are part of, the more (to start with) we are conscious of these wholes at all and notice how we function in them, the more we engage with others to facilitate growth in their contextual consciousness, and the more active we become in working in partnership with others toward maintenance and renewal of our interconnected life systems. It appears to me that above all else what we can do pivots on our knowing. I would go further: When a person’s consciousness of things actually changes there inevitably are consequences in their actions. Probably this helps to

7While choosing to leave an unsatisfactory relationship system or setting is not uncommon, in many cases separation from existing life systems is very difficult or not an option. And where a person does leave, often it appears more a flight from something than an approach to an alternative of different quality.

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explain both why we become more knowing (to enable action) and why we also resist doing so (to avoid the weight of acting).

References


WHITHER COMMUNITY PSYCHOLOGY IN AUSTRALIAN SCHOOL EDUCATION?

Steven J. Fyson
Green Point Baptist Christian Community School

The Bulletin's cover story, July 1991, seemed to capture the spirit of much of the social concern about education in Australia at the moment when it headed its story as "The Getting of Character". The reporter claimed that the "real revolution" (p.78) in education was not about cleverness and economic prowess, but about the "character of its citizenry" (p.83). He lamented that the definition of community had shifted to be focussed on business and technocratic politicians, rather than parents and teachers. And he attempted to support his arguments with evidence from the curriculum emphases in State schools ("crammed with social awareness" - p. 80) and the Independent systems (the drift of so many towards them).

The recognition that character within relationship is important can also be linked to teacher satisfaction. Alan Watson (1992), reported that research neglected consideration of the teacher's relationship to the community - or in other words, how is the "functionary" of the teacher being treated as a person? Teachers need to know that others are interested in their character, and that they can offer something to others in return. Watson suggests formal induction programs into schools and their communities to assist in this.

A.C.E.R.'s 1991 publication by Brian Hill is indicative of the recognized need to explore the role of defining absolutes around which schools can gather as community - the title was "Values Education in Australian Schools", and concludes that

The school is in the business of values education, unavoidably ... The myth of neutrality has clouded the issues for too long ... Australian schools must become more than knowledge factories, and assessment more than apple-sorting, for students are more than disincarnate minds, and so are teachers (p.168).

This corresponds to the 1990 comments made in the American Psychologist by Paul Vitz, who noted that:

Some educators and parents propose that morality should be kept out of the public schools altogether and taught at home instead. This position is unsatisfactory because it is not possible to remove values from education. For
example, every story used to teach reading brings with it a world view and associated values (p.709).

The Right Questions?

If psychology wants to help in this endeavour to educate for character built on values, then it must first look at some of the unattended axioms about schools. David Purpel (1989) seems to have described one starting point by identifying the link between education, values and the need for communities to have a vision greater than the sum of their parts:

[This is].. the crux of our crisis: the difficulty of creating a vital, authentic and energizing vision of meaning in a context of significant diversity, pluralism, division, skepticism, dogmatism and even nihilism (p. 4).

He asks for a reconsideration of the concepts of faith, reason, truth and wisdom in the face of much current ..pseudoscience" (p. 61). It may be suggested that this kind of pseudo-science in education is related to the same trend in psychology:

... what can replace the role that significance testing currently has in the production of psychological knowledge? ... The illusory prospect of indubitability and conclusiveness is likely to continue to be more attractive than the cognitive discomfort occasioned by confronting the abiding uncertainty of our knowledge claims (Ian John, 1992 - see also his 1990 critiques).

Thus, in asking the right questions, Community Psychology must a) recognize the role of values in education, and b) not rely on the rhetoric of statistics.

For the right questions can only be framed when the tension between the individual and the collective can be held together. Values, which give rise to vision, can make the ethos of a community complementary to its response to pathos (the balance between rules and meeting individual needs). Without such vision, a healthy law becomes oppressive legalism, and compassion becomes sentimentalism, leading to individual, self-destructive behaviour and social chaos (Sarason, 1986, Purpel 1989, Hanson, 1986). The need for the Dreamings of the Aborigines to be constantly retold is current case study of this.

Given these parameters of reality construction (see Berger, 1967), Seymour Sarason (1983) has constructed a list of useful questions which can start to identify those aspects of education which are central to its functioning, and yet which often go unstudied. Immediately below is a summary of Sarason's argument and
conclusions:

a. Criticisms of schools are usually too narrow.

b. That there has been a socio-historical development in which all those involved in schooling have achieved certain strong, and often unstated, expectations.

c. These axioms include exploring basic questions of the worth of schools in light of what we would like to achieve and the world views of those attending and teaching in schools ...

d. A summary of the plight of schools today is that there is: an extreme exacerbation of a long-standing disjunction between pupils' need to explore, master and experience, on the one hand, and the impossibility of meeting those needs in the physically and psychologically isolated school on the other (p.105).

e. Subject matter on its own is boring. Experience on its own is mindlessness. The linking of these two within a thinking/action transaction provides education. This is the teacher's role, from their knowledge of the students.

f. Such a role (e.g. an apprenticeship model of teaching) cannot take place in the normal culture of the contemporary school (Sarason, 1983).

Conway (1984) developed some similar themes about the specifically Australian scene in the "End Of Stupor?" He identified a New Establishment in Australian ideology the Left-radical-egalitarian orthodoxy of the recent governments. He claimed that this ideology sees schools as the place for social reform and thus control of community life, and either pretends to compensate for or ignore genetic or domestic deficiencies. They employ theories which uphold an arrogant collectivism (i.e. they are based on theories of social change which are modelled on the centralist notions described by the "collectivism" in Sarason, 1986), which ironically are based on misplaced individualistic notions of personal change (i.e theories based on an empty concept of the self, as in Cushman 1990, and legitamized by the overdependence of statistics applied to individuals - John 1992 and Kline, 1988).

Community Psychology

I believe that our discipline could be assisting in Sorting out the current dilemmas in education if it:-
a. returns to its interest in prevention and not rehabilitation. Individually focused clinical and counselling work still tends to dominate in educational psychology literature in Australia;

b. regains the desire to enhance the sense of communities in which education occurs, and does not play at power brokering for a particular political point of view from a centralized authority e.g. a government of the day;

c. re-establishes collaborative interventions rather than engage in social engineering (see Wildavsky, 1973); and


We may make these mistakes because we do not consider our paradigms carefully enough e.g. empowerment. Empowerment does not help at the "content" level - it is a value laden process strategy which its authors claim to be an ideology (e.g. Rappaport, 1987 & 1981; Wilson, 1987). Yet no standards for life are made explicit; nor does empowerment theory demonstrate the level of causal knowledge necessary upon which to plan the social engineering it desires.

As Wildavsky (1973) so clearly put it- if planning is everything, then perhaps it is nothing. Empowerment, and much education, has no core. Berkowitz (1990) reflected this concern when he wrote that: "For the truth of the matter is that community psychology is not doing much of a job empowering people" (p. 10).

4. **Four Areas of Review:**

Community Psychology must not avoid the need to define values around which society can survive - for we all contribute to complete each other's world in how we relate to each other through the agreed commonalities and experiential differences of life.

In the context of school education, I would suggest the following (after Houston, J. 1986):

a. To counter the cynical spirit, which is an attitude of criticism of others and a claim to rights without reference to responsibilities, we need to create a renewed interest in the protection of childhood by increasing supportive distinctive adult involvement - e.g. competency models for families.

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b. To counter the individualism and an exaggerated sense of independence, we need to develop the call to commitment because of common givens. How do we affirm and promote these?

c. To counter self-destructive permissiveness (if I don’t get caught it’s O.K.), and its attendant need for juridical ethics, we must try to develop models where virtues can be transmitted within and across communities (Vitz, 1990) e.g. self-discipline with some explicit notion of delayed gratification because of higher order principles.

d. To counter narcissism, or an exaggerated pleasure and entertainment relational mode of learning, we need to pursue ethics of responsible use of skills for others and the joy of learning.

Conclusion

...... there will still remain conflicting moral visions, with their different philosophical and psychological rationales. To accept such differences and to learn to live with them might eventually permit psychology to contribute more than it has thus far to that supreme form of moral knowledge: wisdom (Vitz, 1990, p.718).

If Community Psychology takes up these challenges, then perhaps we can be known as helping towards educating for becoming more than a clever country - instead, a country of integrity.

References


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Community psychological theory stresses the importance of researching the values of our society to locate the root causes of social problems. Sexism is one such value. Women are not given the same access to the resources as males. Psychology is overly individualistic (Sarason, 1981) and this is reflected in dealing with sexism. We tend to view sexism as an individual. To do this trivialises the issues. The important aspect of sexism (and racism) is the extent to which these values are embedded in our culture. The following is an example of some of the dynamics of that process.

I was approached by a representative of a group who called themselves Big Beautiful Women who asked me to design a questionnaire to measure big women’s attitudes to a variety of services and agencies. This appeared to be a relatively simple piece of research. Through consultation with a number of large women, and through a literature review, I constructed the questionnaire, which was distributed through the only outlet for bigger women’s clothing in Perth.

Over a period of time 129 responses were collected and analysed. The respondents were asked to identify themselves if they were willing. Most did. The project entered a second phase at this point. A small group of fourth year students then took on the project. They were to follow up a sample of these respondents to get more detail on the nature of the problems facing these women.

The students showed distinct discomfort about interviewing big women. Although some of the students were mature, all expressed concern about the process. Two younger males reported that they felt "disgusted" at the prospect of talking with obese women and that they could not help but feel that the women were responsible for their own situation. Awareness of the psychological principles did not inoculate the students and myself from the pervasive prejudice about obesity. This observation highlighted the whole process of the research.

After analysing the data a short report was written that documented the frequencies of particular problems and some specific examples of the way in which the problems manifest themselves. A brief summary of the main findings follows:

1. 95% of the respondents reported difficulties in getting clothing.
2. 97% reported difficulties in getting their size.
3. Shops did not cater for your size; 69% frequently, 23% sometimes
4. 97% reported problems in getting fashionable clothing
54% reported difficulties with staff

62% found staff sometimes or frequently off-handed or judgemental. People reported that staff would approach them and say that they do not have anything in their size.

These people envied thinner people (83%)

They felt discriminated against (63%) and some indicated that they had experienced discrimination in employment applications. Typically, the women reported that their initial telephone enquiries were favourable but the job would have "disappeared" when they arrived.

They felt they were more discriminated against than big men

Their families were very supportive

They reported some difficulties with the medical profession (37%), specialists (23%) and hospitals (20%).

It was frequently reported that medical professionals often assume that weight is a contributing factor to any illness from colds to sprains or bone breaks. One woman complained that a hospital weighed her on commercial scales in the basement because ward scales were inadequate.

The report was sent to the proprietor of the large women's fashion store who had initiated the study. It appeared that we had completed our involvement. This was not to be. I received regular requests for more copies of the report from a small group of big women, including the proprietor of the fashion shop. They were mounting a campaign which started with sending copies of the report to major clothing outlets.

The activities of these women also included using the media and we were enticed into talking about the research on radio, television and the press.

After two years a small follow-up research project was initiated to explore the extent to which there had been changes. Two research assistants started by interviewing the two most active people, the proprietor of the fashion store for big women, and another woman who had taken on the cause with great vigour that belied her 70 years. The latter women had taken on the role of following up clothing stores with "interviews" to see how things had changed. She reported that a number of stores had not recognised the extent to which they had misjudged the market. Their efforts and the lack of market intelligence was shown in a telephone call I received from the chief buyer for one of the larger chains in Melbourne. She asked me whether it was correct that 71% of Australian women were larger than size 14. This was a gross over-estimate, but it highlighted that there was a growing awareness that the retail sector had underestimated the need for bigger clothing in the community.
The research assistants systematically scanned the larger stores in all major shopping centres in Perth. They also interviewed sales staff and section managers.

Findings

The most impressive finding was that both up market and cheaper stores had increased the range of their sizes. Bigger women now have greater access and range of clothing. This was especially so for the up market stores. There was still a lack of moderately priced fashionable clothing. Lingerie is not available in sexy styles. A comment was that it tends to be in "battleship cream".

When the section managers were asked why they did not sell more attractive lingerie, they replied that they did have some but there was no demand for it, people were not asking for it, and they would not be retailing it next year. The irony is that where some products are sold quickly, the stores do not respond by ordering more. Black slacks and skirts are very popular and are sold very quickly, in large sizes. They are not replaced. Thus lack of demand is seen as a reason for not stocking some lines, while demand has no influence in others.

The cheaper stores have increased the range in clothing. It tends to be in less attractive ranges, and is just a scaling up of the patterns rather than recutting to be more appropriate to larger people. Rather than 16-18 being the upper range size 26 is now being catered for.

The more expensive stores responded to the needs of larger women by setting up a speciality section for large women. In a number of stores this is located beside the maternity section. When questioned further, one section manager retorted angrily that it was not sexist, it was policy that speciality sections went together, and there was a section for big men in the same vicinity (and there was in this store).

Another improvement is that these sections (in the more expensive stores) are staffed by larger women. There has obviously been a recognition that big women feel more at ease with larger shop attendants.

Issues

There were many indications that sexism was a major issue. The first issue arose in the research team. Both the males and the female researchers initially felt uneasy dealing with big women. There was also a feeling that these problems were not serious problems: a view echoed by some academic colleagues. On reflection, the researcher started to see that their values reflected mainstream values; that while in other cultures and at other times being big was seen positively, it was not
now. Moreover, while there is a literature of "victim blaming", or assuming that an ill or disabled person has somehow been responsible for their plight, the researchers were allocating blame to the people. Even when they had heard big women say that everyone advises them to go on a diet, even if they do not know them. What the women said with considerable feeling was that they had been on diets and it had not made any difference in the long run, and that people did not realise the difficulties they faced.

This issue of sexism intrudes into the professional and academic literature domain. There seems to be a basic assumption that obesity is unhealthy. Some academic writers refer to obesity as "self-injurious behaviour". There is an assumption that obesity is due to over consumption, that it is unhealthy, and therefore these people are engaging in self-destructive behaviour. The undercurrent of these world views makes current research difficult to accept in its entirety. There are suggestions now that dieting leads to greater mortality than does obesity, that it is the distribution of fat that is more important than the actual mass, and that women are less prone to problems associated with obesity than men.

There are strong suggestions that the academic literature reflects prevailing assumptions about being overweight. While much or most of the literature might reflect underlying real health problems, there is little research that addresses the issues as social issues. It can be said that the literature reflects an "uncaring and compassionless" professional views of those with weight problems (Sarason, 1987). Rather than starting from the perspective of what are the physical and social problems associated with obesity, there is an assumption that the issues are purely physical. This approach does not simply ignore the social problems but accentuates them. Failure to recognise that size is a social issue, leads to research that can increase oppression of these people, rather than reducing their problems.

What was clear from this research was that sexism is a major issue in fashion. Big women are less well catered for than big men. Big men are "big" (Queenslanders give prizes for the biggest beer gut). Big women are "fat". Big women are under serviced. Big women are not only expected to have to deal with the lack of services, but also the recriminations of others and themselves. They have to monitor what they eat, and expect others to do so. As one of these women said, she wears her sins on the outside.

What was also clear was that stores do not actively discriminate against big women (on the whole), but rather there are assumptions about women and obesity that are so ingrained as to not be questioned. Often the greatest damage that is done through discrimination occurs because people see particular practices as natural, or the way things are.
Small social change

The most important aspect of this area is that all research focuses on the individuals. There was an implicit assumption that the issue of obesity was an individual one. Although there are some comments to the effect that being large was associated with better health in the past, and as desirable in different times and places, there is little recognition of the social construction of beauty. These women suffer from poor body images in a society that idealises youth and youthful thinness. The fact that only 4% of women actually have the idealised figure is ignored.

Being overweight can be seen as a social problem. The problem can be restated in terms of how society is overly concerned with youth and not maturing. Just as wisdom has been supplanted by knowledge, and more recently by information, acceptance of maturing gracefully has given way to overarching concern with maintaining a youthful appearance. What overweight people need is a recognition of them as people, and the right to engage in society as equals. This is denied them, to a large extent. Readdressing this is important. One way is to encourage service and goods providers to extend to them the same access that others enjoy. Improving the range of clothing for big women was important because it addressed a number of issues:

1. It gave them a "win", they were able to empower themselves.
2. It allowed them to have a win in an area that they chose.
3. It is an area that helps them redefine their body image, and to appear in the community in a manner that has been deemed by society to be of such great importance.

References:

HIV/AIDS IS A LOCAL ISSUE
A project of The Victorian AIDS Council and Gay Men's Health Centre

Colleen Turner

The Local Government Liaison Project was the first program of the Victorian AIDS Council and Gay Men's Health Centre (VAC) to use the considerable knowledge and expertise of VAC to systematically inform and educate the wider community on the reality of living with the HIV virus. Until recently VAC has concentrated on those who have suffered the greatest impact of HIV disease in Australia; the Gay community.

It is significant that local government was one of the first sectors of the wider community to benefit from the accumulated experience and expertise of the AIDS Council. The Victorian AIDS Council has a philosophy and practice of using a community development approach to prevention, education and service delivery to people affected by the HIV virus, not only those testing positive but also their families, lovers and friends.

Local government is well placed to act as a leader and as an educator in community issues. It is a large employer and, in country areas, often a major employer. It provides a range of services to the whole geographic community including health and welfare services. The Local Government Project arose out of a growing awareness that communities needed to work together to provide care for the growing number of people who are becoming ill as a result of their HIV infection.

At the beginning of 1989, there was a belief among potential users of local government services, especially people becoming ill with HIV related illnesses, that local government care services were not appropriate, not accessible, not confidential and in some cases actively discriminatory towards people with HIV/AIDS. This belief was based on a number of cases that had been badly handled by local councils whose personnel were untrained, inexperienced and possibly a little fearful about the possibility of caring for clients with the AIDS virus. Therefore it was important to develop a stronger and more positive relationship between local government care services and VAC, particularly the volunteer care program of VAC.

Support of people living with HIV, including direct care, has long been an integral part of the work of VAC. Since the early days of the AIDS epidemic, a dedicated band of volunteers have provided emotional and physical support for those affected by the disease. This support network had become increasingly

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sophisticated to cope with expanding needs, and now includes a number of paid workers who coordinate the work of a large number of volunteers.

The project reported here was the first step in a realisation that the care needs of people suffering from HIV/AIDS-related illnesses are likely to increase dramatically, and that there is a need for the whole community to be involved in caring. A coordinated approach between mainstream services such as local government home care and more specialist services of organisations like VAC is the most effective way to provide community care.

This paper is primarily a report of activities undertaken by the Local Government Liaison project of the Victorian AIDS council. I will explore some of the issues it raised in terms of community consultation, education and service provision in a community context around an issue as controversial as HIV/AIDS still is. I worked as a project officer for a period of 12 months beginning at the end of August 1991. The overall goal of the project was to assist local government services to be more accessible to and more effective in meeting the needs of people with the AIDS virus. The particular methods chosen and tasks under taken to achieve this were:

1. To develop a service delivery model encompassing referral, assessment and care services in consultation with potential consumers, and service deliverers.
2. To train home care workers in the application of this model.
3. To evaluate the model from the perspectives of both the service delivers and the service users.
4. To publish the model in a form that is appropriate for local government home care services in Victoria and to encourage them to use the model and to train homecare workers.

DEVELOPMENT OF A MODEL OF SERVICE

The model of service (shown on pages 39-40) was developed by two reference groups and the project steering committee. The reference groups were comprised of staff from local councils participating in the project, regional volunteers and staff, representatives from the AIDS Council, where possible a person living with AIDS, and the project worker.

Four local councils agreed to participate in the pilot project, and were important in developing and trialing both the model of service and the training program. These consisted of two Melbourne metropolitan councils (St Kilda and Footscray), and two rural councils, (the city and the shire of Bairnsdale).

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The metropolitan councils were both part of one reference group and the rural councils were part of the other group. This was for purely practical reasons. Bairnsdale is four hours from Melbourne by car or train. I was the link between the two groups and there were occasional visits of one group meeting to the next. Because the Melbourne group was operational a couple of months before the Bairnsdale group, the Melbourne group generated much of the material for the model of service and the Bairnsdale group reviewed and modified material.

It was particularly important to have involvement from representative local councils to ensure that the model developed was practical, workable and flexible. In addition the credibility of the project within the local government industry was enhanced by involvement of representative councils who were willing to "sell" the project to other councils within their networks.

A steering committee gave final approval to the model of service delivery, the training program and the guidelines document. The Steering Committee was made up of representatives of industry level bodies including; the employer organisation, unions, the Industry Training Board; as well as the funding bodies of the project and of the AIDS Council.

This process of consultation and involvement at several levels kept me, as project officer, busy with at least three meetings a month to service, but judging by the evaluation comments it seems to have been worthwhile. One respondent of the evaluation questionnaire commented that "despite tight timelines people were not stopped from participating and discussing issues which was very healthy for the groups involved, very informative to all of us in the room about the different perspectives held by representatives of different organisations and different people".

MODEL OF CARE SUMMARY

There are four steps in the provision of home care services and each one is important. The major recommendations for the care of clients with HIV/AIDS at each step are listed below. However, it should be recognised that most of these recommendations are applicable to all clients and that the model is client centred, while acknowledging the rights and needs of workers.

STEP 1 Initial Contact or Referral

Councils should consider limited advertising of the service to appropriate groups.

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. The HomeCare service should consider establishing a working relationship with care and medical agencies before receiving any referrals.
. Initial client contact should be friendly and encouraging.
. Only minimal details should be taken at this stage. These do not include medical details or details of need for service.

STEP 2  Assessment
. Once again contact should be friendly and encouraging.
. Assurances of the level of confidentiality should be given, as well as an explanation of how the service works.
. There are a range of questions which should be asked of all clients and additional questions which should be asked of clients who have HIV/AIDS.
. Assessment workers should be trained in dealing with HIV issues.

STEP 3  Assignment and Briefing of Worker
. Home Care workers assigned to client with HIV/AIDS should have elected to receive skills training in caring for people with HIV/AIDS on the basis they will be assigned to clients with HIV/AIDS.
. All Home Care workers should receive information about transmission of the HIV virus and skills training in Infection Control procedures.
. Workers on new cases should be thoroughly briefed; including on which other agencies are involved and reminded of the need for confidentiality.
. Workers should have access to debriefing and support.

STEP 4  Review and Adjustment of Service
. Where limits have been set on the extent and time frame of the service clients should be aware of how to re-access the service if the need arises.
. At this stage a level of trust will have been built up between the worker and the client and the worker may be able to carry information or client requests to the supervisor or assessment worker.

TRAINING FOR HOME CARE WORKERS

A training program based on a model used for AIDS Council volunteers was modified for home care workers and piloted in participating councils. The program ran over nine hours, comprising three modules of three hours each. The first of these addressed transmission of HIV and infection control. The second module considered medical and psychological issues for people living with HIV as well as the issue of discrimination. Module 3 explored the issue of confidentiality, and then presented a "market place of issues". This allowed participants to talk in small groups with a range of peer educators including a person living with AIDS, Network, Vol. 8, No. 2, 1993, pp. 37-44
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a home care worker from experience with an AIDS-infected client, and other service providers such as the Royal District Nursing Service.

The Course was run three times during the project; in February 1992 for participants from the cities of Footscray and St Kilda, in April 1992 for participants from the city and shire of Bairnsdale and the local Koori cooperative. The final course was held in August, 1992, on a user pays basis, for workers from the four metropolitan councils of Melbourne, Brunswick, St Kilda and Broadmeadows. The course fees were used to recover facilitators' fees and organisational costs. (The small profit was used by the project to offset some of the costs of production of the guidelines document and the poster.

The evaluation of the training program was very positive and drew out the following themes.

* A factor in the development of the pilot training was the evolution of a flexible, interactive course which responded to the needs of course participants.
* The training course facilitated the development of confidence and enhanced participants' sense that they could care appropriately for people living with AIDS.
* The incorporation of people living with AIDS into the training was seen as a very positive and creative way of helping people address their own issues, stereotypes and perceptions of HIV/AIDS.
* The impact of training reached participants’ families and their friends, who may also educate others.
* The project has created a demand for training. A strategy for providing and coordinating this training is currently being negotiated.
* The training program was provided in an atmosphere where peer learning and support were encouraged. Workers appeared to gain a lot from the training in terms of personal feelings of growth and development, attitude change and increased confidence

EVALUATION

It was intended that a process evaluation take place throughout the project, and this was carried through to a certain extent. Participants in the steering and reference groups were encouraged to reflect on the experience of being part of the project, on the progress being made and indicate when and if they thought a change of direction might be necessary.

However the groups were generally occupied with the tasks of developing and
coordinating policy, training, or publicity and these did not devote much specific attention to the process. This appears to be a reflection of the project in that participants were happy to "get on with the job". There were no major disagreements about process.

All respondents to the evaluation questionnaire at the completion of the project perceived that the objectives of the project had been achieved within the timelines. It was acknowledged that a longer time frame was required to judge the effectiveness of some objectives. Some respondents indicated the potential of the project to achieve wider success with other councils in the future. One representative of a pilot council said:

The objectives were certainly achieved within the group. I'm unsure of how effective it will be generally. It's reliant on Local Government reading the output of the group and understanding and being sympathetic to the thrust therein.

A person with AIDS reported his perception that the project had effectively addressed issues that people with AIDS were concerned about discrimination, stigma and a lack of confidentiality. He stated that -

It achieved a lot more than the objectives in terms of attitudes of people in Brunswick, St Kilda and Melbourne councils. Very positive attitudes, real changes I have seen.

The evaluation of improved care by Council home care services is most appropriately judged by clients of the services. However, it is clear for many respondents to the evaluation questionnaire that the project has produced strong foundations for the provision of more appropriate services. It is too soon to attempt a longer term evaluation of the project on local government home care services in Victoria. One indication of its perceived value is that additional funds have recently been approved to continue the training role of this project.

PUBLICATION OF THE MODEL

The material in the guidelines document was written by the project officer with guidance and feedback from the steering and reference committees. The confidentiality guidelines that were a central feature of the broader document were developed in collaboration with the Melbourne reference group. The notion of overcoming hurdles for potential clients in each stage of the process was also initiated by the reference groups and has already been found to be valuable to home care services.

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On ongoing difficulty in the development of the document was how to define and target the most appropriate audience. Because the project was nationally funded there was a question about how the guidelines might be addressed to home care services around Australia. They are administered very differently in each state.

There was also a question of whether the guidelines should be pitched at a service provider level or more at the level of individual workers. In the latter case they would be primarily an explanation of the nature of HIV infection rather than a systematic model for the delivery of a service.

The solution was a compromise. The Guidelines were addressed to a service level, for example, to managers of aged services, home care supervisors and team leaders. However, they were simple and direct enough to be of value, also, to home care workers. In addition a poster was produced to remind all workers, including supervisors, of the main issues in providing home care to people living with AIDS. These were identified as: Infection Control, confidentiality, accepting non-traditional lifestyles, and mutual respect and communication.

The poster and the guidelines were illustrated with cartoons that addressed these issues and some others. Issues used in the cartoon had been identified by the reference groups in the development of the training program and the guidelines. An example of an issue often raised by both home care workers and potential
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clients follows.

CONCLUSION

I have tried to illustrate in this paper the value of a range of levels of community involvement in the development of policy, educational material, and service delivery around an issue that provokes, intense personal reactions. From my point of view as project officer the most valuable involvement was of people at the grass roots level of direct service provision, clients and potential clients of the service and, in this case, AIDS Council volunteers. The participants effectively were introduced to and engaged in a process of community development.

Representatives of these groups understood the practical day-to-day issues faced by their constituents and were able to advise the project so that the final product is realistic and flexible enough to meet the needs of the great variety of local councils in Victoria of which there are 210. In many respects, then, the guidelines and training program will be trialled 210 times as they are implemented throughout the state. However they have the distinct advantage of having been approved at all levels of involvement; clients, workers, councils, unions, the employer association, and State and Federal funding agencies as well the auspicing body, the Victorian AIDS Council.

It is worth ending on a cautionary note. After the conclusion of the project I had verified gossip that the poster developed from the project had been removed from the wall of a rural council chamber on the grounds that it was not appropriate for the issues to be displayed. This goes to show that the need for community education and development is never-ending.

References


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