Office Bearers

Chairperson
Lis Pike
Edith Cowan University

Secretary
Dawn Darlaston Jones
Edith Cowan University

Treasurer
Lynne Cohen
Edith Cowan University

Programme Accreditation
Andrew Ellerman
Anti Smoking Campaign South Australia

Professional Development
Meg Smith
University of Technology, Sydney

Membership Secretary
Catherine D’Arcy
Ovens & King Community Health Service

Student Representative
Emma Sampson
Helena Culbertson
Victoria University of Technology

Tao Jordan
Tracey Ahearn
Sally Chester Law
Edith Cowan University

Committee Members
Colleen Turner
Australian Institute of Family Studies
Julie Dean
University of Queensland
Heather Gridley
Victoria University of Technology

Published by:
The College of Community Psychologists of the Australian Psychological Society

Designed and printed by:
Print and Design Services Services Edith Cowan University.

ISSN 1320-7741

Disclaimer: “The publication of an advertisement by Network is not an endorsement of the Advertiser nor of the products and services advertised. Only those professional development activities carrying the APS logo and an appropriate endorsement statement can be considered to be specifically approved by the APS. Advertisers may not incorporate in a subsequent advertisement or promotional piece the fact that a product or service has been advertised in any publication of the society. The publications of the College are published for and on behalf of the membership to advance psychology as a science and as a profession. The College reserves the right to unilaterally cancel or reject advertising which is not deemed to be in keeping with its scientific and professional aims.”
Contents

Contents ........................................... 1
Call for Papers ................................. 2
General Information .......................... 3

SPECIAL ISSUE GUEST EDITORIAL
Heather Gridley ...................... 5

ARTICLES
Showcasing Community Psychology – Making a difference
Seventh Trans-Tasman Conference in
Community Psychology ...................... 7

Sex, Secrets and Desire: People with an
Intellectual Disabilities talk about their lives.
Lynne Hillier, Kelley Johnson, Lyn Harrison .................. 13

Ishtarim and Post-Natal Depression
Katie Thomas ........................................ 19

Adolescents’ Attachment To and Identification With
Their Community
Kathryn A. Laurent ................................. 26

Paradoxes, Parables and Conundrums: A new
sense of community?
Brian Bishop, David Vicary .................... 33

Australian Psychology and Indigenous People
Pat Dudgeon ........................................ 38

Tensions and Dilemmas in Feminist Research on
Sensitive Issues: The case of Project Hippocrates
Kelley Johnson, Heather Gridley, Susan Moore .......... 45

Too Close to Home: The Politics of
Psychological and Emotional Abuse
Peter Streker ...................................... 53

Community Psychology and/or Critical Social
Theory? – A Personal and Reflective Perspective
Tod Sloan........................................... 57
Contributions are invited for the next issue of Network. The theme of the issue will be Psychology, Multiculturalism, and Racism. The issue will present a selection of papers to stimulate debate about the challenges of cultural diversity and showcase the ways community psychology can contribute the promotion of positive cultural diversity.

To achieve this we are keen to receive a variety of contributions that address issues related to this theme, including theoretical, empirical and reflective pieces. We are also keen to include discussions and book reviews. All papers will be reviewed. Please see instructions for authors for a summary of the review process.

Please send your contribution to the Special Issue Editors, Lynne Cohen and Christopher Sonn.

Att: Lynne Cohen  
School of Psychology  
Edith Cowan University  
Joondalup Dr  
JOONDALUP WA 6027

Email contributions are also welcome

l.cohen@cowan.edu.au
General Information

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

Correspondence Editors
Neil Drew Institute for Regional Development
Lynne Cohen Edith Cowan University

Editorial Board
Heather Gridley Victoria University of Technology
Meg Smith University of Technology, Sydney
Helen Killmier Moonee Ponds City Council
Lindsay Gething University of Sydney

SUBSCRIPTION RATES FOR NON MEMBERS
Institutional rate for 3 issues $50
Individual rate for 3 issues $20

ADVERTISING RATES
Full page $100
1/2 page $50
1/4 page $25

INSERTS
All inserts must be trimmed and folded to at least 5mm less than the dimensions of Network.
A single sheet or brochure equivalent to 1 A4 page $50.

All payments to be made out to:
Lynne Cohen
School of Psychology
Edith Cowan University
100 Joondalup Drive
Joondalup WA 6027
When a small group of people came together at Trinity College, Melbourne in November 2000 to make plans for the future of Community Psychology in Victoria, hosting the next Trans-Tasman Conference was just one of the agenda items, a "by the way..." at the end of a long and challenging day. Our decision to give it a go, novice conference organisers that we all were, carried the proviso that it could not happen without the commitment of a critical mass of willing workers — students, academics, practitioners together. We also decided that it should be a supportive process for all concerned — that it was ok to have fun along the way, and that the best way to keep people involved was to feed them well. We even tried to be democratic about meeting times and venues, alternating between weeknights and weekends, north and south of the Yarra (Grand Prix and assorted other festival-related traffic snarls notwithstanding).

The Melbourne Conference came together in less than six months, and has its own place in the folklore of Trans-Tasman conferences, alongside those evocative names — Pakataa, Maralinga, Rotorua, Yarrabah, Toodyay — and Hamilton. This is not the place to revisit the conference itself, but I do want to acknowledge the work of all the contributors to the Conference Committee: Andria Green, Anita Krautschneider, Anna Shadbolt, Catherine D'Arcy, Colleen Turner, Delwyn Goodrick, Donna Robertson, Helen Killmier, Iain Butterworth, Isaac Prilleltensky, Pam Dawson, Pam Loughnan, Therese Maskell, and a bevy of indispensable student helpers from Victoria University. We also very much appreciated the support of Julie Morsillo at Whitley College, the Community College National Committee and the Victoria University Faculty of Arts, as well as the cooperation of the five community agencies that welcomed us on our "shopping tour" warm-up to the conference: the Victorian Foundation for Survivors of Torture, ARAFEM, Borderlands Co-operative, the Domestic Violence and Incest Resource Centre (DVIRC), and CERES Community Environmental Park. And the sparkling facilitation and evaluation skills of Ingrid Huygens and Delwyn Goodrick were largely responsible for a sustained collective energy and focus right across the four days.

No sooner had the conference ended (in a hospitable Melbourne autumn deluge) when the dreaded word "Proceedings" was uttered, and the prospect of them constituting the next issue of Network, the Community College Journal. Isaac Prilleltensky put out a call to all presenters to submit their paper for publication. All conference presentation proposals had been subjected to a review process, and each of the papers submitted for the Proceedings was further reviewed by two referees. The review panel included Adrian Fisher, Brian Bishop, Colleen Turner, Heather Gridley, Heather Hamerton, Helen Killmier, Isaac Prilleltensky, Lindsay Gething, Marion Kostanski, Neville Robertson, Pam Loughnan, Pauline Clement, and Vicky Totikidis. Thank you all for the serious consideration and constructive feedback you offered. And special thanks to my co-editor, Pauline Clement, who was meticulous in keeping track of authors, reviewers, manuscripts and redrafts — and who did much of the hands-on proofreading and editing herself.

Eight papers survived the review and revision process. While not representative of the entire range of keynote addresses, symposia, workshops, themed discussions, planning sessions and processing activities that took place at the conference, they are certainly indicative of some key debates and research hotbeds in Community Psychology within Australia and beyond. We are delighted with their freshness twelve months on from the
conference, and congratulate all the authors for the way they have managed to balance accessibility with intellectual and critical challenge. In order to contextualise the selected papers within the Conference Proceedings, we have also included a revised version of the conference program, including any available abstracts of papers and sessions not appearing in this issue.

Two of the papers here have been adapted by the authors from their keynote addresses to the conference. As such, they can serve as ‘bookends’ to this edition of Network. Pat Dudgeon is perhaps Australia’s best known Indigenous psychologist, and from this unique standpoint she reviews the ‘black history’ of Australian Psychology’s relationship with Aboriginal Australians. She invites community psychologists to engage with Indigenous realities, and to work with Indigenous people in empowering ways that prioritise the Indigenous community’s own issues and ways of seeing the world.

Tod Sloan was one of two international keynote speakers at the 2001 conference, and his paper examines the interface between critical social theory and community psychology. Drawing on his own journeys around, inspirations from, and eventual disillusionment with both of these traditions, he attempts to frame the major challenges and indicates some areas where one might expect fruitful dialogue.

In similar vein to Sloan’s critique of traditional community psychology approaches, and resonating also with Dudgeon’s invitation to acknowledge the perceptions and perspectives of Indigenous people, Brian Bishop and David Vicary apply their critical torch to one of Community Psychology’s (few?) truly original contributions to theory and practice: the Psychological Sense of Community (PSOC). They challenge theorists to utilise the concept in the service of those denied connection with community, and to learn in turn from their experiences to see ‘the bleeding obvious’ that we so often miss in attempts to pin down and quantify the foundational concept of PSOC.

Perhaps this is just where the value of Kathy Laurent’s doctoral work lies – in sitting down and talking with young people about what sense of community and place attachment mean in their lives. She concludes that adolescents can and do identify with their communities and homeplaces – and that we sell young people short if we underestimate such attachments just because of their youth.

Three of the papers published in this issue come from the symposium I convened on New Directions in Feminist Research. This is not so much an indication of editorial selection bias, but of the limited reach of editorial nagging power. I was enthralled by Katie Thomas’s innovative presentation on women’s experiences of depression particularly post-natal depression. In a ‘new age’ when it is fashionable to draw somewhat randomly on ancient wisdoms to illuminate current dilemmas, Thomas highlights the dark side of the many breasted goddess Ishtar’s legacy for young mothers struggling to meet multiple, often impossibly conflicting demands.

Lynne Hillier, Kelley Johnson and Lyn Harrison illustrate the wide application of feminist research principles, in their report of a project that gave voice to a group of people often constructed as ‘imperfect, irrational and unhealthy’ – women and men with an intellectual disability. The participants’ reflections on autonomy, sex, secrets and desire provide a challenge to traditional models of public health, health promotion, sex education and duty of care. The authors conclude that a focus on regulation and protection of people with disabilities has actually increased their vulnerability and denied their human rights.
Kelley Johnson, Heather Gridley and Susan Moore provide an overview of Project Hippocrates, a four-stage project examining interactions between women and their doctors. The focus here is on the dilemmas and tensions encountered by the researchers, particularly in navigating wide power differentials between groups, and in working across the different discourses of social science and medicine. The lessons we learned have applications for any research that sails close to critical/political edges — as feminist and community psychology research ought to do, if we are heeding the challenges laid down by our ‘bookend’ colleagues above!

The final paper selected for this edition is by Peter Streker, who engages in the highly risky business of researching and theorising family violence. What’s more, his subject matter is the largely uncharted territory of psychological and emotional abuse. Streker’s experience as a facilitator of behaviour change programs for men who use violence has given him a firm grounding in the feminist sociopolitical analyses that are fundamental to this work. His doctoral research draws on critical, profeminist and community psychology frameworks as he attempts to unravel the complexities and contradictions inherent in the use of less visible patterns of control.

We were proud of both the quality of presentations and the processes that supported them in making the Seventh Trans-Tasman Conference in Community Psychology so memorable for visitors and locals, veteran and neophyte community psychologists alike. We are equally proud of this special “Proceedings” edition of Network, which brings together research and practice in critical community psychology, and encapsulates some of the most pressing theoretical and political challenges confronting the field. Having turned the corner into the 21st Century, no longer are we trying to justify our existence or wrestling with tired and inward-looking attempts to define the field. We are getting on with the job of making a difference in our communities, while continuing to refine and reality-test our theoretical constructs.

As I draw together the threads running though all eight papers, I recall Charlotte Bunch’s (1974) five criteria for evaluating feminist reforms. Broad consideration of these criteria in relation to our theorising, research, teaching and practice with any group might go a long way towards keeping us honest:

- Does the reform materially improve the lives of women (Indigenous people…?) and if so, which ones and how many?
- Does it build an individual woman’s self-respect, strength and confidence? (read ‘person with a disability…?’)
- Does it give women (young people?) a sense of power, strength, and imagination as a group and help build structures for further change?
- Does it educate women (community psychology students?) politically, enhancing their/our ability to criticize and challenge the system in the future?
- Does it weaken patriarchal (colonial?) control of society’s institutions and help women (those denied power and connection) gain power over them? (pp. 45-46)

Not a bad way to think about making a difference!

Heather Gridley, Victoria University

Reference
“Showcasing Community Psychology – Making a Difference”

Seventh Trans-Tasman Conference in Community Psychology

Sponsored by Victoria University Faculty of Arts and the APS College of Community Psychologists

Thursday 19th - Sunday 22nd April 2001 Whitley College, Melbourne

Thursday evening

Showcasing student research
Creative ways of connecting young people to their community
Lyn O’Grady – Victoria University

Adolescents and their community: issues of sense of community, place attachment, place identity, and social support
Kathryn A. Laurent – University of Southern Queensland

The Health Experiences of Rural Maori: Social, Cultural and Economic Aspects
Jacqueline Henry, University of Waikato

Friday morning

Indigenous issues

Keynote address: Indigenous Issues and Psychology
Patricia Dudgeon - Centre for Aboriginal Studies, Curtin University

Plenary session: Indigenous issues in Victoria
Convened by: Victorian Aboriginal Health Service
Community psychologists in Victoria are keen to strengthen their links with local Indigenous communities. We invited local Indigenous health workers and researchers to participate in the conference and to present some innovative developments in their work. We hear an account of the culturally appropriate development of a “Healing Centre” model: a youth peer research project, and a mental health initiative exploring what makes a healthy community from an Indigenous perspective.

Indigenous historical perspectives
Wanda Braybrook, Kelly Faldon - Regional Centre for Spiritual and Emotional Well-being, Victorian Aboriginal Community-controlled Health Organisations (VACCHO)
Ann Bambrook

The strength of young Kooris in Melbourne – for psychologists to consider when meeting or working with young Kooris
Paul Stewart, Victorian Aboriginal Health Service

Aboriginal Mental Health Issues
Lance James - Family and Mental Health Program, Victorian Aboriginal Health Service

Friday afternoon

Keynote address: Community Psychology and/or Critical Social Theory?
Tod Sloan - University of Tulsa

Symposium: Doing psychology critically: Making a difference in diverse settings
Convened by Isaac Prilleltensky, Victoria University

The session consists of three short presentations and discussion with the audience. The presentations deal with the role of power, reflexivity, and politics in psychological practice and in psychosocial problems. The audience is asked to participate in the discussion through a series of questions related to the main presentations. The session is interactive and participants have ample time to discuss issues with presenters and other peers. The discussion focuses on the implications of critical psychology for three groups of people: we as psychologists, the people we work with in our daily jobs, and the people we don’t work with but who are oppressed by societal conditions.
Too Close To Home: The Politics of Psychological and Emotional Abuse.
Peter Streker, Victoria University

Global poverty: Challenges for critical psychology.
Tod Sloan, University of Tulsa

Rehabilitative work in prisons: cooperating toward a mission of community welfare.
Kerri Kershaw, Victoria University

In an effort to become more responsive to community expectations, prisons are increasingly turning toward mental health professionals to augment existing rehabilitative programs. This research looks at models of power within the culture of the prison environment and examines ways in which custodial staff and mental health workers can share their knowledge and expertise in order to have a greater impact on rehabilitation.

Workshop: The Values Dimension in Community-Based Evaluation Research
Delwyn Goodrick, Victoria University & Niki Harre, University of Auckland

This interactive and participatory workshop addresses issues, decisions and values involved in 'doing' program evaluation in education, health and welfare settings. Participants engage in activities that highlight the value dimension of program evaluation. The workshop material is based on cases derived from the presenters' work in the field. A structure is proposed to assist evaluators in making values explicit, to enhance communication with clients and strengthen the validity of processes and outcomes.

Symposium: Cultural relevance, cultural competence and cultural safety in community research and practice
Convened by Prasuna Reddy, University of Melbourne

Community psychologists have taken seriously the relevance of culture and nation in their research and practice. We need to consolidate our efforts to address new ways of thinking about specific aspects of culture as lived experience. This discussion focuses on four general areas of research and action: culture-as-construct, culture-as-method, culture-as-practice and culture-in-framework.

A cultural analysis of future trajectories
Prasuna Reddy, University of Melbourne

This paper considers the ways that people in mid- and late adulthood construct future selves. The samples comprise over 2000 men and women in eight nations in the Asia-Pacific region. Values expressed in the Australian community are contrasted with those in Asian communities.

Cultural Diversity, Cultural Equity: A Community Organisation's Approach
Sarah Radcliffe & Malou Anes, Western Region Centre Against Sexual Assault

The Western Region Centre Against Sexual Assault (WestCASA) is located in a culturally rich and diverse Melbourne community. As a small agency with limited resources, we wondered how to respond to the unmet needs of victim/survivors of sexual assault from linguistically and culturally diverse communities (LACDC). Inspired by the Lower Hutt Family Centre (New Zealand) and the Wentworth Multicultural Health Service (NSW), we developed a pilot project entitled the Cultural Equity Program, which is based on principles of respect and empowerment. It strongly advocates a collaborative approach. The program also recognises the importance of adopting a multi-faceted approach which identifies structural, organisational and individual barriers preventing victim/survivors from LACDC accessing appropriate services. Sarah Radcliffe outlines the Cultural Equity model and highlights key learnings and dilemmas. Malou Anes speaks about her experiences as a Cultural Consultant and Community Educator

Working as an expatriate psychologist: Deconstructing self or self destruction?
Anna Shadbolt, Centre for Grief Education

After six years living and working in Fiji, I have gained some insights into the difficulties of attempting to apply the western knowledge base of psychology to the indigenous cultures of the Pacific. In this paper I describe how necessity resulted in my forced rethinking about the assumptive bases of psychological interventions. I also reflect on how this process resulted in a whole new view of the self as a psychological concept, and how it forced me to challenge my own assumptive world. In the end, I am left with more questions than answers, but greatly enriched from having walked down this road.
Challenging Nyaminyami: An exploratory study into the world of the Zambezi Rafting Guides
Fiona J Wiltshier

During a year living in Southern Africa the divide between the indigenous and non-indigenous communities become increasingly evident as I talked to more and more people about their views and beliefs and by just observing the day to day interactions. There was however, one notable exception, the community of Victoria Falls on the banks of the Zambezi River. Here among the beauty of the African bush and the majestic Victoria Falls is a community which thrives on the tourists who come seeking adrenalin pumping thrills. The main focus is the Zambezi River and the sport of white water rafting. Those that guide these rafts on the Zambezi come from a diverse range of cultures and races but between them all is a respect for one another than goes beyond race, that is the respect for another human being who has the skill and courage to face death every day and pursue their dream of being a white water rafter. Through an ethnographic standpoint, this paper explores the world of the white water rafting guides and in providing an increased understanding of them as individuals seeks to determine what it is about this extreme sport that bridges the divide between indigenous and non-indigenous communities, a divide so evident in other parts of the country.

The Health Experiences of Rural Maori: Social, Cultural and Economic Aspects
Jacqueline Henry, University of Waikato

Saturday morning

Keynote address: “Doing psychology critically: making a difference in diverse settings”
Isaac Prilelentsky, Victoria University

The presentation addresses the need to do psychology critically. The basic tools for thinking critically about psychology are power, values, assumptions and practices. Power can be used to promote wellness and emancipation, but also to promote oppression and domination. Values, assumptions and practices can also have emancipatory or oppressive effects. The presentation disentangles the positive and negative effects of psychological practice and point to applications that are empowering and conducive to social justice in diverse settings. Critical practice in counseling, clinical, educational, health, work, and community settings are discussed.

Symposium: Sense of Community, Sense of Place
Convened by Iain Butterworth, Department of Human Services, Melbourne

The physical environment provides the setting and backdrop by which we live our lives, and impacts on our senses, emotions, sense of place and belonging, sense of community, participation in physical activity and civic life, and general wellbeing. Spaces, places and buildings are imbued with meaning and resonance, symbolizing people’s personal histories, and shared events in our relationships, communities and wider culture. Places are created and shaped by those in control of resources and with particular interests, affecting our degree of access to, and the way we use, those places. This symposium explores research and practice into sense of place, sense of community, and its intersection with social policy.

“Who am I?” - The possible roles of place attachment and sense of community
Grace Pretty, University of Southern Queensland

In our attempts to understand the person-in-community - one’s sense of it, attachment to it and identity with it - we have enlisted several constructs to orient our investigations. However, as researchers have foraged amongst their data from community residents in attempts to establish conceptual clarity and to discriminate amongst these dimensions, e.g. Puddifoot (1995), one result has been a tangled web symbolising a psychology of community experience. This brief sketch describes some of the sociological, geographical and psychological background to sense of community, community/place identity and community/place attachment constructs. One possible web of relationships amongst these constructs is suggested. The centre of the web is developed from the propositions of theorists regarding the significance of bonds with place in the dynamic construction of self identity (Giuliani & Feldman, 1998; Prochansky et al, 1983; Sarbin, 1983). This model proposes the relevance of community attachment and sense of community to the lifespan quandary of “who am I?” in terms of “where am I”.

Community, place, therapy and culture
Brian Bishop and David Vicary, Curtin University, Perth WA

Sense of community is argued as a pivotal aspect of mental health. The western concept of mental ill health is examined in terms of its underlying psychiatric dimensions and the attendant social constructions. SOC is seen as central in dealing with the impact of the socially constructed notions of mental health. These views are contrasted with indigenous
views of mental health, where sense of place is integrated with sense of community (or at least in western analyses of these phenomena). The separation of SOP and SOC reflect the Cartesian underpinnings of western thought and represent the failure to adopt a holistic approach, which is essential to the understanding of social contributions to mental illness.

**Place, symbols, and identity in sense of community research**

Iain Butterworth and Adrian Fisher, Victoria University, Melbourne

Sense of place and place attachment is developed from the physical and built surroundings of one's environment. These carry meanings for the person and are indicative of a history shared with the larger community of which the person is a member. In this paper, the authors explore sense of place and place attachment using the example of the identity formed from the symbols of the shared history – the architectural designs of a person's neighbourhood. The genesis of these ideas was part of the environmental education program in the first author's doctoral research in which numbers of participants began focussing on the personal and collective identity gained from heritage areas and the psychological impacts from the threats to these by unsympathetic and out of character developments. Examples are used of housing designs and building densities that are out of context to the surrounding areas.

**Adolescent attachment to and identification with their community**

Kathy Laurent, University of Southern Queensland

**The built environment: A new dimension to municipal public health planning**

Iain Butterworth, Department of Human Services, Melbourne

Local Councils vary widely in the extent of their embrace of a social model of health, and in particular the concomitant appreciation of the link between the built environment and wellbeing. There is also diversity in applications of a 'whole-of-government' approach, for example the engagement of urban planners, environmental health officers, engineers, architects, management, and others in incorporating health considerations into divisional work programs that involve modification of the built environment. Councils also vary in their understanding and embrace of community participation principles in planning. PHO now has an opportunity to engage stakeholders in collaborative efforts to find urban planning and architectural solutions that promote physical activity and health, safety, sense of community and belonging, participation in community life, empowerment and wellbeing. This presentation describes work in progress on the MPHP framework.

**Symposium: New directions in feminist research**

Convened by Heather Gridley, Victoria University

Feminism and Community Psychology share much common ground, yet have underutilised each other's offerings. This session highlights the diversity and complexity in current feminist research that strives to encompass women's rights as human rights in a range of circumstances and settings. Presentations draw on qualitative and quantitative research with women in areas such as sexuality, disability, mental health and service provision.

**Sex, surveillance and secrets: technologies of management and exclusion in the sexual lives of people with intellectual disabilities**

Lynne Hillier, Kelley Johnson & Lyn Harrison

**Motherhood in the life of women with physical disabilities**

Ora Prilleltensky

**Depression and paternalism: the impact of professional worldviews**

Katie Thomas

**Project Hippocrates: towards women-sensitive medical practice**

Heather Gridley, Kelley Johnson & Susan Moore
Workshop: Social Action and Empowerment in Community Mental Health

Meg Smith, Catherine O'Arcy, Judith Player and ARAFEMI

Community Psychology has been supportive of self-help groups' role in mental health, not only for potential benefits to individual members, but for their broader political role in shifting the focus of mental health services and encouraging consumer empowerment, participation, access to resources, and social justice. This interactive forum draws on the speakers' collective experience in research, practice, policy, and/or as members of self-help groups in mental health. Questions are raised about roles of professionals and researchers in working sensitively with self-help groups, including how to help groups to better support members, to involve people who traditionally don't participate (such as young people and those with higher disability), and issues that arise in working with groups.

Saturday afternoon

Keynote address: Walking our Talk: Queries & Advices for Community Psychologists

Kelly Hazel, University of Alaska

This address focuses on the question: what are the ethical imperatives for research and practice in Community Psychology? Beginning with Community Psychology's long-standing value base, Kelly draws on the Quaker tradition of "queries and advices posed as guides for right practice" to pose four queries:

- Is our work grounded in humanitarian values?
- Is our work in and of the community?
- Does our work reflect respect for and appreciation of diversity?
- Does the focus and conduct of our work exemplify social justice?

Practice examples from work with Alaskan Native communities are used to illustrate these "queries and advices" in action.

Workshop: Community-friendly counselling – deconstructing therapy

Jeanette Shopland & Joan Beckwith

Two interactive presentations offer challenges for counsellors, therapists, clinicians and community workers prepared to "walk the talk" of deconstructing professional power and promoting consumer participation. The legacy of psychological training in counselling encompasses twin dilemmas of depoliticisation and expert power, as articulated in feminist critiques of counselling, and more recently in postmodern approaches such as narrative therapies. This session involves two complementary segments addressing issues of power and social justice in counselling/therapeutic contexts. The first uses a workshop format to invite participants to deconstruct therapeutic practices that shore up expert notions of "truth", and to reflect critically on the role of therapy in contemporary culture, by consideration of language, power, and the real effects of commonly used theories, models and ways of working. The second then considers a case study of client partnership in service delivery, involving a collective of service providers and service users, as a form of response that goes beyond counselling dyads.

Interest Group Meeting: Psychology and the Environment

Debra Rickwood, University of Canberra & Jenni Rice, Victoria University

The APS Interest Group on Psychology and the Environment conducted a survey of its members to help determine future directions for the group. Like environmental issues in general, the interest group has been dormant for some time. This has not been due to lack of interest, but rather due to lack of common identified directions and strong networks among members. This session presents the findings of the survey, with the aim of stimulating discussion and developing directions and strategies to raise the profile of environmental issues vis-à-vis community psychology.

Workshop: Diversity in practice – the many faces of Community Psychology

Neil Drew, and representatives from Australia, New Zealand and North America

We proposed to run the session as an interactive exchange of news, views and ideas about what characterises community psychology in the region. Participants are invited to give some thought to the following arranged under the broad question of (but not limited to):

What does community psychology look like to you?

- What do you do in the name of community psychology?
- How do you do it?
- What are the principles and values that guide your practice?
- How are these principles enacted in your practice?
- How do you manage the tensions between the rhetoric around principles and values and reality in your work?
Our purpose? To give voice to and celebrate the diversity of styles in community psychology. During the session a thematic analysis on the run (!) examines:

- The distinctive features of community psychology in the region.
- The shared vision for the enactment of community psychology.
- Identify points of departure.

We hope that the outcomes of the session provide a platform from which partnerships may be established in teaching, research and practice throughout the region. We also hope to take the information and produce a booklet on community psychology, titled surprise, surprise Diversity in Practice, as a marketing and promotional tool.

Sunday morning

Annual General Meeting: APS College of Community Psychologists

Planning session: Community Psychology Horizons

Isaac Prilleltensky, Catherine D'Arcy & Iain Butterworth

AIMS: To develop clear strategies for action on:

- What we can do for society in terms of analysis and intervention;
- What we can do for ourselves, in terms of enhancing the profile of our profession;
- What we can do for students, in terms of securing a future and attracting them to our courses;

We want to try to keep the meeting contained to addressing 3-4 action areas so as to achieve tangible goals. After a plenary to share ideas, small groups can then fine-tune their action plans. A steering committee may oversee implementation of overall plan.
Sex, secrets and desire: people with an intellectual disability talk about their lives

Lynne Hillier, Kelley Johnson (Australian Research Centre in Sex Health & Society) & Lyn Harrison (Deakin University)

Traditional public health and health promotion models rest on the notion that good health should be available to all and, to this end, the State acts in the citizens' best interests by regulating the behaviour of its constituents. On the surface this seems like a fairly benevolent role for the state to play. However concerns have often been expressed about the unequal distribution of health, between rich and poor and marginalised groups and the ways that some groups are regulated in different ways from others.

Regulation of health can be thought of in two ways - self-government, the ways in which we act on our own bodies in order to attain a certain state of happiness, purity, wisdom, perfection or immortality - and the more apparent forms of external government - policing, surveillance and regulatory activities carried out by agencies of the state or other institutions for strategic purposes (Lupton 1995). For a person to be accorded the freedoms of self-regulation s/he must be constructed as being rational, autonomous and trustworthy.

While the rise of public health and health promotion has brought improved health for many in the population, those people who are not accorded a rational subjectivity and can find themselves excluded from access to the services and the privileges of other citizens. The population is split in two. Some people are venerated as self-governing, having internalised the State's requirements. Their private lives are judged to be consistent with the norms established in the society and do not require external regulation. Within these constraints they exercise freedom and autonomy - others are not so lucky. According to Lupton we need to ask why some groups are valued and others marginalised, ... some are given a rational subjectivity and others not (1995 p8).

One group of people who are very often constructed as imperfect, irrational and unhealthy are those labelled as having an intellectual disability. People labelled with an intellectual disability are rarely accorded a rational subjectivity and are less likely to be thought capable of acting autonomously. There is rarely the pretence of the possibility of self-regulation as these people are positioned as unable, unaware and irresponsible. An example of this thinking is that the main paradigm for the management of people with an intellectual disability over the last four decades has been "behavioural modification" which does not depend on the thinking, rational subject for its success.

People with an intellectual disability have historically been the most regulated of groups, but they are rarely asked to comment on this or to talk about their lives. We do not know how people with intellectual disabilities feel about the ways their lives are managed or whether they realise they are managed at all. We know nothing about their desires because we don't ask them. In this paper we present the reflections of people with an intellectual disability about autonomy, sex, secrets and desire in their lives.

This paper emerged from life stories told to us by 25 people labelled with an intellectual disability (Johnson et al 2001). Each story took four sessions to collect and each is unique and rich in its own way. There were many ethical issues around consent and confidentiality that had to be worked through carefully. A critical reference group of service providers and people with an intellectual disability was used to advise and ground the project. Ethical approval was gained through the Human Ethics Committee at La Trobe University.

The stories are profound, moving and recognisable. We have had feedback on a number of occasions from other people with an intellectual disability that "this is my life I am hearing" or "this is what happened to me". Moreover, we have little doubt of the authenticity of the stories and their relevance to a wider audience - one of the most powerful aspects of them is the way that they do speak to people who do not have an intellectual disability - not from a client-worker perspective but from one human being to another.

The storytellers

The project was advertised in advocate and other consumer newsletters. Twelve men and 13 women, aged between 25 and 60 told researcher/interviewers (three women and one man on a one to one basis) their life stories over several sessions with a particular focus on sex, love and relationships. Interviewers were all experienced in working with this group. Interviews were held in locations which were convenient for the story-tellers, eg in their own homes and local community centres. Seventy-five percent lived in Melbourne and 25% in rural areas of Victoria. Twenty-five percent came from linguistically diverse backgrounds. Twenty-percent lived independently and 80% were in supported accommodation. The sessions were taped, transcribed and analysed for themes. Names and places have been changed to ensure anonymity.
Themes from the stories

As well as seeing the stories as separate whole entities, we looked for common themes that highlight the story-tellers' understandings of the regulation of their lives, their active engagement with it and their needs and desires. The story-tellers often had very clear ideas about the ways their lives were controlled by others. They were also very clear about the means that they used to obtain a degree of freedom in their lives. This section outlines the key issues that they raised. Their comments need little analysis. We have used this paper as a means of giving some of the story-tellers a voice.

We are treated like children

Many of our storytellers expressed distress about not having the control over their lives that they wanted, even though they were all adults. They noticed that their siblings or non-disabled peers in the community had more freedom than they did and were respected for their opinions. Decisions were made by others for this group on very personal and basic levels including around sexuality and fertility. This was not the case with everyone but it was an overriding experience in many lives. Molly, who was in her late 20s expressed dissatisfaction with this treatment:

I can't talk with my family 'cause they put me down all the time and they just treat me like I've got a disability and I can't do anything. I can talk to my boyfriend's mum about anything, she wants me to have a baby but my family don't cause they reckon I wouldn't be able to cope. My mum and dad treat my brothers and sisters better than they treat me. They talk to them about anything but they don't talk to me about anything. Probably because they reckon I wouldn't be able to understand but I understand more than they think I understand. (Molly Hope, late 20s)

Molly did not passively accept that she was incapable and untrustworthy and she clearly believed that this treatment was unfair. Her parent's attempts to overprotect her were unwelcome, she tried to resist her parents' negative ways of framing her abilities and she looked for other adults who would treat her as a peer.

Our difference is a problem

The storytellers were well aware that they were regarded as different and that people thought their difference made them inferior. Being regarded as inferior often meant exclusion and sometimes abuse. David never felt he could measure up to his family:

I see my family on and off. Let me say that it's sort of hard to have a disability in the family, when you're trying to be like them and you can't. It feels like with my father and brother that whatever you do it feels like you've done something wrong. So I'm always apologising which I don't need to. (David Warren, early 20s)

Sarah experienced verbal and physical abuse at her school:

Because I wasn't clever or nothing and they'd [other students] come and say "Oh there's something in your locker, spiders in your locker" and all this. One day I was in woodwork and I was putting a chisel away, you know and a girl just knocked my hand and went flying into it, cut me hand open and I think I had four or five stitches. Went back to school and next thing they tripped me over, cracked me teeth open, I just didn't want to stay at school, I thought "No, I've had enough". (Sarah Standish mid 20s)

David found himself on the margins of his family, never feeling as though he could make a positive contribution and always feeling as though he had to apologise for himself, that he was never good enough for them. Sarah's fellow students were not content to passively exclude her and they expressed their disapproval of her difference by physically assaulting her until she decided to leave the school. For many of the storytellers, the attitudes of those around them was felt to be a form of rejection and exclusion. These experiences were made even more painful because they were often created by those close to the person with a disability, for example, other family members.

Sex is taboo for us

Over three-quarters of the 25 storytellers were, or had been, sexually active, some had regular partners and others had regular casual sex. Despite this sexual activity, they knew that for them, sex was regarded as unacceptable by many of those around them. Hannah and Hussein recount their experiences:

Kevin and I met here [supported accommodation unit]. He came here about six months ago and we fell in love. We wanted to share a room. The staff here didn't want us to but after a while they said it was all right. Kevin and I used to - when the staff were saying it wasn't alright to share a room - we'd leave that particular night and go off on our own [and have sex] and then come back the next day. In the end they decided that we could have the room together. (Hannah Booth, mid 30s)

I have had a girlfriend. We went out together and we talked and that and we kissed. We haven't had sex together. She goes her parents will find out and so will mine. When you're living with your folks it's hard. Sometimes it's easier with men. (Hussein Damianis, late 20s)

Past research with marginalised groups who are thought to be unworthy sexual subjects (eg Hillier et al, 1998) tells us that making sex taboo for a particular group does not stop sex, rather it changes, becomes furtive and unplanned and in some cases unsafe. Because sex was frowned upon, people with intellectual disabilities in this research moved out of the gaze of their families and carers to out of the way places, taking advantage of sexual opportunities whenever they could.

Kevin's ideas about where people could have sex reflect this:
We learn about sex through doing it

Formal sex education was rare in the group and when it was taught it tended to be decontextualised and therefore irrelevant. As a result very few of the participants had a good working knowledge of safer sex practices. Luigi, who regularly attended beats for sex was asked about AIDS:

I know nothing about AIDS. But plenty of people have talked about it. You have to buy condoms at the chemist. They are for your thing, you know your dick. They stop sperm to come out. I don’t know why. Good question that. (Luigi Favolore, late 20s)

Neville had a lot of misinformation about the spread of HIV:

You get AIDS mostly through homosexuals. You get it from homosexuals if you go and use the toilet. And you can’t get it from anywhere else. You can get it from cars or buses. Someone can have HIV and you go sitting in the bus in that seat or tram after the person’s been in it. You don’t even know. Anyone can catch it. Anyone can catch it homosexual or not. Eating out of rubbish tins, picking up any dirty stuff and so on you get HIV. (Neville McDonald, 50s)

One of the consequences of denying a person independence and information is that power is positioned externally and the power is often misused. Much has been written about the sexual abuse inflicted on people with an intellectual disability (McCarthy, 1999, Turk & Brown, 1993). Most of what the storytellers knew about sex came from personal experience and in many cases these experiences were abusive. Hussein’s first sexual encounter was with a neighbour who was nine years older than him:

I was thirteen when I first had sex. Well it was someone from the same street as us. He was 22 and I was 13. I was going for a walk. And I snuck in quickly when they weren’t looking. Into the guy’s house. And he let me in. He didn’t tell on me. And we did it together. And then we talked and then we, he showed me his penis. And when he showed me I showed him mine and I touched his. And he got, what’s the word? ... When you get carried away? When you start having sex and he come? And we went into the bedroom. And he took his clothes off and I took mine off. And he kept on going and going and doing the same thing to me till he first went off. And he said, “Don’t tell your parents, it’s a secret.” And no-one knew about it. It was between him and me. He was about 22 and I was 13. And then I saw someone else and he goes “Have you done it before?” And I go “yeah” and we did it. He was a neighbour. About 29. I was turning 14. I didn’t tell my parents. (Hussein Damianis, late 20s)

Two-thirds of the storytellers recounted sexual experiences with fathers, workers and strangers, some of which they perceived as abusive and all of which would be regarded as abusive by society at large. Because families and carers rarely expected sex to be a normal part of these people’s

We are dissuaded from having children

This issue is probably the most contentious in relation to people with intellectual disabilities. It has informed government policies in relation to their early exclusion from the community into institutions and remains a source of anxiety for service providers and families (Johnson et al., 2000). There were no examples of the normalising of parenthood and fertility for the story-tellers in this research. Their stories indicate that it was mainly the women’s sexuality which was surveilled and controlled. A number of the women had been sterilised and in most cases there was coercion involved. Some women were told that their babies would be disabled, even though their disability was not genetically based. Others were emotionally blackmailed into sterilisation procedures. In some cases pregnancy occurred and this created a great deal of stress for the women and their families. Molly is an example:

I went on Depo because I kept forgetting to take the pill and I accidentally fell pregnant once before to a friend, a one night stand I had and my mum and my dad and my sister didn’t want me to have the baby because I’ve got a disability and they reckoned I couldn’t look after it and my sister booked me into having an abortion, and the day before I had a miscarriage. Mum said to me don’t you ever do that again because if you did you’d be disowned from this family. (Molly Hope, late 20s)

We are not saying here that pregnancy and parenthood are unproblematic for people with intellectual disabilities, rather that in the name of protecting families and the women themselves, the notion of rights seems to have been forgotten. Moreover the problematising of fertility is gendered. We had no evidence of any of the men in the research being sterilised or that these issues were ever raised with them.

And when they, people have sex, they should do it where nobody can see them.... Yeah that’s what they should do... if their parents are around they shouldn’t have it they should go where it’s more private and they can do it and that. Because they don’t know, but the parents might go into their house and they’re don’it and get caught. So they should do it somewhere where it’s private and personal and that. Or when they go away or something like that, and then they can do it where nobody can see them. Like camping or going away in a motel or something like that they can do it. Or in a car... If there’s nobody around they can do it in a car. Or in the bush somewhere. Yeah. (Kevin Ryan, mid 30s)

We would not expect most adults to suggest the bush or cars as preferred places to have sex, but private spaces such as bedrooms, available spaces that the rest of us might take for granted, were not available to many of the people in this research.

We are not saying here that pregnancy and parenthood are unproblematic for people with intellectual disabilities, rather that in the name of protecting families and the women themselves, the notion of rights seems to have been forgotten. Moreover the problematising of fertility is gendered. We had no evidence of any of the men in the research being sterilised or that these issues were ever raised with them.
lives, it was rarely discussed, and these people were left without the skills and knowledge they needed to protect themselves from inappropriate advances by others in the community. Sex education was often of limited use to the story-tellers because of the power imbalances they experience in relationships.

Voicing Desire

It is clear from people's stories that they were well aware of what people thought about them and they resisted this in many ways, including finding ways to express their sexual and other desires. Their stories revealed that their desires differed little from the desires of non-disabled community members and as in the wider community, their desires were gendered.

The desire for independence

The women in particular in the research expressed a strong desire for independence, including control over where they lived and handling their own finances. The men appeared to have greater freedom of movement. They were less likely to be watched over, monitored and protected. This is a gender difference that moves across populations of marginalised people (Warr et al, 1997). Hannah wanted to move out of the residential unit she was living in:

I'd rather have my own place. I asked my brother about having my own place and he's told me no, that I wouldn't be able to cope living in a flat. He had the final say because he's in charge of my money. I suppose I've kind of got to understand it. I don't agree - it makes it really difficult. It's better having my brother than the state trustees I can tell you that much. It was awful; I had no money and no rights (Ruth Booth, mid 30s)

Ruth looked forward to moving from her parents' house into a house that had been modified for her needs:

In this house I'll be able to do everything, everything I've ever wanted all by myself. You know, I'll be able to cook by myself, hang out washing by myself. I'm hoping it's going to be low enough for me to do it. It'll be great. I can't wait. I'll still have attendant care every day of the week, 7 days a week. I'm with Support now, which is an organisation who help people move in to houses, or who are already in houses, they come and they help out. You know they run programs and stuff like that. They're helping me with extra home care when I need it and they're helping me get carers to pay my bills. They're paying for the carers to help me with extra time to pay my bills, help me with shopping, helping with banking, anything I need really. (Ruth Simpson, 30s)

Ruth's new situation describes a much more independent way of living with carers to assist her in what she wants to do rather than dictate to her. Kevin stayed in the supported accommodation he was living in because of his partner Hannah. He didn't want to leave her but he felt as though his needs were compromised where he lived:

I like it [here] but one day I'd like to leave, a couple of years I'd like to leave....I'd like to get a cheap house, a cheap house 'cause I'd like to get an Alsation. We had a dog here but the staff got a bit funny about it. So I want to get an Alsation but they wouldn't let me have one here. Yeah. I'm vegetarian....'cause I don't like animals gettin' killed that's why. Sometimes we have barbeques and some days we have roasts. [It's a bit of a problem]. [They do buy] vegetarian sausages and vegie burgers. They're beautiful. They cook our meals, yeah. (Kevin Ryan, mid 30s)

The desire for friendship

Themes of loneliness and the desire for friendship often emerged from the stories. This was particularly true for the men in the research. Darren was very lonely, in part because he had a drinking problem:

I'd like more friends. I'd be friendly, make them coffee, whatever they want. Go out yeah - to the pictures or out to dinner. Not the pancake place. The place you wouldn't go is the pub. That's how I got myself into trouble going to the pub all the time gettin' drunk that's how I got myself into trouble. If I drink too much grog say seven or eight I don't know what I'm doing. (Darren Walters, 40s)

David, who lived independently, felt that his friendships were one-sided but felt powerless to make a change:

I have a few friends but...I'm always contacting them, they're not doing the same, they're not doing the same to me. It's always on their terms not on mine. And it's not often people drop around and say, "Oh I felt like droppin' in. Oh let's do something." People talk to me at the pub but it's only just a conversation. But you can see sometimes it is difficult to keep a conversation going. I know what to try, you know what you want to say, but it's kind of hard to put it into words (David Warren, early 20s).

The stories tell us that living alone did not satisfy all of these men's needs and sometimes it meant that they were cut off from any community. They also expressed the desire for intimate relationships.

The desire to love and be loved

Related to the desire for friendships was an expressed desire to love and be loved. Less than a fifth of the participants were in relationships. Shaughan, who identified as gay wanted a boyfriend:

At the moment I'm still looking for a relationship. Have had a relationship with a man once but my flatmate was jealous. My favourite thing to do is to make friends and do things together. I haven't got a closest friend yet but I do things with my flat mate. I'd like to have a boyfriend and do things together. I'd like to share feelings with him. I'd like to find a caring loving sort of man (Shaughan Taylor, 30 yrs).
Darren had recently broken up with his girlfriend and was missing her dearly:

I do miss her. Oh I really miss her, oh I know I can cook, but I really miss her cookin' Oh I miss being with her and watching TV and stuff like that. Oh I miss going shopping with her. Going for a drive with her mum stuff like that. Oh we cuddle, yeah I miss that stuff too, cuddlin' and kissin'. I miss that stuff too... I miss, miss, miss having 'sex, sex with Simone. Havin' sex and havin’ fun with her. (Darren Walters 40s)

Tom had never had a girlfriend and was unsure about how to get one:

I'd like to know about how to get a girlfriend. What do I have to do, sort of? And what places do you have to go to get a girlfriend? And how do you approach them? All that sort of thing? (Tom Harris, 20s)

Desiring children

Children, and the desire to parent were often mentioned by the group. For some the issue had been settled by sterilisation or the passing of time. others like Ruth and Derek continued to wrestle with those desires:

I should have waited you know. but at the time I guess I wanted a baby really because I wanted to prove to myself that I can care about a child better than what my father did, when he left me. I wanted to prove to my child that I can do that I could stay with the situation. I also wanted a kid because I love children. I wanted a child because I wanted someone to love me I guess, cos at the time I was feeling that nobody loved me. (Ruth Simpson, 30s)

Hope that one day I might become a father. Maybe move into a house on the Gold Coast. Settle down, maybe pick up a young fass, start all over again. But I would do different things. It wouldn't be so hectic or heavy. I would do different things that I would be able to do like say I'm a father now, I've got my own children. I would concentrate on the children, the house, the wife, the family. (Derek Housemann, 50s)

Motivation to have children was fuelled by many different personal issues and needs, all of which, it could be argued are present in the desires of the general population to have children.

Conclusion

We have learned from the stories of the men and women in our research that in many ways their needs and desires parallel those of men and women in the general community. However their opportunities have been restricted. Sexuality and sexual expression have been denied them and in resisting this they have lived very different sexual lives.

People with intellectual disabilities are very aware of what the community thinks about them. They know that sex is taboo but they don't stop desiring. Instead they find other ways to express their sexuality away from the surveillance of their carers. Because there are no legitimate private spaces available to them, many people with intellectual disabilities are forced to resort to semi-public places that are inherently unsafe. Moreover, because sex is not regarded as an expected part of their lives, very few men and women with intellectual disabilities have had relevant sexual health education and this leaves them without the information they need to protect themselves against pregnancy and STIs including HIV.

The stories have demonstrated that denying the storytellers in this research a position of independence and self determination particularly in terms of sexuality and relationships has not kept them celibate, safe or healthy. Nor has it contributed to public health in general. What is has done is leave them defenceless when threatened with abuse and the risks associated with being sexually active. Despite their different positioning, people with intellectual disabilities share more similarities with the rest of the community than differences. Many are living an active sexual life in spite of the obstacles but because they have been positioned as externally regulated they have not been given the skills needed to keep them safe and healthy.

In the past, service providers and families and carers of people with intellectual disabilities have focused on their duty of care to protect at the expense of the rights of this group. However this has not achieved the aim of protecting them and in many ways it has left men and women with intellectual disabilities without the knowledge and skills to protect themselves and to know what is appropriate sex and what their rights are.

We believe that rather than focusing solely on protecting clients, service providers should focus on supporting clients to protect themselves.
References


Contact Details

Dr Lynne Hillier
Australian Centre in Sex Health and Society
La Trobe University
Locked Bag 12
Carlton South 3053

Ph: 92855360
Fax: 92855220
ISHTARIM AND POST-NATAL DEPRESSION

Katie Thomas (The University of Notre Dame Australia)

Conference Presentation for the 7th Trans-Tasman Conference in Community Psychology

Introduction

I once dug at an archeological excavation known as the City of David in modern Jerusalem. In addition to unearthing the skeletal remains of home-sites and looking for all types of pottery shards we were looking specifically for ishtarim — small clay fertility goddesses which were a common household item. While an intact goddess was rare we often uncovered pieces of the many-breasted figurine torsos. The numerous breasts were symbols of the nourishment that could be obtained from the ever-giving Goddess mother. The abundance of torso pieces unearthed in one summer of excavation was a clear demonstration of how central she was to the culture of that time. Even the poorest of homes had a clay figurine and a small shrine to ensure that the Goddess’ feminine energy could be easily entreated and accessed. This image of the many-breasted woman is one that many western people would dismiss as primitive folklore. The citizen of the 21st century commonly assumes this image was erased long ago in technologically sophisticated industrial cultures and that we embrace more educated images of womanhood. In this paper I would like to challenge the assumption that we have transcended the mythology of the ever-giving mother and in particular to suggest that this mythology is still normative and informing the social and self expectations of women today. Using the phenomenon of Post-Natal Depression I explore how the western notion of rugged individualism can be neatly dovetailed with myths of female inexhaustibility to make it difficult for new mothers to make sense of their work, exhaustion and role overload. The paper begins with an epidemiological review of PND and individualistic models of understanding PND and explores the consequences of these epistemological models for women. It then moves to the findings of a thematic analysis of the explanations of depression given by 60 women who presented to a PND clinic over a 12 month period and of the compilations of femaleness drawn by ninety women who participated in a series of workshops run in rural Western Australia to examine their workload and community needs: Interviews and workshops with women confirm that the image of the inexhaustible, ever-giving woman is a still a western cultural motif. Following Freire’s (1970) understanding of conscientisation, the findings of this research would suggest that women who have been taught to attribute their emotional and physical exhaustion after birth to personal inadequacy rather than to social issues are at a higher risk for being diagnosed with Post-Natal Depression.

Epidemiology

Postnatal depression (PND) is a major health issue for women in western nations. In the first twelve months after birth the risk of developing depression for a woman is tripled (Cox, 1993) and the risk of developing psychosis increases 16 fold (Kendall, Chalmers and Platz, 1987). The first twelve months following birth are the time in a woman’s life when she is more vulnerable to psychological complications than at any other (Cox 1994). This time period therefore provides a unique window for the examination of western female mental health issues. Postnatal depression is a gender specific issue that has primarily been researched in western, industrialised nations. While not including all female experience or the experience of all females, birth is a period of time where female physical and economical vulnerability is amplified. Because of this increased vulnerability the time after birth provides a unique window onto the impact of workload inequity as a function of the physical work of birth and the physical and emotional responsibility for children. It provides a unique microcosm of the salient issues that contribute to female subjectivity and gendered power inequity in western cultures.

Prevalence

How prevalent is postnatal depression in western communities? Estimates that exclude mild to moderate cases of depression, anxiety disorders, puerperal psychosis and undetected or misdiagnosed cases place the incidence of PND (as a non-psychotic clinical depression occurring at any time in the 12 months after birth) at 15-25% (Paykel, Emms, Fletcher and Rossaby, 1980). For Western Australia alone this translates to 3,000 to 5,000 women annually (Pope and Watts, 1996). In West Australia fifty two percent of participants who attended community information workshops on ‘Enjoying Parenting’ (for parents of children 0-5) self-reported a history of PND (Watts and Pope 1998). When asked why they do not report depression earlier, women often cite fear of reprisals such as the loss of their children through the intervention of welfare services. Other studies have found a reported rate of PND up to 42% (Caltabiano and Caltabiano 1996). Even the lower statistical reports acknowledge that PND is a widespread phenomenon in western childbearing women (Cox, Murray and Chapman, 1993).

Certain risk factors for PND have been identified. Women who undergo caesarean section have a higher incidence of
PND than women who deliver vaginally (Edwards, Porter, Chalmer and Platz, 1994), as do women with limited social and emotional supports (Paykel, et. al. 1980). There is a higher risk for women who have a past history of depression, for themselves or in the family of origin (O'Hara and Zekoski 1989) and/or have significant life stressors concurrent with or occurring around the time of birth (O'Hara, 1995). Women who have babies with health or temperament difficulties (Cutrona and Troutman 1986) are at higher risk than other mothers. Studies have found that not breast-feeding, unplanned pregnancy and unemployment for the mother or partner also increase the risk of the woman being postnatally depressed (Warner, Appleby, Whitton and Famagher, 1996).

Etiology, Epistemology and “Expertology”

So what is postnatal depression? Biochemical imbalance, cognitive distortion, socio-economic disadvantage, insanity…? At the present time, the majority of treatment plans for PND are based upon epistemological assumptions of biomedical and empirical philosophy. The biomedical model assumes that abnormal mood and behavioural patterns can be accounted for by the client’s deviation from “the norm” on measurable biological variables and that once a specific “pathogen” or single cause is identified the “illness” can be eradicated (Di Matteo, 2002), primarily through chemical treatment (Kumar, 1994). Over a 24 month period, 86% of women referred to the regional Post-Natal Depression clinic where this research was conducted had been prescribed anti-depressants prior to referral. While not disputing the chemical effectiveness of anti-depressants; their use has significant implications for how women with PND are viewed by others and also for how individual women view themselves and their depression.

The Biomedical Model

Mothers who present to their general practitioner with a report of high anxiety or a high level of depressive symptoms such as sleeplessness, low energy, negative cognition and affect are often given anti-depressants as the sole intervention for their symptoms, especially if the woman is not privately insured and cannot afford counselling. This response rests on specific assumptions about the etiology of female distress. This includes a range of undefended epistemological and personal assumptions about what the “good life” is for women and a "normal" female response to birthing a child in the modern context should be (Prilleltensky, 1997). It also places medical professionals into the role of the all-powerful rescuers springing to the rescue of modern "damsels in distress" on the white steed of Prozac or Zoloft. The biomedical model implies that women who express distress about their experience of childbirth and their subsequent vulnerability - physical, economic or emotional- in western cultures are mentally imbalanced, certainly biochemically, and need biochemical adjustment.

In fact, women who are severely depressed may be referred to psychiatric services and/or a psychiatrist. Psychiatric admission typically means that the mother is separated from her infant, an event that can disrupt attachment and cause significant trauma for both mother and infant.

The separation of depressed mothers from their children through psychiatric admission is not a new phenomenon in western cultures as research into the admission records of any lunatic asylum of the 19th and 20th century clearly demonstrates (Matthews 1984). Thus, there are serious implications for individual women when the epistemological assumptions of the biomedical model are the primary explanation used for their distress. One of the risks of the biomedical model of PND, even in the 21st century, is that a diagnosis of PND puts women at risk of losing their children. In the case of divorce, (affecting nearly half of all marriages) a recorded medical history of depression counts against a custodial parent in the custody and access decisions of the Family Court System.

Historical records show that once women are labeled "insane" or biochemically imbalanced they are often forcibly restrained from contact with their child for long periods. In the past this meant that some women were never again allowed to mother their children (Matthews, 1984). Enforced separation of mother and infant risks creating an iatrogenic cycle where the experience of separation increases the mother’s trauma and inhibits her recovery, then leading to longer periods of enforced separation and so on. The experience of separation instigated by the mother for a period of rest, or willingly accepted by the mother, is quite different to that enforced by a medical professional who has judged the mother as inadequate.

The varied solutions offered from the biomedical model share the common theme of allowing the scientific hierarchy and a range of "experts" to excise or anaesthetise female distress with medication. To continue such benevolent rescue operations, the bulk of scientific research dollars must be poured into identifying the genetic and biochemical causes of PND rather than working on prevention or social change strategies. The inexorable conclusion of the epistemological assumptions of the biomedical model - biochemical imbalance and disease orientation - are of unlimited research dollars and the state subsidisation of Prozac so that, as the soma did in Huxley’s "Brave New World," western female distress, in the form of PND, could be chemically erased (Huxley, 1977).
The Psychological Model

There are limited studies asking mothers themselves what they think caused their depression. The psychological model of PND proposes that women who are depressed post-natally are cognitively homogeneous and have distorted and irrational thought patterns (Watts & Pope, 1988). Based on this assumption women who present for psychological treatment may have their “irrational” thoughts challenged and be enrolled in a cognitive behavioural course to enable them to think more “rationally.” The assumption behind this approach is that the woman’s report of her experience is not grounded in reality, but comes from cognitive distortion. When this philosophical belief system is extended so that women who become post-natally depressed are themselves considered irrational, all self-reports of their experience are excluded from consideration as possible antecedents to PND. It is impossible to authentically research the etiology of PND when the subjective experience of women is filtered through the lens of assumed irrationality.

The Distressed Voice

So what do women who are depressed post-natally have to say about the causes of their distress? The following discussion represents the reports of sixty women over a 12 month period who presented to a women’s health clinic for treatment of PND. In individual interviews and small focus groups the women articulated and identified the factors which they identified as etiological in their depression. Individual descriptions of etiology were recorded to identify core themes. The five main themes are presented below in random order under the main thematic headings of: Birth Trauma, Female Isolation, Fears of Punishment for the “Inadequate Mother”, Workload Stress and Self-Blame.

Birth Trauma

Many women identified the etiology of their depression and distress as being their loss of personal autonomy and safety in the medical control of the birth experience. Women used descriptors such as ‘barbaric’, ‘humiliating’, ‘inhumane’ and ‘horrifying’ to describe their medical experience. For some women this was extremely difficult to talk about and sobbed involuntarily while recounting their story or could not articulate the full story; only repeat adjectives such as “It was horrible, horrible…” while crying. Women who described their birth process as ‘barbaric’ reported distress at having procedures they considered humiliating or invasive performed against their will (such as vaginal examinations), at losing their autonomy and having to conform to hospital regimes that they felt were harmful to them.

Women who had involuntary caesarean sections commonly reported intense fear, helplessness or horror. The theme behind this was commonly of women being told dogmatically they could not continue in labour, having their protests over-ridden, and being anesthetized a short time after the verbal exchange. For these women, awakening a significant time after their child’s birth and finding that numerous other people had already had contact with the child was described as particularly distressing.

The body trauma, pain and recovery required after a caesarean was cited as significant. The loss of control over one’s body and the labour process was cited as particularly traumatizing. Losing control over a bodily process is acknowledged as a traumatizing experience with other medical procedures but is often dismissed by medical professionals with labour because of the assumption that, because labour is a common experience for many women, the loss of body control is somehow less of a problem.

The body trauma of a caesarean in terms of the size of the incision and the movement of body organs resulted in significant pain for many women who were then inhibited from picking their baby up unaided or enjoying the immediate time post-birth, with their child. Because a caesarean is considered a routine procedure, women reported that hospital staff demonstrated little sensitivity to their frustration in regards to what one woman described as “an unnecessary wound.” The theme of having been wounded unnecessarily was one that many of the women who had had caesareans reported. Their lack of recourse and “voicelessness” in the face of hospital procedures compounded their frustration and pain, and also their sense of helplessness and depression. A final trauma cited by women who had caesareans was the social and hospital expectation that, after a few days—sometimes only one or two, she return home and pick up responsibility for other small children without any further aid. One woman juxtaposed the social complacency towards mothers and the social reaction that would occur if this was expected of someone after a bowel operation (a similar size incision).

Women’s responses to having an impersonal “expert” controlling their birth process and their bodies ranged from the being highly distressing to some women to horrifying for others. Women often expressed rage at themselves for not preventing unwanted medical procedures and self-ridicule because they were distressed by an experience that medical staff viewed as “routine.” These findings suggest that the loss of power for women in the western medical context needs to be challenged. Indigenous cultures are highly aware of the need for women to be supported during the birth, physically and psychologically, and surround the birthing mother with other women and rituals that acknowledge her need for control over the birth process, the significance of her body trauma and the arrival of the child. They have skills to support the woman in her birth process rather than control it for her. Because of the enormous power of the medical model of birth in western cultures, women who experience distress or complain about their loss of control during birth are commonly dismissed or pathologised. The silencing of their experience leads many women to a sense of internal rage at their own helplessness and ultimately to depression.
Female Isolation

In the modern era western women may enter labour without ever having witnessed another birth, and without an adequate social and emotional framework to negotiate the significant life change that accompanies childbirth (Berk, 2001). Commonly, women reported being left isolated after birth, with limited opportunity to discuss their birth process with other women and little support in coming to terms with a major lifespan event. The lack of physical, emotional and social support was cited as terrifying by first time mothers who had had little of no previous exposure to babies.

In the fragmented modern society young women often live in suburbia, isolated in their homes. They spend long periods of time alone with the strong social expectation that, as modern Ishtarim, they should intuitively know the complex skills of mothering and understand how to care for a small child. This concept itself is unrealistic and leads to distress for women who report feeling ‘defective’ if they experience any difficulties. Women talked about being keenly aware of the social imperative for a mother to be able to do everything in isolation and their fears of punishment if they did not manage the adjustment to mothering and the work of mothering without complaint or distress. While realistic and accurate knowledge about mothering was less available, the women related abundant knowledge of stories of punishment for distressed mothers.

First time mothers talked of their despair at the lack of support offered to them and their fears that if they didn’t mother correctly, without assistance, they would be punished or something terrible might happen to the baby. Indeed, these young women may not have been given adequate knowledge and support for the needs of their infants. One first time mother reflected on the horror she felt when the midwife visited her at home and reported that her baby was dehydrated. In her words:

“I realised that I could have killed my baby through my ignorance, and there was no-one there to help me.”

Women commonly attributed this lack of knowledge about life issues to personal inadequacy as a female rather than to their lack of training in child-care because of the fragmentation of modern life.

The creation of the modern isolated individual is well known in academic circles but is knowledge that many of these women have not had access to (Everingham, 1996). In the place of this understanding, the myth of the all-knowing ever-giving mother leaves women in the position of judging themselves as personally inadequate. Further, the diagnosis of PND can intensify that sense of “inadequacy” and expand it to the fear of being personally insane when a woman is distressed. It also decreases the likelihood that women will discuss their distress or reach out for support.

Fears of Punishment for the “Inadequate Woman”

Fears of insanity reflect the vulnerability of women who become depressed after birth. This was often framed as: “Do you think I am mad?” or “My GP says I have Postnatal Depression; does that mean I’m crazy and will I lose my baby?” Women discussed cultural and personal stories of grandmothers, aunts, friends and mothers institutionalized for “not coping” and their own fear of being separated from their child. Female fear of the power of the etiological labelling process is a valid one. As previously discussed, historical studies have illustrated that women who were admitted to mental hospitals as “insane” often had suffered no mental illness prior to childbirth (Matthews, 1984). There is ample historical precedent of women experiencing ambivalence or difficulty with the task of mothering being perceived as abnormal and deviant in the extreme. It is probable that the historical label for PND was “insane”, and a woman who was diagnosed as such was unlikely to be able to overcome the stigma and consequences of that label.

Work Overload

Women who did not have a support network reported exhaustion from the work of mothering small children (Caltabiano and Caltabiano, 1998). This may be coupled, for the women living in western cultures that deify individualism, with the horrifying realisation that there may be no-one to take care of the baby if the mother becomes exhausted. This exhaustion is exacerbated for mothers with babies with sleeping problems (Armstrong et. al 1998a; Armstrong, 1998b). Within the Ishtar myth of ever-abundant energy, women are not supposed to experience sleep deprivation as stressful.

The Ishtar myth of the inexhaustible feminine rises clearly in the following composite of “good” woman compiled by fifty two rural women attending a community workshop:

Ideal body (50kgs), capable of running the home, the farm and a cottage industry without help and without ever being tired or whinging. Has a model home, garden, children and husband. A competent member and office bearer for several committees. Well educated, intelligent and organized. Keeps her husband happy (dotes on her man. Does everything possible to keep him happy and is never too tired for sex!). Is a wonderful cook and hostess. Has a freezer full of home made food. Financially secure and competent; generates income for the family. Never needs sleep, never sick, doesn’t whinge or grizzle. Is cool, calm and collected. ALWAYS has time for other people and their needs.

The consequences of these unrealistic expectations of the feminine are exacerbated during the post-birth period. Many women reported that the reality that the female gender carries major responsibility for child rearing and housework really hit home after childbirth, along with the concurrent
realisation that carrying this responsibility affected the choices they could make and the individual freedom they would have for themselves in the near future. Even in two career families eighty percent of women still carry the primary burden of housework and childcare (Hochschild and Machung, 1989). In addition to the loss of leisure time the uncontrollable volume of unpaid and unvalued work for young mothers can be depressing. Freire understood well the implications of uncontrollable workload and of work that is considered to be outside of the "productive":

Men (and women) are fulfilled only to the extent that they create their world... If for men to be in the world of work is to be totally dependent, insecure, and permanently threatened - if their work does not belong to them - men cannot be fulfilled. Work which is not free ceases to be a fulfilling pursuit and becomes an effective means of dehumanisation. (Freire, p.114).

Women in violent marriages (13% of the sample) described an intensifying of the partner's anger when the woman had less energy to devote to keeping her partner happy because of her increased workload. These women described an increased sense of urgency in trying to meet their partners demands, not only to protect themselves but now also carrying the responsibility of protecting their children. This distress is exacerbated by women's awareness that the increased demands on their physical and emotional resources postnatally make it more difficult for them to meet their partners demands and/or to separate from their partner.

Self-blame:

Finally, women reported that the awareness of their lessened personal, economic and physical resources led to a feeling of self-disgust. That is, they attributed their discomfort to personal inadequacy for not adjusting 'properly' to social norms of motherhood and to not "managing" their increased workload properly. Many women expressed the opinion that the difficulties they experienced after birth were managed by other unseen "good" women ("Ishtarim" perhaps?) and saw this as further proof that the responsibility was person rather than social. This attribution of external problems to personal inadequacy is seen in the following comment from a young woman living in poverty, with no education, no work prospects, three children under the age of 5 and a violent partner:

"I am just lazy, selfish and demanding. I am just a bad mother. I have it much easier than my Mum, so I have no excuse for feeling bad, I know I shouldn't."  

Her statement suggests a belief that if she was adequate as a woman (and an ever-giving one at that) the other issues would cease to have impact. The social reality that gender inequity is heightened at childbirth for all women but that some women have sufficient power in other arenas (social, economic, status, referential) to buffer the effects of childbirth was overridden, even for the women themselves, by the social myth that PND reflects only individual and not social pathology.

Summary

The self-reports of these women reflect their experience of working as mothers in an industrialized culture based on the protestant work ethic and the myths of the inexhaustible feminine and "rugged individual." Their reports suggest that the workload of sole female responsibility for children, the medicalisation of birth and unrealistic and punitive social expectations of women were highly traumatic and caused them significant distress. Childbirth exists at the intersection of many different power arrangements: professional intervention and definition, societal myths and taboos, physical vulnerability of women, female responsibility for children and unpaid societal work, domestic violence and economic dependence, to name a few. Clearly then, power inequity and the social expectations of the ever-giving "Ishtar" female disadvantage women. The covert nature of many modern power inequities can lead individual women to interpret their own distress at their birth experience and transition to parenting as personal pathology.

It is then up to professionals to conceptualise PND in a manner that reflects the seriousness of female distress and the implications for the child's mental health and yet does not contribute to that distress by individualising and pathologicalising female experience. The power that professionals have to further disadvantage people who are depressed by narrowly conceptualizing the issues and disregarding the lived experience of the other is stated succinctly by Hill-Collins (1991):

An oppressed group's experiences may put its members in a position to see things differently, but their lack of control over the ideological apparatuses of society makes expressing a self-defined standpoint more difficult...Groups unequal in power are correspondingly unequal in their ability to make their standpoint known to themselves and others. (p.26)

A sound etiological model for PND takes female distress seriously and remains aware of the implications of the treatment for the individual mother and infant and for the establishment of social norms. An intervention based on the individual level of etiological factors will focus only on treatment and risk becoming iatrogenic (Reilff, 1975).

The widespread chemical muting of PND in western cultures has compounded female distress by not acknowledging its source and thereby facilitating the practices that caused the distress in the first instance. Medicating women simply delays the inevitable task of facing the questions posed by the high levels of post-natal suffering experienced in industrialised nations. Some of those questions might be:

What is post-natal depression telling us about our society? What are the features of the childbirth period that intensify the increased psychological risk of depression already associated with feminality? How does the assumption of pathology impact on women as in the role of patients, women considering the role of mothering, and on female subjectivity?
A holistic framework prevents the risk of treatment that can compound suffering by holding individuals responsible for social issues. Any holistic response to PND needs to include conscientising women to the prevalence of PND in western cultures and to the impact of modernization and macro-social issues on the individual.

Further, a comprehensive etiological model needs to recognise and incorporate the current resilience, adaptiveness and skill levels that women demonstrate, even in the face of hardship and stress. Post-natal depression occurs at a time where the demands on the lone individual are so great that it is no wonder that individual resources are stretched beyond the capacity for coping. In the face of this, the great wonder is not why women are depressed but rather that the work of mothering and caring done in our culture, despite lack of social support, continues. Therefore; an effective intervention should also conscientise women to their strengths (Freire, 1970) as part of the treatment process. Rather than negating the strengths developed by women in their roles as mothers the death of the "Ishtar/Goddess" myth enables proper appreciation and respect of the work involved in parenting. The skills of communication, flexibility, responsiveness and nurturing often developed in the work of parenting are beginning to command high prices within the workplace - see the last decade of empowerment literature (Blanchard 1995; Brewer 1995; De Tienne, Smart and Jones, 1995). Perhaps the work of mothering should receive equal recompense?

Recognition and enhancement of current levels of functioning can be included in an effective treatment model which responds to the distress experienced by mothers, validates their experience without pathologising them, clearly identifies and makes overt gender and social inequities and highlights the capacities individuals have demonstrated in the face of those inequities.

On a final note, the unequal distribution of privilege on the basis of class, sex, gender and age exists at so many levels that we are all experiencing some of the effects of inequity and that we all have the capacity to oppress. Different power resources mean that adults have the capacity to oppress children, upper class the lower class, whites the indigenous person, professionals the lay person and so on (Freire, 1970). Remaining aware of our own power as professionals, to define and therefore empower or oppress and of our own vulnerability in other contexts, can help us to avoid the traps of separatism from women experiencing postnatal distress. Those working with post-natal depression have the challenge to develop and offer an intervention model that advocates for mothers and infants as vulnerable members of society, appreciates and honors the existing resilience of women and advocates for gender equity and social change. A model that requires professionals to think at all of these levels has the greatest likelihood of promoting humanizing and supportive interactions with those who entrust themselves to professional care.

References


Contact Details:
Coordinator of Behavioural Science
College of Health
PO Box 1225
Fremantle WA 6959
Ph: (08) 9239 5780
Fax (08) 9239 5790
Email: k.thomas@nd.edu.au
Adolescents' Attachment to and Identification with their Community
Kathryn A. Laurent (University of Southern Queensland)

Some researchers, such as Brown (1987a), have proposed that place attachment and community identity intensify with age. There is an assumption that adolescents have not experienced their community over a long enough period of time to develop a deeply-rooted attachment to, and identification with, their community, if in fact they do so at all. This paper investigates this assumption through the thematic analysis of the content of discussions from 10 focus groups involving a total of 110 adolescents. It is proposed that adolescents do identify with, and become attached to, their communities. It was hypothesised that differences in this experience would be found between age groups and the results partially confirmed this, with older adolescents experiencing a deeper level of community identification and attachment than younger adolescents. Although not part of the hypotheses, boarders also appear to experience their community attachment and identification differently than adolescents living in their community. This difference warrants further investigation.

Conceptual framework of the research
The conceptual framework for this research is a synthesis of several theoretical and empirical perspectives regarding adolescents. It draws on the following perspectives: a) adolescence as a time for development of self and social identity (Copeland, 1996); b) community affiliation and belonging as important to the psychological well-being of adolescents (Pretty & Chipuer, 1998); c) community situations as central to development of self and social identity at this time (Pretty & Chipuer, 1998); and d) place identity as a substructure of self-identity (Prochansky, Fabian, & Kaminoff, 1983).

This paper describes the author's initial study for her dissertation research, which explores the suggestion by Prochansky et al. (1983) that disruptions to place attachment and identity may have implications for adolescents' psychological well-being. Thus, the primary variables for this study were place attachment and place identity and the overall purpose was to determine the existence of adolescents' place attachment and place identity.

Place Attachment
Place attachment is defined as the feeling of being 'at home' or the process of a place becoming home (Brown, 1987a). Fullilove (1996) describes it as a bond between an individual and a special place. Cuba and Hummon (1993) explored the concept that an individual attaches or identifies with some or all of three levels of home (i.e., the dwelling, the neighbourhood, and the community).

Adult research concerning place attachment suggests its origins are varied and complex (Low & Altman, 1992). A specific space is given a meaning due to the interplay of emotions, knowledge, affect, beliefs, and behaviour in that place. This combination of experience bonds people to that place. Such attachment may vary in intensity from surface feelings to a deep, secure attachment. Some individuals become more attached to places than others, and there are some places to which people become attached more easily (Taylor, Gottfredson, & Brower, 1985).

Males and females seem to experience place attachment differently (Brown, 1987a). Females personalise their environment in a more intimate manner and are more likely to describe home as their "own home". Males, on the other hand, are more likely to describe home as their "childhood home" and relate themselves to a larger geographical area beyond the residential dwelling such as the neighbourhood or community.

Researchers such as Brown (1987a), have proposed that attachments intensify with age. Brown suggests that an individual differentiates places by attaching personal significance to that place in relation to their personal history. Therefore, the longer an individual remains in a place, the more they become a part of that place. The place is almost an autobiography or extension of the self. Taylor (1996) proposed that stability deepens attachment and involvement in the neighbourhood.

The findings of the research with adults raise the question as to whether adolescents could similarly become attached to places. There is little published research which answers this question. Some evidence seems to indicate that adolescents would not have such strong attachments to places, given the short amount of time that they have lived there. However, Korpela (1992) found that when adolescents experience events that are threatening, they go to a consistent favourite place for introspection. Adolescents also tend to seek out their favourite place after positive or supportive experiences. The most popular favourite places in Korpela's study were inside the home, and most often the adolescent's own bedroom. The fact that adolescents seek out places where they feel "safe and secure" when they feel threatened would seem to contradict the belief that young people would have little or no place attachment.

-Also, for young children, socialisation is limited to the immediate geographical area (Mesch & Manor, 1998). The child plays and often goes to school in the neighbourhood. Neighbours, as well as family, become important social agents. This process may also foster local attachment. It is possible that place attachment may lessen or even disappear with the onset of adolescence. This is a time for the adolescent to move beyond the family and neighbourhood and place more emphasis on socialising with peers. Therefore,
the wider environmental context of the community at large may become more important to them.

**Place Identity**

Cuba and Hummon (1993) proposed that place identity answers the question "Who am I?" by countering with the questions "Where am I?" and "Where do I belong?" Place identity is therefore an integral part of the development of self and social identity and thus helps the individual to distinguish themselves from others. The way that an individual personalises their environment expresses their unique self. An individual's dwelling becomes a museum of their lifelong personal symbols, which helps them to preserve their self-identity. The person also forges emotional ties to the place and has a sense of shared interests and values with others in their neighbourhood. This is experienced as feeling "at home" and "being comfortable" (p. 113).

Puddifoot (1994, 1995, & 1998) found that community identity in adults was manifested primarily in a sense of belonging to a particular geographical area, long term residence, and family ties. Neighbours and local amenities were less important. Cuba and Hummon (1993) found that different social and environmental factors discriminate between the form of identification which occurs. They found that the demographic quality of residents (such as length of residence, and number of residences prior to move) and interpretive residential affiliations (i.e., strong affiliation to the dwelling rather than the community) were critical to dwelling identity, while social participation in the community was essential for community identity.

Place identity appears to be a mixture of environmental, psychological, social, and cultural factors for adults. However, there is little research investigating this concept in relation to adolescents, again possibly due to the assumption that adolescents have not lived in a place long enough to develop community identity. If adolescence is the time for developing self and social identity, and if place identity is indeed a substructure of self-identity, as proposed by Prochansky et al. (1983), then it could be hypothesised that place identity is also emerging at this time. Homesickness research has found that college and boarding school students who are homesick have a disrupted identity (Brown, 1987b), providing further evidence that place identity is likely to be found during adolescence.

Place attachment, in the current study, refers to an adolescent's attachment or emotional bond with a residential dwelling, neighbourhood, and/or community. It is hypothesised that this experience may vary with age, due to the developmental processes undergone during adolescence. Place identity in the current study may refer to an individual's identification with their residential dwelling, neighbourhood, and/or the community. It is also assumed that place identity and place attachment are separate but related concepts. The distinction for this research was based solely on the nature of the measures used in previous adult studies. At the time that this study was conceptualised, this theoretical distinction was not clear and the goals of the dissertation research included proposing distinct models of adolescent attachment and identity. The constructs considered to be aspects of community attachment included behavioural and affective components of belonging to a community such as things that are done together with friends or family or emotive expressions of belonging or feeling at home. The constructs incorporated into community identity included cognitive components such as aspects of self-identity related to place or pride in a neighbourhood or community.

**Purposes of this Study**

The purpose of this study was to determine the existence of adolescents' attachment to and identification with their home. This was to be achieved by exploring whether adolescents, when asked to talk about their feelings and experiences of home, would readily talk about concepts assumed to be related to place attachment and place identity. The analyses used for this study examined the groups developmentally. Developmental research (e.g., Chawla, 1992; Mesch & Manor, 1998) has concluded that older adolescents place less emphasis on parents and family and more on social ties. As well, adolescents' exploration of their community goes beyond their neighbourhood to a wider social area as they become more mobile and less reliant on school for their social interactions. Therefore, differences in the nature of place attachment and place identity were expected when examining these data developmentally.

The questions to be asked of these data include: a) Is there discursive evidence of adolescents' attachment to and identification with their community? b) What conclusions can be reached about the nature or such attachment and identification? and c) Is a developmental analysis appropriate for the purposes of the research?

**Method Participants**

Ten focus groups were conducted in schools within Toowoomba, Queensland. A total of 110 adolescents (68 Male and 42 Female) from five different schools participated in this study voluntarily with no incentives offered. Their ages ranged from 11 to 18 with 34 participants (11 M, 23 F) being in early adolescence, 33 (25 M, 8 F) in mid-adolescence, and 43 (32 M, 11 F) in late adolescence. Length of residence in their present community ranged from less than 6 months (11) to whole life (38). Eighteen of these students were boarders, 8 (6 M, 2 F) from the mid-adolescence group and 10 (6 M, 4 F) from the late adolescence group.
Measures


For example, Do you feel at home where you are living now?; What makes you feel that you belong to the place that you call home?; Where do you feel that you belong to? and How sorry would you be to leave where you are living now? were questions typical of place attachment measures in adult research. Alternatively, How strongly would you say that you identify with or feel that you belong to this area? and What does the word neighbourhood mean to you? were included as typical examples of place identity questions in adult research.

The first four groups used this original question route (Krueger, 1994). This question route was then modified to attempt to extract more discussion about the physical place and belongings rather than just the people in the place. The new questions were based on Korpela's (1992) analysis of adolescents' favourite places and Kaltenborn's (1997) study of place attachment to National Parks in Norway. Kaltenborn's questions were different in that they attempted to discover what the place meant to the individual and how this place was different to other places they knew, for example, What is your favourite place?; When do you go to your favourite place/s?; What do you do in this place? and Does this place mean more to you than other places? The new question route (Krueger, 1994) also attempted to use the concept of cognitive imagery to elicit discussion about the place as well as using prospective techniques (i.e., asking the participant what they would do if a certain scenario occurred), as opposed to the retrospective techniques used by Marcus (1992) and Chawla (1992).

For example, in the same house scenario, participants were asked to visualise a scenario such as What if you lived in a street where all the houses in the street were the same: all the same gardens, all plants in the same place, inside there were chairs but no pictures, ornaments, and so on? In your room there was a bed and a wardrobe. Nothing else. All the houses were the same inside and out. When the participants could see the visual image, they were asked Could this place ever be your home? and discussions were elicited about why or why not. Examples of prospective techniques included asking If you did move, where would you call home then? and When would the new place be home? as well as What kinds of things would help you to feel at home in the new place? after the question How sorry would you be to leave this community?.

The modified question route (Krueger, 1994) was used for the remaining six groups. Questions were developed in addition to the above that were specific to the boarders' situation. For example, Has being away from home made you feel any differently about the place that you call home?, What was the first thing you did when you got home on holidays, apart from saying hi to family and friends?, What was the first place you went to?, and Do you bring things with you to boarding school to remind you of home?. These questions aimed to determine if boarders' perceptions of home were different from non-boarders perceptions, or if boarding changed the experience of home.

Procedure

Permission to approach the various schools was obtained from Education Queensland and the Catholic Education Office. Classes, houses, or boarding houses were chosen randomly by the school contact in each school. Each student in those groups received letters outlining the study and a consent form, with the exception of the boarders whose Director of Boarding received a group consent form designed for boarders. Consent forms were signed by both the prospective participant and either the parent or Director of Boarding. Approximately 70% of students returned consent forms to the schools. Times that were convenient to the school were arranged with the expectation that no more than 45 minutes of class time would be required for each session. However, at the boarding school, sessions were conducted in preparatory class time in the evening.

Focus group sessions were audio-taped with the consent of the participants. All 10 sessions were moderated by the researcher while a research assistant took notes. For each group, a written question route was used. However, prompts were used where necessary to extract further information or to encourage responses to the questions.

Results

Tapes of the 10 focus groups conducted were transcribed and the transcriptions were analysed using thematic analysis techniques. As mentioned previously, this paper only describes the developmental groups' analyses. Similarly, not all of the questions asked in the focus groups will be discussed in this paper.
**Place Attachment**

Q1 & 2: Do you feel at home where you are living now? Do you feel that you belong where you are living now?

The majority of participants (66/110) felt at home in their current residence. Just over half also felt as though they belonged there. In the older boarder group, all 10 participants said yes to this question. Table 1 shows the themes, and examples of quotes within these themes, for why the participants felt they belonged or did not belong in this place. For all groups, when asked what it was that helped you belong or not belong, answers relating to people were readily offered. Further probing was required in all groups except the fourth group of the early-adolescence group before things rather than people were offered. The older group was the only group to offer aspects of the wider community (such as community involvement or the community itself) as reasons for belonging. People, environment (e.g., weather), safety and security, belongings, born there, and length of residence had an impact on both feeling that they belonged to or feeling that they did not belong to where they were living now.

The participants were given a list of reasons offered in previous adult research (e.g., Cuba & Hummon, 1993; Puddifoot, 1994, 1995 & 1996) and were asked if these things helped them to belong here. Examples of these reasons included "parents are here"; "friends are here"; "brothers and sisters are here"; "other family is also here"; "things about the place itself"; "it's where I live" and "I was born here". The reasons involving parents and siblings received a strong 'Yes' response (30/34 for parents and 31/34 for siblings) in the early-adolescence group. A strong 'No' response was seen in the mid-adolescence group for "parents are here" (15 'No' and 3 'Yes' responses) and in the late-adolescence group for "siblings are here" (11 'No' and 1 'Yes' responses). "Friends here" received a strong 'Yes' response (31/34) in the early-adolescence group while the number of 'No' responses was similar in all groups. "Things about the place" received a stronger 'Yes' response in the two older groups. "I was born here" was strongly rejected by the older group, with 10 'No' responses and only 2 'Yes' responses.

**Table 1.**

Examples of Themes and Notable Quotes

<table>
<thead>
<tr>
<th>Q1. What is it that makes you feel at home / not at home in this place?</th>
<th>Safety and security (e.g., comfortable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;It's a hole&quot;</td>
<td>&quot;Safe&quot;</td>
</tr>
<tr>
<td>&quot;I like where I am living, but I hate Toowoomba&quot;</td>
<td>&quot;Insecure&quot;</td>
</tr>
<tr>
<td>&quot;No beach&quot;</td>
<td>&quot;Feel welcome&quot;</td>
</tr>
<tr>
<td>&quot;Bored&quot;</td>
<td>&quot;settled in&quot;</td>
</tr>
<tr>
<td>&quot;the surroundings&quot;</td>
<td>&quot;used to it&quot;</td>
</tr>
<tr>
<td><strong>People related (including belongingness and love)</strong></td>
<td>somewhere you feel welcome&quot;</td>
</tr>
<tr>
<td>&quot;the friendship&quot;</td>
<td>&quot;Yeah, you think everything is where it should be …everything is in its place&quot;</td>
</tr>
<tr>
<td>&quot;friends&quot;</td>
<td><strong>Own belongings, room, or place</strong></td>
</tr>
<tr>
<td>&quot;Friendly&quot;</td>
<td>&quot;It's where you sleep …&quot;</td>
</tr>
<tr>
<td>&quot;knowing people&quot;</td>
<td>&quot;Yeah, your own bedroom and your own things&quot; Your own things around you</td>
</tr>
<tr>
<td>&quot;Good neighbours around the area&quot;</td>
<td><strong>Community involvement</strong></td>
</tr>
<tr>
<td>&quot;All my relatives live here&quot;</td>
<td>&quot;sport and that…getting involved with things&quot;</td>
</tr>
<tr>
<td>&quot;family members&quot;</td>
<td>&quot;Activities…sport and things like that…the things that you’re involved in&quot;</td>
</tr>
<tr>
<td>&quot;not the house or the room but the people&quot;</td>
<td><strong>Length of residence</strong></td>
</tr>
<tr>
<td>&quot;have a loving family&quot;</td>
<td>&quot;I don’t remember where I used to live I’ve lived here so long&quot;</td>
</tr>
<tr>
<td>&quot;wanted&quot;</td>
<td>&quot;I’ve been living here for a long time&quot;</td>
</tr>
<tr>
<td>&quot;fit in&quot;</td>
<td>&quot;living there so long&quot;</td>
</tr>
</tbody>
</table>

Knowledge and experience of community

Kathryn: "What is it that doesn’t make Texas home?"
K: "I've never been there"
Kathryn: "So you didn't get to know it at all?"
K: "No"
Q. 6. What if you lived in a street where all the houses in the street were the same: All the same gardens, all plants in the same place, inside there were chairs but no pictures, ornaments, etc? In your room there was a bed and a wardrobe. Nothing else. All the houses were the same inside. Would that be home?

Feeling at home in the same street scenario was rejected by all groups, with 26 of the 32 participants asked this question responding negatively. Some groups readily offered comments such as “you’d get used to it”. However, most groups required probing before admitting that they would probably get used to it. All groups eventually agreed that belongings and possessions did help you to feel “at home”.

When asked How important to you is your own room? 31 out of the 32 participants in the late-adolescence group stated that their own room was very important to them. For all 10 boarders in the late-adolescence group, their own bedroom was the first place they went to when coming home. The reason offered for this was to ensure that things were still the same and had not been touched by their siblings while they were away. The bedroom was not as important to the younger students or to the boarders in the mid-adolescence group.

Q7. Where is your favourite place/places?

The adolescent’s own room was the most popular favourite place and the majority of favourite places cited were inside the house. It is interesting to note in the mid-adolescence group of boarders (n = 8), the girls said that they had a different favourite place for different situations while this was not the case for the boys. When questioned about how much the favourite place meant to them, 9 out of 19 in the early adolescence group and all 10 boarders in the late-adolescence group said “a lot”. When the older boarders were asked whether this place felt more a part of them than other places, they all replied that it did. However, it was not the only place that they felt that they could “be themselves”. One replied that “you can be yourself at home wherever you are” and the other nine agreed.

Q8. Do you feel an emotional bond with your community?

Twenty-three participants responded ‘Yes’ to this question while 27 responded ‘No’. In the mid-adolescence groups, a stronger ‘No’ response can be seen while a stronger ‘Yes’ response is found in the early and late-adolescence groups. Note that all 10 boarders in the late-adolescence group replied ‘Yes’ to this question.

Q9. If you had to move away from here... How sorry would you be to leave?

The majority of responses to this question were ‘very sorry’ or ‘moderately sorry’, with a slightly lower number choosing the ‘being ecstatic to be leaving’ option or choosing a conditional response to having to move, such as “not if my parents stayed here”. Interestingly, all 10 boarders in the late-adolescence group responded that they would be very sorry to leave and when one stated “I wouldn’t want to leave”, four agreed with the sentiment.

Q10. If you did move away from here, where do you think you would call home then?

Fourteen participants replied that the new place would be home while eight stated that they would call the old place home. It is noticeable that none of the older group believed that they would call the old house home. It was readily acknowledged by 22 participants that they would get used to the new home after a while and would then begin to call it home and some added the comment “when you knew where everything was”. Eight responded that home would be wherever their parents were (all boarders). All 10 boarders in the older age group responded that their current home would still be home when they moved away to university.

Place Identity

Q2. How strongly would you say that you identify with or feel that you belong to this area?

More than half of the respondents stated that they either very strongly or moderately strongly identify with where they live. This positive response is stronger in the early-adolescence group, with 26 of these 47 responses being in this age group. All 10 of the older boarders either very strongly or moderately strongly identify with where they live. In all groups except the mid-adolescence group, these are the most common responses. In the mid-adolescence groups, it is the neutral response that is the most common.

Q3. Are you interested in what goes on in the area?

All 10 of the older boarders replied that they were interested in what went on at home. The older boys from the boys’ school showed more interest in the school newsletter than the community news, unless it related to sport. There is a stronger proportion of ‘not interested’ responses in both the early-adolescence group (11/29) and the late-adolescence group (12/32) than in the middle group (4/23).

Q4. Are you proud to live in your neighbourhood?

At the all boys’ school, 31 out of the 37 boys and all 10 of the older boarders responded positively to this question. Only six of those asked in these two age groups responded ‘no’ and these were all in the older age group. Very few participants in the early-adolescence responded to this question, and the fourth group were especially quiet.
Discussion

There appears to be evidence to support both previous research and theories of development, as well as the notion that adolescents do in fact attach themselves to, and identify with, their community. A greater proportion of respondents felt "at home" or that they belonged than did those who did not feel "at home" or that they belonged. As with adults, the nature of such attachment and identification varies between individuals. Some individuals who had been in a place for only a short time felt at home or that they belonged to the area whereas others who had been there for a considerable time (e.g., 5 years) did not. Possible reasons for this difference need to be explored in further research.

Differences are seen between the various age groups in several areas and these could generally be supported by existing theory (e.g., Chawla, 1992; Mesch & Manor, 1998). For example, the older students seemed to have a wider experience of their community, parents were more important to the younger children and sibling relationships seemed to be less important for the older students. Younger students were generally less interested in what goes on in their area and also had little response to the question "Are you proud to live in your neighbourhood?". This could be because their identification of aspects of home is not as well developed as in the older students. The developmental analysis would seem to be useful. There is also evidence to support the belief that boarders perceive their communities differently from non-boarders. Although the analyses did not compare these two groups formally, trends were noticeable in the data and future research comparing the experience of the community of boarders and non-boarders is warranted.

As expected, people were more readily given as reasons for belonging than things or places. New question routes and persistent probing were required to elicit responses specific to the physical place or belongings rather than to people-related responses. Once the respondents thought about this in more depth, they generally responded that things and even places were important. The same houses in the street scenario yielded the most interesting responses although the prospective questioning regarding where home would be if they moved also received some interesting responses. There was evidence of adaptability to new environments, as most respondents appeared willing to call the new place home either straight away or once they had got used to it. This was especially prominent in the older age group. The concept of cognitive mapping appears to be important to the feeling of being "at home" as the condition of "knowing where everything was" was an important part to feeling "at home" in the new place.

As Korpela (1992) found, places inside the house were the most popular favourite places. The participants' own room and possessions within were especially important for older adolescents and boarders. Consequently, the adolescent's "own space" is a major factor in satisfaction with the environment. It was interesting to note that in one group the girls had different places for different situations while the boys did not. Brown (1987a) also found gender differences in place attachment. The presence of gender differences in adolescents needs to be investigated in further research.

It should be noted that identification questions yielded different results when asked in different ways. For example, the response was more positive when asked if they were happy to admit that they came from Toowoomba or when asked if they were proud to live in their neighbourhood rather than being asked if they identified with their neighbourhood.

This research was limited by the fact that a contextual analysis could not be conducted, as the sessions were not video-taped. It might have been useful to compare responses against time of residence in the area. Also, some of the groups were too large to allow the researcher to ensure that each member of the group had input into the discussion. Peer pressure could have influenced the responses in these two groups. There were also limitations of space for one of the groups. This caused similar problems, in that the room was too small for the number of participants, and so it was not possible to establish eye contact between the researcher and each group member.

In summary, further research is warranted to further explore the concepts of place attachment and place identity in adolescents, as well as the distinction between community attachment and community identity. Contrary to previous assumptions, this study quite clearly indicates that adolescents do have a relationship with their community and that this experience varies with age. The importance of this line of research lies in its implication for communities wishing to provide a supportive environment for the young people who constitute their future.
References


Research into the psychological sense of community has been characterized as largely being based on an idealized form of community (Dunham, 1986). Community has been seen in terms of a functionalist perspective with few researchers looking at the conflicts and tension of community living. There has been little critical analysis of what community is and what our sense of it is. A series of parables, paradoxes and conundrums are presented to raise the questions of what we are dealing with when we look at people's psychological sense of community. We speculate, even pontificate, about some of the issues that we suggest may help in a more critical examination of the concept and role of sense of community.

Parables, paradoxes and conundrums of sense of community

The research on the psychological sense of community (SOC) in community psychology has been largely positivistic and not particularly instructive. It has been more reflective of the demands and constraints placed upon researchers than on the substantive domain itself (as in Wicker's, 1989, notions of substantive theorizing). Sarason (1974) saw sense of community as the foundation of community psychology. This has yet to be realised, and we would argue that the concept has not been well articulated (as others have, e.g., Dunham, 1977, 1986; Hunter & Riger, 1986; Weisenfeld, 1986). In this paper we raise a number of issues related to sense of community and then offer some comments on where we would see the field developing. Our observations are offered as reflections on the domain and as 'seeding thoughts'.

Polkinghorne (1983) advocated the concept of 'assertoric knowledge' in which knowledge claims are 'asserted', or put in the public domain for critical comment. We hope we have not taken too much license with his notions of the promotion of the 'human sciences' in our assertions. In keeping with the religious references in our names, we felt the inclusion of some parables was appropriate.

Parable #1

These parables are too short to be realistic. Our poetic license has been used to cut to the chase of the parable. Parables are metaphorical stories designed to let us know how to lead our lives. We have short-circuited the story and cut to the punch line.

Sarason (1982) wrote:

If anybody asked me wherein my thinking had any distinctiveness, I would say it was in taking the obvious seriously. American psychology has had trouble recognising the obvious, perhaps because so much attention has been given to the distractions of theory. (p. 234)

We need to take the obvious seriously, as community is obvious, so obvious that we have difficulty seeing it. In a novel by Douglas Adams (1988), he tells a story of the intersection of the Norse gods and modern humans. The worlds of the gods and humans run in parallel, and differ by only a small part of a degree, which, by and large, makes the world of the gods invisible to us. Adams tells us that if you turn quickly enough, it is possible to get a glimpse of their world. We would argue that Adams has provided a metaphor for understanding society and community through the examination of these small differences. Thus we need to look at SOC in its obvious manifestations, but to do this is not so simple. Some of the following may offer some directions of how this can be undertaken.

Parable #2

Reiff (1966) made the point that the use of the medical model for mental health was inappropriate. His argument was not based on an analysis of the politics of aligning ourselves with the health sector. Rather he pointed out that physical ill-health is defined by abnormality; high blood pressure, elevated temperatures, medical equipment that goes 'ping-ping' rather than just 'ping'. We know you are healthy because of the absence of abnormal symptoms. Physical health is then defined in terms of normality. On the other hand, mental ill-health is defined in terms of DSM IV symptomology. We know when you are mad because you have abnormal symptoms, but not when you are sane. We do not know what mental healthiness is. While the concept of wellness has been developed recently (e.g., Prilleltensky & Nelson, 2000), it still presents problems in deciding what aspects of human functioning lead to wellness. Reiff's comments are equally applicable to SOC. We have no conceptualisation of what the 'good community' is. We do know what unhealthy communities are by the presence of people with low or no existent SOC.
Similarly, Sarason (1986) commented that SOC is something we don't know we have, but very well know when we haven't. As Joni Mitchell sang, "you don't know what you've got, till it's gone". More importantly, the slow ebb of our collective SOC is not easily recognised. Sarason pointed to the increase in mobilisation of American society as potentially one of the worst impacts on wellbeing. The loss of community that has arisen by increased mobility can be seen in increases in mental health problems and may be seen in the increased levels of depression in the Western societies.

**Paradox #1**

The traditional approach to SOC has met with only small gains in understanding. The positivistic approach to the study of SOC has considerable limitations. Psychology has been slow to respond to the commentaries of people like Cronbach (1957, 1975), Hollway and Jefferson (2000), Polkinghome (1983), Sarason (1981), and Smith, Harre and van Langenhove (1995) who warned of the inadequacies of the application of hard science methodology to psychology (we even got the wrong model, according to physicist and 'father of the atom bomb', Robert Oppenheimer, 1956). The thrust of these arguments was that experimentation alone does not provide ecologically valid understandings of phenomena. Coronach, for example, called for a mix of methods to give both a broad and in-depth views of human action. Ironically, the pragmatists had warned us about these issues over a century ago. The re-emergence of phenomenology and other qualitative methodology has signalled the need for a contextualist approach in psychology, especially, community psychology. (It is interesting to observe how slow the rise of contextual research has been in community psychology, even with ecological principles being at the heart of the discipline). Positivistic methodologies bring a restricted view of the objects of concern. The correlational methodology that predominates SOC research has the problems of positivistic research and some further conceptual problems. Sense of community relates to our place in local communities or relational communities; we have not contemplated how SOC will be defined in terms of post-modern communities, as described by Newbrough, 1992). Those who have a sense of community are part of that community. The quantitative methods of measuring SOC have taken a qualitative aspect of human life and made it an individual differences measure. What does it mean to have a lesser sense of community than someone else in that community? Correlational research necessarily involves only those who have a sense of community. For those who do not, the concept does not make sense. To assess SOC quantitatively there must be an identifiable community. In locational communities, it is possible to ask someone without a SOC questions about SOC and get meaningful responses. In relational communities, the process is more difficult. Chavis, Hogge, McMillan and Wandersman (1996), or Buckner's (1988) scales, for example, do not cater for the 'Not applicable' response. These scales are only meaningful to those who have at least some modicum of SOC. Those who are alienated are qualitatively different from those who score low on a SOC scale. Individual differences research (correlational research) can only measure the relationships between SOC and other variables, such as wellbeing. The typical question that can be addressed is whether people who have a stronger sense of community have higher levels of well being, for example. It can address issues such as the impact of declining levels of SOC (possibly). What it does not address, nor can it, is the impact of the loss of a sense of community or being alienated. Individual differences research can only address relative differences in SOC, not the presence or absence of SOC.

The study of SOC needs to be more exploratory and qualitative. We need to have a conceptual grasp of what SOC is in relational and locational communities, and this requires some basic descriptive and interpretive qualitative research. Even more pressing is to begin to understand what the impacts of postmodern conceptualisations of community (e.g., Newbrough, 1992) will have on the way we approach SOC.

**Paradox #2**

Grace Pretty presented a paper at the Seventh Trans-Tasman Community Psychology Conference in Melbourne in 2001 conceptualising sense of place, place attachment and sense of community. It is instructive to recognise that these concepts are rarely looked within the one research design (Puddifoot, 1994, is an exception), and that the concepts appear in different literatures. Sense of place occurs in environmental psychology, human geography, planning and sociology. Sense of community is largely seen in community psychology journals. Why is there this failure to integrate the concepts? Some cultural work may be helpful. The second author has been studying mental health service delivery to Aboriginal communities. One of the key findings has been that Aboriginal mental health is related to place. There is some evidence that emotional wellbeing is related to contact with the land. The extent of mental ill health seems to be correlated with the distance from the person's land. Connection to land is very important for the maintenance of wellbeing. The implications appear that for traditional Aboriginal sense of place (SOP) and sense of community (SOC) are not conceptually separated; community and the land are integrally related Dudgeon, Mallard, Oxenham and Fielder (2002).

Why do SOP and SOC seem so tightly related in some cultures and so easily separated in the non-Indigenous society? The failure to recognise and deal with this separation indicates that conceptualisation of the concept of SOC may have problems. Does it reflect that in a mobile society, sense of place has lost its connection to community, or does it reflect a collective denial that mobility has impacted on the strength of sense of community? Have we convinced ourselves that
modern communities can be created and modified in short periods of time? Does this indicate that we have not grasped the concept effectively? In response to a question from Bob Newbrough at the Yale biennial community psychology conference, Seymour Sarason said the reason why he saw SOC as being so important was that he had experienced times during the great depression when there was no one that he could rely on to help him survive. The extent of the economic situation meant that his (and his family's) survival was at real risk. This sense of that alienation needs to be at the heart of our considerations of SOC.

When visiting New Zealand a few years ago, the first author visited a cave renowned for fire flies. This cave was reported to have been discovered centuries before when a Maori woman had sought a hiding place there. This woman had run away from her tribe and entered another tribe's land. She was afraid she would be enslaved or worse, so she took refuge in the cave. She would emerge at night and either find or steal food. She survived to quite an old age before she was discovered and looked after by the locals. The story indicates the strength of community and the social regulations in her tribe and the extent to which banishment impacted upon people. When we talk of the loss of SOC, these are the kind of people we need to consider.

We need to look at community and SOC in a variety of cultural contexts rather than only from a white, middle class perspective, and to attempt to understand how SOF, place attachment and SOC are interrelated.

Paradox #3

From our work in rural communities we come across strong communities. They will quickly tell you of the collective and caring exploits of the community, such as building a swimming pool when government would not provide the funds, and supporting the local hospital and school, both financially and in terms of human resources. In one community we were told that when there was a bereavement or someone is seriously ill, the community would provide support to the family with meals and other assistance. This is done with little planning, or the expectation of thanks. It is just part of rural life. It is part of the interrelationship and expectations. Yet if a family fails as farmers, if the farm is no longer financially viable, the people walk away with little apparent sympathy or obvious support. Why are there aspects of rural community life where compassion and aid is immediate, yet there are other aspects where this is not apparent? What does this mean in terms of community? Does it reflect that community and sense of community have both positive and negative aspects?

Paradox #4

Assessing community resilience was an important part of the Regional Forestry Agreement process in Australia. Social assessment was a part of the process of developing state and federal governments to agree on the setting aside of forest to ‘maintain a sustainable environment’. One of the comments that came out of this process was that only a short period of time was required in a community to get a strong sense of the strength of the community. As part of her PhD research, Coakes (1995) noted that quantitatively measured SOC seemed to be negatively related to participant observations of a number of rural communities. The first author and Coakes rated the six communities. These ratings were negatively correlated with aggregate SOC scores. Thus we seemed to be attending to different aspects of community than what the scale measures (see Bishop, Coakes & D'Rozario, 2002). Again, this suggests that we need to take a broader approach to the concepts of community and SOC. Cultural and location variations need to be understood using a variety of methodologies that may provide a fuller understanding of community and SOC.

Paradox #5

The concept of community is layered (Broksky & Marx, 2001) and the way in which you address it determines its apparent nature. For example, if you ask residents of a particular community, there will always be some other sector of the community that they see as the out group. These can be located geographically. In Perth, residents of suburbs north of the river are seen as being different from those south of the river. But these out-group differences diminish when we compare ourselves to those of other states, and when we, as a nation compare ourselves to New Zealanders or Americans. The sense of 'we-ness' changes with the way the questions are framed. Is this a psychological example of Heizenberg's uncertainty principle?

Conundrum #1

Sense of community is a concept that relates to how we interact with our communities and the psychological sequela of our involvement. Community is obviously central to this. Yet there has been little written in community psychology on this topic. Hilery (1964) reported 94 definitions of community in sociology, yet community psychologists have been relatively mute. Dokecki (1996), Heller (1989), Hunter and Riger (1986) and Newbrough (1992, 1995) are notable exceptions. Newbrough (1992, 1995) has written of the 'third position' community. He argues that the Gemeinschaft (which we tend to assume is the basis for SOC) and the Gesellschaft society do not reflect the communities we have in the postmodern first world. The 'third position' community a complex mix of social structures and local communities. The conundrum here is how can we conceptualise SOC without a thorough understanding of community.
Conundrum #2
The experience of SOC is not peripheral to living in community, yet we see it only at the margins. In the novel by Douglas Adams (1988) referred to above, about the intersection of the Norse gods and modern humans, he described a violent episode where an attendant Heathrow airport disappears in an explosion. He wrote that the event was a mystery to humans, but to Odin the event had Thor written on it in letters so large that only another god could see. The analogy here is that SOC is visible at the margins and yet it is written so large that we fail to recognise it. It is so obvious as to be invisible.

Paradox #6
Lizzie Finn, a PhD student at Curtin is currently working with GROW, a mental health self help group. She has found that the Alcoholics Anonymous type of structured meetings takes people who are lonely and isolated and creates a sense of belonging, and improves social skills. Through GROW's advocacy work, these people are then linked back into the broader community. An important aspect of this process is what she referred to as the 'educated heart'. It seems that GROW supports the participants to regain a sense of who they are, and a sense of community through acceptance and love. It appears that a person's sense of community is damaged by the experience of an episode of mental illness and the attendant stigma. The GROW program seems to have some positive impacts on the psychiatric or psychology illness. GROW's effects may be more significant on the social aspects of mental ill-health (alienation and stigma) through the process of restoring people's sense of community. We can speculate that the importance of SOC is that it may be a buffer to the social impacts of mental ill-health, rather than the mental health, per se. Thus, where a community is able to maintain SOC for its members suffering from mental health problems, the nature of the expression of those problems may become less severe. The failure of the maintenance of SOC for those with mental health problems or intellectual disabilities maybe the key to the failure of the deinstitutionalisation policies (Warner, 1989).

In summary, the parables, paroxes and conundrums presented above indicate that the concept of SOC is more complicated than that presented by McMillan and Chavis (1986). The positive Gemeinschaft community that is implicit in much SOC research needs to be seen as somewhat unrealistic and not reflecting on the costs and benefits of community life (Dunham, 1986). The nature of community needs to be understood before we move to SOC. Part of that understanding requires investigating communities in a variety of locations and cultures.

Where to
These paradox and conundrums present issues that we would suggest need examination in conceptualising sense of community. It is not an exhaustive list and others should add to the list. There seems some central issues that need to be addressed in the shorter term.

We would suggest that the following four, related points of departure.

1. We need to concentrate on the obvious aspects of sense of community. This can be done in the short term through the eyes of the disadvantaged. Just as optical illusions have been used to understand normal perception, the experiences of the marginalised and disadvantaged could help with understanding the concept of sense of community.

2. It is those who are denied connection with community that we need to work with and for. Sarason (1974) saw the lack of a SOC as psychologically devastating, and that the remediation and promotion of SOC should be a core principle of community psychology.

3. Sense of community is (arguably) the central aspect of the socially constructed aspects of mental health (e.g., stigma). The social ramifications of having a mental health problem present issues that are somewhat independent of the experience of the illness itself. Sense of community is a key to understanding these social issues.

4. The investigation of SOC needs to be preceded or accompanied by the study of the postmodern community. Community also needs to be studied in a variety of different contexts. Community needs to be understood in its diversity and people's sense of these diverse communities needs also to be understood.
References


Australian Psychology and Indigenous People
Pat Dudgeon
Centre for Aboriginal Studies, (Curtin University)

This keynote address gives an overview of the history of Indigenous Australia. This is an inevitable start to any discussion of Indigenous issues given that Indigenous people and their history and issues are not part of the Australian consciousness. This is followed by a brief overview of the contemporary social, political and economic status of Indigenous people. Drawing from a number of recent papers the history of psychology and Indigenous Australian people is presented, with particular reference to the publication 'Working with Indigenous Australians: A Handbook for Psychologists'. The development of this Handbook has symbolised the processes of reconciliation and Indigenous self-determination at work. It has been an Indigenous led project and has included the voices of Indigenous people at all levels.

Acknowledgements
I am very pleased to be here presenting at the Seventh Trans Tasman Conference in Community Psychology. Before I start I need to acknowledge the local Indigenous people of the Melbourne area. As an Indigenous speaker myself, it is particularly important that this is acknowledged, although I look forward to the day when such acknowledgements are a matter of course at any formal gathering of peoples, anywhere in the world. I would like to mention and acknowledge the Indigenous people of this area, and acknowledge their ownership of the country where we gather to speak and discuss our important business. I hope that we are welcomed here for our conference.

Representation
I take this opportunity to remind my colleagues that I speak for my group and myself. Some of my ideas and information may be generalisable, but much may not be. I am not the Indigenous voice; I am only one of many and our diversity must be honoured by not assuming that one person can speak for the entire group. Often this is an issue in non-Indigenous perceptions of Indigenous peoples and issues. It is restrictive and divisive. Our unity and commonalities are strong but our differences are strong, and rich too.

Terminology
Indigenous Australian people are the Aboriginal people of mainland Australia and the Torres Strait Islander people. The term Indigenous covers both cultural groups and it is rightfully inclusive. However, sometimes when I use the term I may be referring mainly to Aboriginal people. This was a big issue in the production of our 'Working with Indigenous Australians: A Handbook for Psychologists' (2000) text.

Opening Remarks
For my presentation, I intend to cover a number of issues under the banner of Indigenous issues. I am compelled to do the usual brief history lesson of Aboriginal history. Still, now, there is a situation where many Australians do not know the history of this country and the Indigenous people. This is changing, but slowly - too slowly.

I am going to go over the developments in Indigenous mental health as well, and look at some recent developments that augur well for our future. This presentation should serve as giving some information but, more importantly, as the stimulus for more discussion.

Historical Context
To understand the diverse contemporary culture of Indigenous Australian people today, the way of life practised in pre-colonial times needs to be overviewed. Today, some Aboriginal people may live fairly traditional lifestyles, and others may live Westernised lifestyles. This is a part of the diversity of Aboriginal society. Cultural ways are still prevalent in most groups. Although these may not appear overt, there are still cultural values and ways of operating that are practised by all groups. In recent years, there has been a renaissance of Aboriginal culture, where cultural renewal is taking place. To fully appreciate Aboriginal cultural difference, traditional cultural lifestyles and practices need to be considered, as well as the impact of colonisation.

Aboriginal culture is one of the oldest surviving cultures of the world. Aboriginal presence in Australia has been estimated as at least 50,000 years; however, other archaeological evidence may extend that time to even 150,000 years. There were at least 300,000 Aboriginal people here in Australia at the time of contact.

Although what is known about Aboriginal culture prior to European contact is somewhat speculative, some definitive assumptions can be made.
Aborigines were all semi-nomadic hunter-gatherers living in diverse environments. Prior to European invasion, Aboriginal groups occupied the entire continent. Groups hunted and gathered in defined areas. Groups had special relationships with their 'country'. Aboriginal people were the most successful hunter-gatherers in human history. A concept of oneness with the land, and all that lived upon it, meant that Aboriginal people were conservationists, in that local resources were effectively utilised in a manner to guarantee ongoing productivity.

Importantly, the land was a materialisation of the journeys of spiritual ancestors from the time of creation. The Dreamtime is a period of creation when, in the dawn of time, the great spirit ancestors arose and created the land and all living things. Taking different forms they wandered the earth. After their journeys, some went to the sky and others went into waterholes or the earth leaving behind signs of their earthly existence. These were in the form of caves, hills, rocks, rivers and other natural features.

The land was, and is, the basis of spiritual life and, in a sense, a religious text. Land was not 'owned': one belonged to certain areas of land or country. Individuals and groups had, and in some areas still have, hereditary rights and obligations to their country. These obligations include looking after the country by maintaining sacred sites and performing ceremonies to ensure the country's well-being. The attachment to the land is still powerful for many Aboriginal people today. Even those not living in their country have spiritual bonds with places of origin.

It is said that the entire continent of Australia is a sacred site - as all the land was formed by the actions of ancestral beings during their Dreamtime journeys. Some places or sites, however, are of greater significance than others, as these places are where the ancestral beings undertook particular actions in the time of creation. Different groups are the custodians of different stories. Not everyone will have access to knowledge about sacred sites as that knowledge may have to be earned or may be gender specific.

Kinship is an important part of Aboriginal life. This includes but is not confined to those related by blood ties. In traditional times, everyone had certain roles, and obligations attached to relationships with others were part of those roles. Ways that determined who one was, were based upon totemic relation and 'skin' systems. Social structures included complex 'skin' groups or blood descent systems that determined kinship relations and marriage rules. Totemic affiliation was another categorisation where one's relationships with creation ancestors were determined.

Sharing is important in any Aboriginal group. Sharing is usually conducted along the lines of kinship and family. The basic concept of sharing is still a part of contemporary Aboriginal life and includes goods such as money, transport, food and housing.

In olden times, the law from the Dreamtime guided and enforced Aboriginal social systems. Life was seen to begin and end on a spiritual level. A spirit entered the body of its future mother and a child was born. Children were not restricted in childhood. All members of the group nurtured and cared for the child; all members took an active part in the child's upbringing and learning; instruction was both formal and informal. Aspects of daily life were sanctioned by traditional law and upheld. Serious infringements of the law resulted in punishments such as beatings, spearings, banishment or even death.

Previous depictions of Aboriginal women have been through non-Aboriginal perspectives. Anthropologists, largely males, who recorded the cultural realities of Indigenous peoples, did so from their own cultural perspectives. Therefore, what they recorded was seen from their own implicit understandings of the world, life and the roles of women in their own cultures. Throughout colonisation the role of Aboriginal women was erroneously characterised as subservient to men.

Aboriginal women have authority and roles in the economic and spiritual well-being of their group and country. Women have their own religious rites and sites for ceremonies. Women have a significant, if not equal, role to men, both in the provision of food and in the engagement of the creation, transmission and maintenance of the knowledge, values and spirituality of their society (Brock, 1989).

Women are the proud nurturers of the people and country; in ritual and their daily lives, they are independent individuals living within a woman's domain. However, while it may be a relatively autonomous two-sexed or gendered society in terms of authority and power, male and female practice has a common purpose and is complementary. It comes together to maintain a harmony and a check so that neither can become supreme over the other. The structuring principles of men and women's rituals work to maintain land and society in accordance with the Dreamtime law.

Over the last two hundred years the processes of invasion and subsequent colonisation have dramatically changed Aboriginal culture and society. Most contemporary Aboriginal people are still affiliated with their country, but in different ways. This connectedness, along with the process of cultural reclaiming or Aboriginal renaissance, augurs well. However, colonisation has had many different impacts on Aboriginal people and one of these is the distortion of our tradition cultural realities. We have been misrepresented. And we continue to be.

And oppressed. Our history is one of genocide, of slavery and forced removal. Each of our personal histories is one of our foremothers and fathers being abused and imprisoned into missions and reserves - to be trained as menial workers for white society. I am starting to read my grandmother's history and have found that she went to prison for assaulting a white man. She was protecting herself. This is just one instance in the many incidents of oppression that she experienced all her life.
Contemporary context

The reality of contemporary Aboriginal life is grim. Many Indigenous people and communities live in terrible social and economic situations. This is not to deny the empowered and fulfilling experience that life is for some individuals and communities. However, for many Indigenous families and communities, life is a daily struggle of poverty, unemployment, housing problems, substance abuse, violence and racism. The social conditions of some Aboriginal people are inferior to those of third world countries: Aboriginal people suffer the worst health of all Australians; they die younger; they are hospitalised more often; and they suffer more complex health problems.

The historical, social and economic background of Australian Indigenous people is of great significance in examining our current situation, as these issues relate directly to what would be called 'within-cultural violence'. Nowadays, Indigenous people are more likely to have been hurt, both physically and psychologically, by people from their own racial group. Intra-cultural violence is based on proximity: there is a general tendency of hurting the closest to you because they are there, and this means hurting other Aboriginal people in the same grouping or community.

There are about 386,000 Indigenous people in Australia. Indigenous people make up 2.1% of the total Australian population of 18.3 million. Despite such comparatively small numbers, Indigenous Australians are over-represented in most statistics pertaining to unemployment, poor health, education and training as other Australians, and suffer the greatest unemployment rates. Income levels are very low; the average income is $12,000 per annum or less.

The 1995 National Prison Census notes that Indigenous people represented 17.1% of all people in prison. The prisonable age for Indigenous people was 1.3% of the total population so the proportion of Indigenous people in prison was 10 times more than that of other Australians. Of male prisoners, one of every two 17-18 year olds was Indigenous. This meant that a 17-year-old Indigenous youth was 34 times more likely to be in prison than his non-Indigenous counterpart.

The pattern of offending by Aboriginal people is predominantly for violent offences and offences against property and good order. In Western Australia, police charged 1 in 5 Aboriginal people each year. The corresponding rate for non-Indigenous people was 1 in 50. In one year Aboriginal people represented 40% of the prison population and 65% of the lockup population in our state.

Research indicates that there is a relationship between powerlessness, substance abuse, and violence to self and others, such as suicide, self-mutilation, assaults, rape, homicides, child neglect and abuse. Indigenous people are living out the consequences of colonisation and dispossession. The history of Australia is based upon the systematic conflict, removal, displacement and incursion of people into prisons, reserves and missions. Very few Indigenous families have no institutional or removal experience in their history. Australian history is built upon racial crimes and an ongoing denial of this history. In 1977, Kevin Gilbert, an outstanding Koori social justice fighter, described the situation in this way:

*It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is a psychological blight, more than anything else, that causes the conditions we see on reserves and missions. And it is repeated down the generations.* (p. 3)

Indigenous psychologist Joyleen Koolmatrie worked with the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, and also with individuals and families who are part of the process. She observed (Koolmatrie, 1998) that 'echoes from the past' resulted in shattered families, broken relationships, people dislocated from their countries, people who had their language and culture taken from them. Echoes from the past have led to unbearable pain which has caused suicide, alcohol and drug abuse, anger leading to violence, and sometimes death. Aboriginal people themselves, with the aid of Government, are dealing with these issues. That is a key issue: that dealing with these issues needs to be undertaken by Aboriginal people themselves or it will not work.

My response to these social issues

During my undergraduate studies, and even in recent times, there seemed to be an odd ignorance or masking of Indigenous mental health. Right now it is a focal issue for both Indigenous and non-Indigenous professionals, but twenty years ago it was peripheral and almost invisible.

When I graduated I really could not see the usefulness of my profession in 'the cause'. There seemed to be little research in Indigenous psychology and the little there was came from a profession in 'the cause'. There seemed to be little research in Indigenous psychology and the little there was came from a place that did not fit my world view. A lot of emphasis was placed on measuring cognitive abilities. Much seemed to be within the dominant world-view we were forced to measure against.

It is appropriate to have a discourse within the western domain about Aboriginal realities. It is important because, sometimes, the only reality and language that Western professionals understand and respect is their own. Sometimes, you have to challenge issues from within the castles. For instance, I always respect the work of Judith Kearins (1976; 1981) where, in a time of social hostility, she undertook research to investigate whether Aboriginal children might have cognitive strengths in different areas to that of non-Aboriginal children, particularly in visual-spatial memory.
Historical changes in Psychology

Times and attitudes have changed, somewhat. Working with Indigenous Australians: A Handbook for Psychologists (Dudgeon, Garvey & Pickett, 2000) and the Australian Psychologist Special Issue on Australian Indigenous Psychologies edited by Sanson and Dudgeon (2000) contain two different but important papers on the history of Indigenous mental health. Davidson, Sanson and Gridley (2000), examine the underlying political and social narratives of psychological research and Indigenous people, and how these change over time. In the Handbook paper, Garvey, Dudgeon, & Kearins (2000) also give a history (drawing substantially from the first paper!). Darren Garvey came up with the title ‘Australian Psychology has a Black History’, which was important because it drew on the theme of one of the annual NAIDOC Week Celebrations. This theme expresses the concern that Australian history does not recognise Indigenous people and their history. We thought that this was the case also with the profession of psychology: Indigenous people have been, at best, invisible or, at worst, oppressed by the practice of psychology. History is a strange thing. It is easy to look back and judge with impurity the actions of the past. I wonder whether judgements of the future will be kind to us and our work today. In our paper (Garvey, Dudgeon & Kearins, 2000), we make this statement:

Often the recording and reporting remembering of history is done by those who have power to do so. They bring their perceptions and bias into the writing of history. Reporting history is not an objective activity, but a subjective one. Even at a local level, history varies according to whose voice is being read, heard or viewed. Different people will have different views according to their interests; different elements and aspects of what is happening will be taken into account. (p. 231).

Psychological involvements with Indigenous people of the past reflected the social views of the time and were discriminatory. Firstly, Indigenous people were treated as objects. Secondly, while it may be undeniable that such (early) research, which sought to categorise Indigenous people, used methods and instruments that were appropriate for the time, we now see those methods and events in a different light. Indeed, if we apply contemporary standards to those endeavours, we might conclude that they were less than conciliatory for the Indigenous subject. Furthermore, if we include Indigenous perspectives, we might conclude that the consideration, treatment and reference to Indigenous people would today be considered unethical and inappropriate. This point brings us to an important issue regarding the reporting and interpretation of history.

Early Psychological Practice

Early psychological involvement with Indigenous Australians was part of the prevailing European scientific interest in Aboriginal Australians. Beginning almost four centuries ago, European visits to the shores of Australia involved some contact with Aboriginal people. Intermittent reports on their appearance and speculations on their lifestyle found their way back to Europe and seem to have stimulated increasing interest with each fresh report. Comments on the inhabitants were generally derogatory, and such racist, primitivist, and romantic perceptions of Aboriginality litter 19th Century writing, and frame much of the ‘scientific’ and psychological literature of the first half or so of the 20th Century.

Garvey, Dudgeon & Kearins (2000) trace the influences of these early psychological discourses, focusing on Social Darwinism, The Cambridge Anthropological Expedition, S. D. Porteus, H. L. Fowler, The Queensland Test, Piagetian Studies, and IQ tests. Psychological research and investigation into the characteristics of Indigenous people probably serves to reveal as much about the limitations of the investigative tools, as it does about the psychologies of the subjects of their studies.

Critical changes

The Handbook also outlines the critical changes that have occurred since the 1960s. Drawing on Hunter’s 1997 account, Garvey, Dudgeon and Kearins (2000) trace the shift from what can be termed the ‘psychopathology of the exotic’ to more participatory approaches emerging from such historical events as the 1967 Referendum, black liberationist movements, protest and politicisation, Land Rights, and self-determination. A timeline is provided as an outline of the major changes in psychology since the 1970s. It is worth revisiting this timeline to stress the significant changes over the past three decades.

Kearney (1973) produced the first Australian psychology volume focussing upon Aboriginal people, entitled The Psychology of Aboriginal Australians. In 1974 a Cognition Symposium held in Canberra, in conjunction with the Biennial General meeting of the Australian Institute of Aboriginal Studies was first formal cross-cultural meeting held in psychological studies relating to Indigenous people (proceedings published in Kearney & Mcllwain, 1976). Judith Kearins (1981) published Visual Spatial Memory in Aboriginal Children of Desert Regions, which challenged previous work and proposed that Aboriginal Australians have different cognitive strengths compared to other Australians. In 1985, he First Australian Conference on Testing and Assessment of Ethnic Minority Groups in Darwin saw a number of psychologists and educators from around Australia discussing Aboriginal and other cultural group issues in education.

The 24th International Congress of Psychology was held in Sydney in 1988. According to Gridley et al (2000), an incident occurred where the lack of Indigenous content in the
The development of an Indigenous menial.health movement client, or at other levels such as establishing services and the level of an interaction between a psychologist and a developing policy (Dudgeon APS Conference. The symposium was significant in that the changing perspectives in the discipline of psychology and the with Indigenous people needs to ensure that mechanisms are Indigenous people. This means that any service that works Indigenous people need to be fully involved in any mental health activity for Indigenous people. Indigenous politically and culturally informed and/or appropriate approaches. The constructions of health and mental health began to emerge at this point and change had occurred in perceptions of Indigenous mental health in that, rather than the 'disease model', there was a prioritising of wellness, holistic health and culturally informed and/or appropriate approaches. The commissioning of the Ways Forward: National Consultancy on Aboriginal and Torres Strait Islander Mental Health (Swan & Raphael, 1995) was one of the most significant events in placing Indigenous mental health on the agenda. The publication of that report was a marker in the consolidation of numerous national inquiries, reports and reviews that had been generated by Indigenous people themselves or in partnerships with non-Indigenous people.

Many of us in the field saw changes in the 1990s. As well as Hunter (1997) and Davidson, Gridley and Sanson (2000), myself and my colleague Harry Pickett (2000) wrote papers reflecting on this transformation. In particular, we overviewed changing perspectives in the discipline of psychology and the emergence of different areas that augur well for Indigenous people.

The development of an Indigenous mental health movement requires a change in the way psychology works with Indigenous people. The key elements were to include a philosophical approach of empowerment and self-determination in the provision of mental health services for Indigenous people. This means that any service that works with Indigenous people needs to ensure that mechanisms are in place for collaboration and direction from the client groups. Indigenous people need to be fully involved in any mental health activity for Indigenous people. Indigenous people themselves need to direct the engagement, whether this is at the level of an interaction between a psychologist and a client, or at other levels such as establishing services and developing policy (Dudgeon & Pickett, 2000).

On the ground this has meant many things. We at Curtin University had always been involved in the mental health area and had initiated one of the first counselling training courses for Indigenous people. This was on request from members of the community who saw their workers at the cutting edge dealing with clients and their issues without any training and more importantly without culturally appropriate training. The Aboriginal Medical Services (AMS) started to take up the challenge of providing mental health professional positions and programs for the community. The AMS have been, and still are, involved in the training of Aboriginal counsellors and non-Aboriginal professionals to a lesser extent.

Within Australian psychology, the momentum for change continued through the 1990s, with the formation in 1991 at the APS Conference in Adelaide of the APS Interest group on Aboriginal Issues, Aboriginal People and Psychology. Since then, an Indigenous presence has been ensured at all the APS Annual Conference. At the 1995 APS Conference in Perth, for the first time there was an Indigenous keynote speaker, the late Rob Riley (Riley, 1997). Also, for the first time, there was a traditional Indigenous welcome to the country by Aboriginal Elders at the Conference opening.

In the early 1990s, debate emerged as to the existence of an 'Indigenous' or Aboriginal psychology (Reser, 1994). Caution was urged as the prospects of courses teaching 'Aboriginal psychology' were discussed. What was being referred to as Aboriginal psychology was critiqued for its lack of scientific rigour. Such concerns persist at an international level. Typical of the comments regarding 'Indigenous psychology' include: 'Are we merely indigenising mainstream psychology, or are we adapting mainstream psychology to Indigenous contexts and calling it Indigenous psychology?' Furthermore, the implications of this proposition were queried. Are there 'Indigenous psychologies' and, if so, is it practical and realistic to consider them if, for example, their pursuit means arriving at a different 'psychology' for each group that you investigate? If so, would this be a divisive and an all too time-consuming endeavour?

Following recommendations from a 1993 conference convened by the Centre for Aboriginal Studies at Curtin University and the APS Community Board, the APS council established a working party to prepare guidelines for psychologists working with Indigenous people. The development of these Guidelines were based on and connected to the NHMRC Ethical Guidelines. The Guidelines for the Provision of Psychological Services for and the Conduct of Psychological Research with Aboriginal and Torres Strait Islander People of Australia were adopted by the APS in February 1996. They now form part of the Ethical Guidelines accompanying the APS Code of Ethics (2001).

The Guidelines represent a commitment on the Society's part to the process of reconciliation and its social responsibility vis-a-vis Indigenous people. Now that they are public, so to is the Society's commitment. The Guidelines have already been
a valuable resource for the APS when considering its position on Wik and the Stolen Generation Report. APS was a signatory to the ACOSS Statement of Apology and Commitment to the Stolen Generations of Aboriginal Children and the statement was delivered directly to the Aboriginal people at Yarrabah, during a visit that followed the 1997 APS Annual Conference in Cairns (Gridley et al., 2000). Sanson et al. (1998) produced an APS position paper *Racism and Prejudice: Psychological Perspectives* as a significant step towards formally recognising the existence of racial and ethnic prejudice in Australian society and within psychology itself. The paper is comprehensive and overviews racism and prejudice at all levels and recommendations for the professional body and the individual psychologist.

At the Indigenous Forum convened at the 1997 Cairns Conference, a number of practising psychologists from a variety of settings commented freely on the value of the Guidelines. Interestingly and importantly, one of the common uses for the Guidelines has been as an ethical rationale for reconsidering psychological service provision. That is, psychologists now have an ethical commitment and the documented, ratified backing of their professional organisation to question psychological interventions that may be inappropriate for their clients. The psychologists who shared such comments did so with an audible sense of relief that they now had this backing.

The Guidelines also raise an important dilemma. Although guidelines exist for psychological testing, there are currently few psychological tests that have been specifically developed for use with Indigenous people and that provide current-day norms and measurement statistics for Indigenous test takers. In addition to their content, the importance is not so much in the Guidelines themselves but the pause that they place in the process of intervention. This pause allows us to consider where we are and where we are going. However, if the decision is made to change or review aspects of interventions and theories, then the emergence of the Guidelines also highlights that they are merely an important signpost of the longer road for Psychology and Indigenous issues.

Notably, dissatisfaction from both Indigenous and non-Indigenous quarters contributed to the development of the Guidelines, and must now contribute to their appropriate implementation. A starting point was heralded when in 1998, a mini-conference of Heads of Schools of Psychology convened at Curtin University in order to discuss issues surrounding the inclusion of Indigenous studies in undergraduate and postgraduate psychology courses. Some of these educational activities (Williams, 2000; Sonn, Garvey, Bishop & Smith, 2000) are presented in the *Australian Psychologist Special Issue on Australian Indigenous Psychologies* (2000).

The publication in 2000 of both the special issue of Australian Psychologist and our own Handbook represents an unprecedented indication of genuine collaboration between Indigenous and non-Indigenous mental health professionals.

**Conclusion**

The future is optimistic, I believe. There are many examples of psychologists working in empowering ways with Indigenous people. There are many examples of Indigenous initiatives working to help their own people. Dudgeon and Pickett (2000) discuss history in regard to Indigenous people as a subjective exercise and conclude that most people in the past did not see themselves as committing acts of injustice and oppression. They were products of their social and historical places. As we are now, of ours. It is easy to look back and make judgements on the actions of those in the past. We should do this. We should look at past mistakes to learn from them, but not assume that our current thinking and actions are without mistakes that will not be revealed in the future.

History and psychology are not neutral. Davidson, Sanson and Gridley (2000) call for a retelling of the history of Australian psychology and its relationship with Indigenous people. They look at history from a different perspective, examining the social and political narratives that underpinned the activities of those in the past. A change has come about where the relationship between psychology and Indigenous people needs to firmly prioritise what Indigenous people themselves want from the relationship.

To work towards reconciliation, psychology needs to acknowledge that this discipline is immersed within a culturally specific worldview. Further, psychology as an institution is part of a broader dominant discourse, so there needs to be recognition that there is a political dimension to psychology by virtue of the history it is embedded in. The current status quo maintains inequality and oppression.

For psychology to transform these politics, it must engage with Indigenous realities, appreciating a different cultural reality and being open to understanding the Indigenous community's issues, priorities and ways of seeing. It is critical, then, for psychology to work on issues with Indigenous people in an empowering way to break this historical pattern.
References


Tensions and dilemmas in feminist research on sensitive issues: The case of Project Hippocrates

Kelley Johnson (La Trobe University)
Heather Gridley (Victoria University)
Susan Moore (Swinburne University of Technology)

Project Hippocrates, a series of four studies of interactions between women and their doctors, originated with reports from women of sexually intrusive practices during consultations. It developed into a broader examination of women-sensitive medical practices, from the perspectives of both doctors and patients. Because sensitive issues were raised, several dilemmas and tensions were encountered by the researchers. They included naming the issues conceptually and in practice, involving women and doctors in the research, and working across the different discourses - social science and medicine. This paper suggests reasons for the tensions and discusses several ways the dilemmas were addressed within the project.

Introduction

There are many conflicting views of what constitutes feminist research (De Vault, 1993; Harding, 1987; Reinharz, 1992; Roberts, 1981). However these different approaches share a common focus. For feminist researchers "it is important to centre and make problematic women's diverse situations and the institutions and frames that influence these situations, and then to refer the examination of that problematic to theoretical, policy, or action frameworks in the interest of realising social justice for women." (Eichler, 1986, p.68). Such research involves two important and quite different tasks. Firstly it is concerned with providing opportunities for women to have a voice about issues that concern them and the way in which research about them is carried out. Secondly it involves a responsibility on the part of the researcher (and possibly research participants) to engage in some form of action to address the participants' concerns and issues. This necessitates work which can take the form of research, advocacy, policy development or direct action with institutions, groups and individuals who hold power and may not be sympathetic either to the concerns being raised or to the evidence on which they are based. Each of these tasks confronts the researcher with particular dilemmas and tensions.

Feminist writers have documented many of the difficulties they have encountered in undertaking research with women. Difficulties of access to participants, power imbalances and cultural differences between women participants and researchers, and the representativeness of the voice of women participants are among the issues with which feminist researchers have struggled (Oakley, 1981; Patai, 1991; Stacey, 1991). However the tensions involved in the second task, that of taking the research to an action stage that challenges a powerful stakeholder have been less well documented.

Difficulties in obtaining funding for research of this kind, tensions between the requirements of advocacy and academia, and researcher anxieties about the purposes to which research material is put, are among the issues raised by feminist writers (Britton, 1993; Benmayor, 1991; Johnson et al, 2001; Mercier & Murphy, 1991; Spender, 1981).

The dilemmas and stresses encountered by feminist researchers are exacerbated when the issues they are studying are sensitive ones. A sensitive research issue has been defined as one which "potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or dissemination of research data" (Lee & Renzetti, 1993, p.5). The difficulties of carrying out research on sensitive topics have been well documented in the literature (see for example Kellehear, 1996; Macintyre, 1982; Kimmel, 1988; Sieber & Stanley, 1988; Lee & Renzetti, 1993; Wyn, Lumley & Daly, 1996).

However, few links have been made in the literature between the difficulties of undertaking research from a feminist standpoint with the problems encountered in undertaking research on sensitive topics. Consequently this paper is concerned with the methodological tensions and dilemmas that result when a study on sensitive issues is undertaken from a feminist standpoint.

The research: Project Hippocrates

Project Hippocrates was a three-year action research project that examined aspects of medical practitioner-women patient relationships. It developed from concerns by health agencies in a working class, industrialised area of Melbourne (the western metropolitan region) about reports by some women of sexually intrusive practices during medical examinations. It was based on prior work that included a state-wide survey of doctors to explore issues arising for them in relation to sexually intrusive practices, and discussions with some women residents and health workers in the western region.

The project was undertaken from a feminist standpoint building "on and from women's experiences" (Olesen, 1998, p. 309). Several different research methods were employed, but the project was essentially framed within an empiricist model. The studies included within Project Hippocrates were:

- a survey of 472 women in the western region to obtain their views about physically intimate examinations and
related matters (Moore, Gridley, Taylor & Johnson, 2000);
• focus groups with women from Vietnamese and Spanish speaking backgrounds to gain an account of their experiences as patients (Gridley, Taylor, Moore, Johnson, Papsis, & Hoang, 2001);
• semi-structured interviews with thirteen women who had experienced a negative encounter with a medical practitioner (Gridley, Moore, Higgins, & Johnson, 1998);
• semi-structured interviews with twelve general practitioners to obtain their perspectives about working with women patients (Johnson, Gridley & Moore, 2001).

This paper is not concerned with the results of the four studies, which can be found elsewhere (Johnson & Gridley, 1999), but rather with issues arising from particular tensions encountered in the life of Project Hippocrates.

The project dealt with highly sensitive issues of concern to both women patients and their general practitioners (GPs). In particular:

• It intruded into the private sphere of relationships and dealt with highly intimate and personal issues (Lee & Renzetti, 1993). Specifically, the study dealt with the essentially private and confidential nature of medical consultations and also with issues around intimate physical examination and the possibility of inappropriate sexual behaviour;

• It was concerned in part with issues of deviance and social control, insofar as within the project there was a focus on inappropriate sexual behaviour by medical practitioners;

• It dealt with content that impinged on the vested interests of a powerful group within the community and their potential exercise of coercion or domination in some circumstances.

We recognised that in undertaking this research the sensitivity of the topics it raised was likely to create dilemmas and tensions for us, some of which have been documented in the literature. The study encountered problems of definition (Herzberger, 1993) of what constituted abusive, intrusive and/or inappropriate practitioner behaviour; confidentiality (Sieber, 1993); difficulties in obtaining access to research participants (Bergen, 1993; Lee & Renzetti, 1993); and challenges to the credibility of the research (Lee & Renzetti, 1993). The rest of this paper describes how each of these problems was met and managed.

Tensions and dilemmas

In undertaking Project Hippocrates we encountered a range of dilemmas, some of which were the result of the ways the research developed, while others were concerned with the different discourses under which researchers and participants operated. These included decisions on how to describe the focus of the research to potential participants so as to obtain the broadest possible involvement, how to encourage women and doctors to be involved when they may perceive the research as threatening, and how to disseminate the results of the research in effective ways. Elements of these dilemmas are described in the following section.

I ideological positioning of the research

"This study seemed to be about nailing your GP... They [the doctors] were very upset about it." (Health professional)

"These issues are very important: it's good that you are researching them." (Woman patient)

These quotations summed up the different and sometimes opposing views held about Project Hippocrates by some doctors and women involved in the research. For some (though not all) doctors, the study was perceived to be ideologically driven. It was being carried out from a feminist perspective, it was auspiced by a women's health service and in the beginning it focussed on sensitive and difficult issues in medical practice. Media headlines such as "Women Hide GP Abuse", "When Health is a Hazard", and (more mundanely), "Call for GP Guidelines" did little to endear the research to doctors. It is hardly surprising therefore that there were negative responses to the research. The term often used was 'doctor bashing'. Complaints from some doctors about the project were made informally to the researchers and the women's health service and more formally through medical practitioner associations. At various times, the researchers were asked to explain aspects of the research focus to the Australian Medical Association, local Divisions of General Practice, Community Health Centres, and the Medical Women's Association, as well as Victoria University's Human Research Ethics Committee. Such requests were welcomed by the researchers as opportunities to hear concerns first-hand and to disseminate accurate information about the project.

As feminist women researchers we were coming from a marginalised position from which to research the medical profession, a group with far greater hegemonic power. So it was difficult to change negative perceptions of the research, although some attitudes did change over time.

In contrast the women's health service and the Victorian Medical Practitioners' Board saw the research as an important vehicle to air concerns and issues relevant to women patients. Both bodies expressed hopes that changes to medical practice would result from the research.

As researchers we balanced uneasily between these anxieties and expectations. We were careful to develop the research in ways that would not lead to an attack on its credibility. For example we used a reference group to advise on the design and implementation of the research, and made many invitations to local practitioners to contribute to the research.
Naming the unnamable

Project Hippocrates began as a study of sexual exploitation and abuse and later was refocused more generally on sexually intrusive medical practices. Still later its parameters were broadened to examine what we called ‘women-sensitive’ medical practices. Such changes in focus were inevitable in a project that developed heuristically over a long period of time. They also arose because of our wish to provide research data which would be useful in improving medical practice, so that we needed to understand the subtleties of women’s discomfort during medical examinations, beyond examples of blatant abuse. From the doctors’ point of view we needed to understand what difficulties were encountered in working with women patients, among doctors who may have had the best intentions but did not necessarily have the best techniques or interpersonal skills. The gradual change of focus did, however, create confusion and anxiety for both medical practitioners and women participants. For example some medical practitioners were resistant to taking part in later stages of the project because of the earlier emphasis, even though this emphasis had been largely consumer driven. On the other hand, some women saw the shift in focus as a ‘watering down’ of their original concerns.

Some of the anxieties expressed by medical practitioners in relation to naming the topic of the research were increased by the emphasis given to sexual exploitation of women by professionals in the literature and in the press (for example, Council on Ethical and Judicial Affairs; American Medical Association, 1991; Ellard, 1991; Ontario College of Physicians and Surgeons, 1991; Vallentine, 1992), and locally, by the Medical Practitioners Board and the Office of the Health Services Commission (Gallois & Griffin, 1996).

Difficulties in focus were exacerbated by problems in defining clearly what was meant by sexual exploitation or abuse within the context of a medical consultation where both parties often seemed unclear as to what actually constituted abusive practice. In fact the lack of clarity by women patients and their doctors was an important finding from the research because it influenced both the reluctance of women to report incidents and the readiness of doctors to take action about such reports. However during the research itself, anxieties about the nature of sexual exploitation or abuse or intrusive medical practices led to anxieties among doctors (and sometimes women participants) and resistance to discussing the issues.

The research was a response to some women’s concerns about sexually inappropriate behaviour or abuse by general practitioners. This aroused strongly ambivalent feelings among health professionals. There was a general consensus that when such exploitation or abuse occurred, the medical practitioner should be dealt with by available mechanisms within the profession or through the law. However the determination of when such action should be taken was more problematic and raised issues of professional loyalty and judgement. Some medical professionals were concerned that the study of these issues would lead to a lack of trust between women patients and their doctors or that some medical practitioners might be ‘falsely accused’ by women participating in the study. Other professionals expressed some relief at the inclusion of sexual exploitation in the study, as it was perceived to be less threatening to consider negative practices by a few “deviant” doctors than to consider the broader implications of professional privilege and the appropriateness of all medical practices for all women.

Women doctors were particularly torn – overall they were stronger in their expressed willingness to support women disclosing experiences of inappropriate practice from other practitioners; but they were concerned that any increase in the trend for women to seek out women doctors for intimate examinations and emotional concerns would further restrict their own practice to “tears and smears”, as one put it – “I like nitty-gritty medicine”. There was also concern that women might overly compartmentalise their health care by seeking women doctors for intimate examinations while expressing less marked gender preferences in their overall choice of GP (a clear finding from the first study).

Accessing and giving a voice to women patients:

“’Some organizations were resistant to the survey (of women patients). Some were anxious that it might upset people who were already vulnerable.”

(Research assistant)

“Some women believed that doctors would not do things like that.”

(Research Assistant)

As other researchers have noted, access to people willing to take part in a study of sensitive issues is always problematic. And in this study three very sensitive issues were involved: sexuality, health, and the private relationship between a doctor and patient. This difficulty was particularly apparent in the survey of women’s experiences of intimate physical examinations. Originally it had been planned that the survey would be distributed through health service clinics. However concerns were expressed by doctors and health administrators about the appropriateness of such a strategy. These concerns included the possibility of upsetting women who were already vulnerable, the possibility of undermining the patient doctor...
relationship and issues of confidentiality. As a result of these concerns a networking approach was taken to distributing the questionnaire, using trained research assistants from diverse cultures. When women from minority cultures were included in focus groups, members of their own community were involved in recruiting them and facilitating the groups in their own language, with the emphasis being very much on establishing an atmosphere of confidentiality and trust. Feedback from the cultural consultants and research assistants was also documented, providing a reflexive loop to monitor cultural and methodological concerns as they arose. The use of networking and cultural consultants proved to be a successful means of involving women in the study and the research would have benefitted from an earlier decision to use this approach. The attempt to involve medical clinics in the survey distribution proved unhelpful as it further alienated health professionals from the work. The possibility that some women would be upset or traumatised by the nature of the survey or the interviews was met by ensuring that research assistants, cultural consultants and the women themselves were given careful briefings and provided with contact numbers for support groups and relevant organisations. While the use of networking or 'snowballing' to establish a sample is well established within the social sciences, it is less familiar to health professionals experienced in medical research where variables can be more clearly defined and where rigorous sampling procedures can be applied. The use of this methodology was questioned by some medical practitioners. Comments about the 'non-randomness' of the sample were received, as were concerns that these studies did not fit the model of 'randomised control trials' so familiar to the medical profession.

Involving doctors in the research

"I don't think these issues are of concern to many doctors." (General practitioner)

"Doctors really don't like talking about this kind of issue. So you'll find it difficult to get them involved." (General Practitioner educator)

"GPs are very busy and have a lot of surveys arriving on their desks" (General Practitioner)

Some of the issues discussed earlier in this paper describe why it was difficult to involve general practitioners in the research process so they could add their voices to those of women patients. However their participation was integral to the success of the project. Among other things we intended that the results from it be used to assist general practitioners to further develop practices sensitive to the range of needs expressed by women patients. The research was grounded from the outset in women patients' concerns and it was very important that the views of general practitioners also be heard. While in the abstract this should not be a problem, in practice it created difficulties because doctors were suspicious about the rationale for the study and concerned that women's stories would be given greater credibility. Their concerns were exacerbated by the fact that the women's stories were gathered before the project moved on to consider the views of medical practitioners.

It proved very difficult to gain access to a sample of doctors willing to talk about their practices in relation to women patients. Concerns about the sensitive issues involved, anxiety about confidentiality and possible publication of controversial or negative findings were heightened by the time pressures experienced by doctors in the region. For example, one doctor commented:

"I mean as a professional I hate to say to anyone that another doctor is wrong. I mean, forget about sexual intrusion and things like that. Even if I believe that a doctor has given the wrong antibiotics or something like that I'll probably say something like it might have been the thing to do at the time."

The group of twelve doctors who finally participated in the study was not necessarily representative of doctors in the region, since they were individuals who either felt interested in the issues or confident in their own practices.

Discussion

Some of the resistance and the problems encountered in this project arose from the particular ways in which it was designed and developed. However others related to the very different research discourses of the participants and to the anxieties raised by the focus on sensitive issues. Different disciplines bring with them different approaches to the acquisition of knowledge and its use. When people from such disciplines attempt to work together, tensions and differing expectations can result (Johnson & Scott, 1997; Zifcak, 1995). Project Hippocrates brought together health professionals trained within a medical discourse that values experimental research and the use of rigorous sampling procedures and feminist social scientists trained in a discourse more concerned with perceptions and attitudes than physical variables. For the medical professionals perceived objectivity was an important issue in research. In contrast as feminist social researchers we took the view that no research is completely 'objective' and that it was important for us to be clear and open about our values and perspectives. For example the sensitive nature of the topic meant it was neither possible nor ethical to approach a random sample of women to obtain their views about intimate physical examinations. While the sampling method chosen by the researchers provided a group of women whose views reflected a diversity of cultural and age groups, it remained a methodology that...
was alien to and regarded as suspect by some health professionals. Further, questions were raised by medical professionals about the validity and reliability of questionnaires and qualitative data obtained from focus groups. We found it difficult to take into account a discourse that was very different from the one in which we were used to working. Accommodations had to be made on both sides. For example, as researchers we worked hard to manage press coverage to avoid sensationalising the issues and alienating the doctors; the GP Divisions agreed to the use of their newsletters to disseminate some of the project recommendations. The checklist reproduced as an appendix to this article was developed at the suggestion of a local Division and distributed to all GPs in the region. It provides a concrete example of the fruits of extensive consultation with an initially wary stakeholder group. We came to recognise that an important factor in working as feminist researchers was a willingness and an ability to talk to those who were engaged in very different kinds of research. The content of the research was not the only thing that needed to be shared.

Issues which raise high anxiety for groups and individuals lead to defensive reactions which can include denial of the issue involved, criticism of the methodology and a displacement of the issue onto other members of the group (Menzies-Lyth, 1988). The issues raised by Project Hippocrates were anxiety-creating for all participants. For general practitioners these anxieties included possible criticisms of the relationship they developed with individual patients, a possible questioning of the trust which forms the basis for medical consultation, and anxiety that issues of sexual exploitation by a few medical practitioners might be sensationalized in the media or generalized to their own practices. For some women the anxieties were similar. Stories of negative experiences, discussion of intimate physical examination and a consideration of the issues arising from these events were anxiety-creating. Some women were also concerned that the survey in particular was an implied criticism of their general practitioner or their relationship with him/her.

The establishment of a reference group in which these issues could be discussed, and a willingness by the researchers to engage with both doctors and women patients about issues that caused anxiety did something to relieve these tensions. Discussions were held with representatives of health service organisations throughout Project Hippocrates. However it took some time for this to be formalised into a reference group with the following functions:

- It included representatives from all groups participating in the research.
- It offered opportunities for input into the development of the project.
- It provided a forum for discussion of different approaches to research methodology.
- It allowed ownership of the research to go beyond the researchers.

The reference group proved to be invaluable in the design and implementation of the last stage of the project. Members assisted in designing the interview schedule for doctors and used their networks to assist in recruiting participants. Had the reference group been established at the commencement of the project some of the problems that arose may have been avoided.

But it was the publication of the results and the recognition that the research was concerned with positive change and not negative publicity that decreased anxiety among both groups. The project's final report was launched by the Victorian Vice President of the Australian Medical Association, who commended its concern to promote women-sensitive practice. And the Medical Practitioners' Board invited the researchers to provide in-service training for Board members investigating allegations of professional misconduct (Gridley & Moore, 2000).

**Conclusion**

As feminist researchers we are concerned to undertake research that places women's concerns at the centre of our work. We are also committed to social change that will lead to positive outcomes for women. However in Project Hippocrates there were problems in undertaking both of these tasks. The issues we were dealing with were sensitive and also involved open discussions of power relationships between women and men in situations often regarded as private and privileged. To achieve something beyond giving women a voice we needed to be able to see these situations from the doctors' perspective, yet the very topic of the research made it difficult for us to do this. We did succeed in interviewing some doctors as well as women patients but many doctors refused to participate in the study. We learned a great deal in this research about the need to develop representative critical reference groups early in the research, the importance of cross-disciplinary discussion and engagement and the need to think laterally in developing research strategies. It could be argued that the voices of the less powerful group(s) – women patients, and feminist social scientists themselves – eventually carried less weight than those of the more powerful medical profession. However Project Hippocrates sustained itself over a number of years, and remains one of the most challenging and contentious, yet ultimately satisfying research projects in which we have been involved.
References


IN RESPONSE TO: PROJECT HIPPOCRATES: TOWARDS WOMEN-SENSITIVE MEDICAL PRACTICES IN THE WESTERN METROPOLITAN REGION OF MELBOURNE.

Project Hippocrates was developed from concerns by health agencies regarding reports by some women of sexually intrusive practices during medical examinations. It is based on prior, related research and takes into account the experiences of both women and general practitioners in the Western region. The resultant recommendations of Project Hippocrates aim to enhance medical practitioner-women patient relationships, particularly where associated cultural sensitivities exist.

The following checklist intends to provide a valuable resource for this purpose. However, the points outlined can only be effective if they are given proactive consideration. Quotations are taken from the Project Hippocrates Report, available from Women's Health West, telephone - (03) 9689 9588.

CARING FOR PATIENTS
"When I am having intimate examinations, I like the doctor to explain to me what he/she is doing" (p.18).
- Does your practice emphasise clear and concise communication strategies?
- How can you be sure your patient understands the procedure about to be performed?
- Does your patient have any questions regarding the procedure?
- Would she perhaps feel more comfortable with another party present?
- Are you familiar with the Medical Practitioners Board brochure(s) Trust In The Doctor/Patient Relationship, Intimate Examinations and/or other locally produced guidelines?

CULTURAL SENSITIVITY
"I couldn't speak the language to say anything or even to ask him what he was doing" (p.26)
- How can your practice ensure that it is meeting the needs of different cultural groups?
- Which ethnic groups most commonly utilise your practice?
- Are there any culture-specific issues that require special consideration?
- Does your practice ever use the services of a qualified interpreter?
- Overleaf is a list of Migrant Resource Centres that may be of direct assistance or used as an initial reference point.

PATIENT COMPLAINT PROCEDURE
"I would have liked to have done something but I wasn't sure what or where to go" (p. 36).

Should a patient require information regarding appropriate complaint procedures they may be directed to contact The Health Services Commissioner, 30th Floor, 570 Bourke Street, Melbourne, telephone 8601 5222 or the Medical Practitioners Board, Level 16, 150 Lonsdale Street, Melbourne, telephone 9655 0560.
CARRYING FOR DOCTORS

"Sometimes I just shut the door and sit for a few minutes, if it's been difficult" (p.45).

- What supports does your practice offer its doctors?
- Has your practice considered debriefing procedures for doctors who may be under stress?
- Does your practice have strategies for the management of boundary issues with patients?

Prepared by Eliza Carey in consultation with Heather Gridley (Victoria University), Kim Wilson (Women's Health West) and the Divisions of General Practice in the region.

Contact Details

Heather Gridley
Department of Psychology, S089
Victoria University
PO Box 14428
Melbourne City Mail Centre
Melbourne, VIC 8001
Telephone (61) 3 9688 5224
Fax (61) 3 9688 4324
Email heather.gridley@vu.edu.au
Too Close to Home: The Politics of Psychological and Emotional Abuse

Peter Streker (Victoria University)

When the topic of psychological and emotional abuse is discussed among psychologists, it is generally in terms of the abuse committed by others. However, this appears to be only part of the story. Who defines what is psychologically or emotionally abusive? Whom does this protect and whom does it place at risk? This article opens a new way of looking at this ancient topic and explores alternative approaches that critical community psychologists can adopt to prevent psychological and emotional abuse.

Stories and Reflections from Practice

While working as a drug and alcohol counsellor, I heard countless stories of emotional and psychological abuse. I remember a woman, who I will rename as Christine, explaining how she felt under siege from an ex-boyfriend.

“He kept at me like a woodpecker. Constantly. Peck, peck, pecking away. All the time. It was like he was chipping off pieces of who I was…”

I was trying to gather the pieces together, but as I was picking the pieces up off the ground, he was on my back still pecking away. Even when he wasn’t there, he was still in my head. I just couldn’t escape him.”

Christine used alcohol to cope with the impact of this treatment during and long after that relationship.

Another story, which will probably stay with me for life, was told by a 43 year old man, who I will call Bill. Bill started seeing me after he was being repeatedly arrested for stealing cans of aerosol spray (usually fly spray) from local supermarkets. Bill would spray the contents of the can into a plastic bag and then inhale until he became unconscious. If he could not access the cans, he would steal bottles of methylated spirits and drink until he achieved the same effect. Here is a portion of Bill’s experience:

“When I was six, dad used to come home drunk from the pub, wake me up, get me out of bed and chase me around the house with his shotgun…”

I can still remember running, screaming through the paddocks when it was pitch black, with dad shining his spotlight on me, shooting just over my head…”

I used to hide in the bush until he had gone. Then I would sneak back to the house, watch him through the window and wait for him for pass out.”

Psychological and emotional abuse was also a recurring theme in discussions I had with ex-partners of men I counselled in a family violence program. As a result of these discussions I became fairly confident that the program had helped many men stop their physical abuse, although I was not convinced that we were as successful when it came to preventing psychological or emotional abuse.

I was also very conscious of the criticism levelled against programs for perpetrators of family violence - that they did nothing more than train men to become better abusers. The thought that this was happening horrified my colleagues and me, and motivated us to focus on developing better methods of addressing this form of abuse (e.g., attention to voice intonation, ambiguous or devaluing statements and intimidating postures).

I was genuine about working to prevent violence and abuse and did not want to be seen as a man colluding with other men who have been abusive. This motive, coupled with my (hyper-)consciousness of my maleness, led me to dismiss men’s stories of times when they had been victimised. I also was very aware that these stories were presented in a context where the men were trying to muster sympathy, and in many cases, excuse their behaviour. Stories of men receiving psychological abuse from women clashed with my pro-feminist framework, even when they were acknowledged directly by the men’s (ex-)partners. Without minimising the men’s responsibility for their own abusive actions, I eventually arrived at the resolution that female-initiated abuse, if it did exist, was merely a response to patriarchal oppression.

Reflections on my personal experiences

Reflecting on my own personal life, I realised that I had experienced times, both as a perpetrator and a victim of psychological and emotional abuse, that involved people of a variety of genders. When I brought this realisation into consideration, the experience of psychological and emotional abuse no longer appeared to be gender exclusive.

I revised my original resolution and concluded that it was patronizing to see women as only acting in response to men. Further, I recognised that a dismissal of abuse by women rendered it and its recipients invisible.

This position is not an attempt to excuse men from their violence or abuse, to minimise or legitimise their abuse, or to try to equate male and female violence or abuse. In fact, I strongly advocate for many more resources to be invested in efforts that aim to prevent abuse by men and assist the victims of their abuse. I am interested in contributing to a system that reduces the abuse committed against all people regardless of the gender, race or other feature of the perpetrator or the victim. I am strongly influenced by feminist theories of violence and use them to frame my work with men who have been abusive.
As a young boy, growing up in a working class culture, I learned that psychological abuse was an important method of communicating with my peers. It was at once a source of achieving power, status and cheap entertainment. The abusive tactics that the men confessed to in the family violence group were not foreign to me - many were those I had honed against others during my teens. The more I reflected on this, the clearer it became that it was not only the men in the group who were psychological abusers, but also me! I do assume, however, that this form of abuse was very prevalent and very serious and that its prevalence and seriousness are generally under-rated by many professional and lay people.

While reviewing the literature, I also found it difficult to settle on a satisfactory definition of psychological or emotional abuse. I found that many researchers relied on at least one of the following three criteria to establish the existence of this form of abuse (Follingstad & DeHart, 2000; Glaser & Prior, 1997; O'Leary, 1996; Fortin & Chamberland, 1995; Jory & Anderson, 1999). I do not particularly care whether they are or they are not the most prevalent or damaging, as I am not interested in getting involved in a "my topic is more important than your topic" debate, which draws energy away from more important considerations. I do assume, however, that this form of abuse is very prevalent and very serious and that its prevalence and seriousness are generally under-rated by many professional and lay people.

What does the mainstream psychological literature say?

As my interest in this phenomenon grew, I turned to the psychological literature. I was surprised to find that psychological and emotional abuses are widely regarded as the most prevalent and most damaging forms of abuse (Arias & Pape, 1999; Brassard & Hardy, 1996; Dutton, Goodman & Bennett, 1999; Fortin & Chamberland, 1995; Jory & Anderson, 1999). I do not particularly care whether they are or they are not the most prevalent or damaging, as I am not interested in getting involved in a "my topic is more important than your topic" debate, which draws energy away from more important considerations. I do assume, however, that this form of abuse is very prevalent and very serious and that its prevalence and seriousness are generally under-rated by many professional and lay people.

While reviewing the literature, I also found it difficult to settle on a satisfactory definition of psychological or emotional abuse. I found that many researchers relied on at least one of the following three criteria to establish the existence of this form of abuse (Follingstad & DeHart, 2000; Glaser & Prior, 1997; O'Leary, 1996; Tomison & Tucci, 1997):

- the abuse must be a pattern of behaviour, rather than a single act;
- the perpetrator must intend to harm the other person; and
- the victim must perceive the act as abusive.

At first glance, these criteria may seem quite reasonable. However, under closer inspection it appears that the application of these criteria effectively excuses and legitimates countless abusive actions, leaving the recipients even more vulnerable to further abuse.

For example, it seems that many authors prefer to conceptualise psychological and emotional abuse as a pattern, rather than a single act, presumably to avoid over-reactive interventions and litigation. That seems to be a sensible approach in accord with the culture's legal maxim of assuming one's innocence until proven guilty. Yet on the other hand, it excuses the majority of psychologically and emotionally abusive behaviour as an aberration. Even though it is acknowledged that the effects of a single act may be quite different to the effects that result from more prolonged and highly developed patterns of abuse, the excuse of a single act is not accepted in the context of either physical or sexual abuse and should not be legitimised with regard to actions of psychological or emotional abuse either.

From a critical perspective, the criterion of a pattern serves to capture people at the extreme end of the spectrum; thereby creating a "them" that is separate from "us". It creates some space between our own infrequent acts of psychological or emotional abuse and the more regular acts of others (i.e., the so-called perpetrators).

It is also worth noting that a person may suffer not only from a pattern of abuse inflicted by a particular individual, but potentially also from the aggregated acts of many people using similar themes, such as race, gender, intelligence, or aesthetics. Single, seemingly isolated, acts of abuse can be much more powerful than they superficially appear.

I also have concerns about relying on the perpetrator's intent. Although, it may be useful to consider intent to improve one's understanding of the dynamics involved with potentially abusive actions, I do not believe it should be regarded as an essential determinant of the existence of psychological or emotional abuse.

Morally, the actions of somebody who intends to harm may often appear quite different to the actions of somebody who does not. However, practically, the effects may be much less disparate. Delving into someone's motives with any certainty is incredibly difficult. Often those with a vested interest in hiding their motives are easily able to do so, by directly lying or couching their actions in contexts that create ambiguously jumbled possibilities (e.g., a joke, an act in the other person's "best interests"). Pragmatic progress in this field may be best achieved by not considering intent in the judgement of psychological or emotional abuse, as it is too often presented in a way that disguises the intention of the abuser and exploits the judge's tendency to apply a "benefit of doubt."

The political nature of the choice of this criterion is highlighted when we look at how a quite different standard of responsibility is applied when damage occurs to property. "I know you didn't mean to drive through my loungeroom, but...[you are responsible for the damage]." If responsibility can be easily located with the non-intending actor in this setting, there is no reason why the same cannot occur in situations of psychological or emotional abuse. Recipients can still be damaged even when the actor's intent is good.
The third criterion also carries a number of flaws. If the victim’s perception of harm relied on to determine the existence of psychological or emotional abuse, it is likely that subtle and potentially more sinister forms of psychological or emotional abuse will be missed. Psychological and emotional abuse are often part of the “normal” process of everyday interacting and not just the result of major conflictual incidents (Marshall, 1999). The incident of abuse need not cause trauma or psychological suffering in an immediate sense, as it often exerts its most powerful impact when the actions form into habits that persistently erode the confidence and security of the other person—a form of psychoemotional death by one thousand cuts.

It is also relatively common for recipients of psychological or emotional abuse to internalise responsibility for the abuse (i.e., “there is something wrong with me”) or accept it as a normal aspect of life. Bill, the man in my earlier example, did not realise his drunken father was being abusive until many years later. He thought he must have deserved his father’s treatment, because he was bad. If the judgement is at least partly dependent on the victim’s response, then people who are able to withstand the abuse may absorb the damage and absolve the abuser from responsibility for their actions. This effectively blames the victim for the result, as any damage that occurs is accounted for by his or her personal weakness or inadequacies, rather than the actions of the person performing or neglecting the act itself (Glaser & Prior, 1997). If the victims internalise and own the blame for this experience, as many do, their perception of the abuse will be dramatically different than if they externalised the blame for the abuse with their assailant (Philleltensk & Gonick, 1996).

The issue of the victim’s perception places the practitioner in a very difficult predicament. Even though the perceptions of the victims need to be respected and valued, many have been subtly trained to excuse, accept or feel as though they deserve abuse. Others will experience transient or subclinical effects that are easily dismissed. Relying heavily on perceptions that have been skewed in such a way assists the abuser, at the expense of the victim. Only naming and addressing abuse after waiting until significant damage has occurred, places enormous numbers of people at great risk of harm. Attempts to adopt an easy solution, such as either always or never accepting the victim’s stance, are likely to lead to an inadequate response.

Whose interests does the mainstream framework serve?

The heart of my argument is that the mainstream framework of acknowledging psychological and emotional abuse serves to protect many abusers and place many victims at risk of harm. For example, it effectively prevents prevention by encouraging no action until the damage has been quite severe.

Psychology’s positivist and empiricist traditions of research seem to encourage a focus on more tangible issues (e.g., physical and sexual abuse) and discourage research on concepts that are more slippery and contextual (e.g., psychological and emotional abuse).

The mainstream framework that focuses predominantly on individuals generally neglects or minimises socio-political conditions that facilitate, legitimate and maintain psychological or emotional abuse. When these psychological or emotional abuses are addressed, an aberration model tends to be used. That is, the individual bad apples are singled out, while any systemic issues that contribute to the abuse are ignored.

The mainstream model’s static framing of the actor’s identity as either a victim or a perpetrator increases the likelihood that the perpetrator will be them, and not us. We can easily frame our abuse as an aberration, as not intentional or we can interpret the response of our victim in terms of their personal deficit. There are numerous examples of this. For instance, school bullying interventions are more likely to focus on students, than on teachers or systemic issues. Although, having said that, there have been some impressive inroads into cultural practices recently, such as bastardisation in the military, racial vilification in sport and sexual harassment in the workplace. These examples need to be built on.

Conceptual Steps Forward

One important step in the conceptual development of this phenomenon involves recognition of the dynamism of psychological and emotional abuse, the fluidity of one’s identity and the broader socio-political framework of abuse.

It also seems that psychological and emotional abuses are intertwined and mutually dependent. That is, whenever either psychological or emotional processes of abuse are engaged the other is also activated and present. Indeed, for this reason, I prefer to refer to this form of abuse as psychoemotional.

I believe it is critical that psychologists’ conceptualisation of psychological and emotional abuse cast a wider net that even we may find ourselves tangled in from time to time. While the concept of psychoemotional abuse may defy a fixed, all-encompassing, watertight definition, it is possibly best conceptualized as a process that continuously changes and unfolds as relationships between individual actors shift and are renegotiated (Labonte, 1997). To be consistent with other
forms of abuse, I propose that psychoemotional abuse should refer to the process where one or more people, via a wide range of means (e.g., verbal, the enactment of legislation or policy), use psychological or emotional processes to overpower another and exploit the other's subordinate position by gaining an advantage in some way (i.e., the psychoemotional hit). The existence of psychological or emotional abuse should not depend on a pattern of behaviour, the perpetrator's intent or the victim's perception.

The conceptual understanding of psychoemotional abuse presented here aims to capture more abuse than the definitions of many others. I understand that this definition is not ideal, comprehensive or finite. Indeed, it is likely to generate lots of comments that begin with "what about...?" This conceptualisation is not an attempt to settle the issue, but rather to unsettle it. This is an attempt to err on the side of protecting the most vulnerable and develop greater sensitivity to the exchange of power between people.

In doing this, I recognize that this stance carries its own particular problems. For example, more frequent accusations of abuse may potentially erode the gravity of the concept of "abuse". However, at this point in time, I believe this is a risk worth taking. We can always sharpen our language or invent another word or phrase later. Widespread adoption of a broader conceptualisation should heighten all parties' awareness of the seriousness of actions that are too often misinterpreted as benign, and lead to a reduction of legitimated excuses. Such a conceptual shift has the potential to prevent enormous amounts of harm, as it should foster conditions where people are encouraged to take more personal and collective responsibility for their actions. We need to plant more seeds of doubt, rather than fumigate abusive practice with the benefit of doubt. This is risky, but the risks of not doing this appear potentially much greater.

I acknowledge that this broader net can itself be used abusively. For example, some of us may remember the legal cases in the United States, where people sued their parents for a poor upbringing. I believe that it is vital to promote methods of resistance and resilience that move beyond counter-abuse. A race to the bottom is ultimately in no-one's better interests.

Finally, it is crucial that we are conscious of the interests we serve when we apply our power. I do not believe that mainstream psychologists deliberately chose to protect abusers and place recipients of abuse at greater harm when deciding on a set of criteria for psychological and emotional abuse. I perceive their position as an unfortunate oversight by some well-intentioned people who did not adequately reflect on the unintended side-effects of their use of power. Critical community psychologists are well placed to address the politics of psychological and emotional abuse, and help bring about dramatic improvements to the quality of life of many.

References


Community Psychology and/or Critical Social Theory? — A personal and reflective perspective

Tod Sloan*

As I became acquainted with the general perspectives of community psychology in the United States, I was often struck by the fact that this subdiscipline attended to topics such as neighborhood, social support networks, local participation — that were nearly completely neglected by critical social theory, especially the lines of thought associated with the famous Frankfurt School. On one hand, this made community psychology appear flat and undialectical, for lack of attention to macrosocial and intrapsychic processes; on the other hand, critical theory seemed to have under-analyzed major contexts of social action. This essay explores the tension between community psychology and critical social theory and examines the potential for critical community psychology.

The sheer pace of life, the speed at which our lives live themselves out astounds me. It feels just like the other day that I was opening my first introductory textbook in psychology, full of excitement for this discipline I had chosen as the focus for my university studies. But that was over a quarter of a century ago and things look quite different from this side!

In my studies, I quickly gravitated toward theories of personality, especially those with a humanistic bent. Self-actualization, authenticity, individuality were the concepts that fascinated me most. These concepts fascinate when one has been produced by a social order that individualizes without fostering meaningful individuality and commands self-actualization and authenticity when its primary institutions routinely block the self-reflection and collective dialogue that might make possible the actualization of self in an authentic manner.

In postgraduate studies, thanks to a few professors and fellow postgraduate students, I gradually worked my mind (but not my body and my actions) out of the humanistic individualism into which I had been seduced by the North American ideological apparatus. My encounters with psychoanalysis and critical social theory (the early Frankfurt School, Adorno and Marcuse, in particular) forced me to recognize the extent to which social order and personal character are entwined through a powerful, ongoing ideologizing process.

By ideology, I mean a system of representations and practices operating at the subjective, institutional, and macrosocial levels to reproduce social relations of oppression and domination. Ideological processes should also be seen as fully material and corporal, not merely cognitive. Although I perceived this intellectually, I still conceived of only individualistic modes of intervention for the solution of human problems and even completed full clinical training as a backup plan in case I could not find an academic position.

I eventually discovered community psychology in the mid 1980s, when I developed ties with Latin American colleagues such as Maritza Montero in Venezuela and Ignacio Martin-Baró in El Salvador. In the face of widespread misery in both rural and urban settings, they could not justify individualistic approaches to social and personal problems. With few resources and great commitment, Latin American community psychologists organize extensive collaborative projects with marginalized communities to make concrete improvements in their access to resources, organizational capacity, and connections to political allies. Inspired by their examples, I returned to the States and tracked down North American versions of community psychology and explored options for action in my own local community in Tulsa. I was too snobbish and spoiled by the philosophical sophistication of critical theory to be much impressed with the plodding style of most North American academic community psychology, but directors of local community agencies were thrilled when a social scientist wandered in inquiring about opportunities to participate in prevention-oriented community research and action. In particular, in the late 1980s, agencies were under increasing pressure to be accountable to funding sources, to demonstrate that their programs were actually having some sort of impact. They needed professionals with basic research skills to evaluate their pilot prevention programs. Recently this pressure has been even more intense. I read up on basic program evaluation and gradually over ten years developed enough business to organize a Center for Community Research and Development at the University of Tulsa, which keeps several faculty members and a team of doctoral students and undergraduates very busy. (For example, in recent years, we have done evaluations of community coalitions for the prevention of adolescent problems, programs to improve school readiness, media campaigns for mental health awareness, school-based violence prevention programs, and also need assessments for marginalized populations, such as the growing Hispanic population.)

Now, I said we developed 'enough business' for the CCRD because business is what it begins to feel like. A surprising amount of time is spent calculating budgets, hassling with the dean or the university research office about overhead rates and indirect costs, negotiating a renewal of contract, sitting in planning meetings, setting up databases, reviewing performance indicators, supervising personnel. Remember that this is just a small-time community research center at a small private university. My sense is that roughly half of the academic community psychologists in the United States are engaged in this manner in a hectic scramble to follow federal
and state dollars as they shift from homelessness to teen pregnancy to smoking prevention to HIV/AIDS to welfare-to-work programs. Recent concerns about the utilization of program evaluation findings mirror our own experience that decisions to replicate or discontinue programs were made far in advance of receiving evaluation feedback. This does not help one feel that cutting through endless red tape to do meaningful community research is worth the trouble!

Given the way our system is organized, most of this work actually needs to be done, but one wonders after a while, where is the psychology in this? Where is community, for that matter? More importantly, where is the social justice and the critical reflection? The value of this work needed to be examined in the broader context that I felt community psychology rhetoric was addressing. It is in this context that one can fruitfully address the tension between critical social theory and community psychology.

On the side of critical theory, especially in Marcuse and Adorno, but even in Fromm, we find an exciting and penetrating analysis of the ways in which personalities and lifestyles are produced as constraining and compulsive compromises between, on one hand, the commands of an exploitative and manipulative social order (consumerist corporate capitalism, in this case) and human needs on the other hand. Whether these compromises are called narcissism, neurosis, alienation, or estrangement is not the issue at the moment. I primarily want to point to the fact that in critical theory the mediating processes between social order and subjectivity, i.e., the formal and informal institutions and social relations that constrain agency and critical self-reflection, are surprisingly under-theorized. It is thus no surprise that critical theorists have long been criticized for seeming not to know where to begin when it comes to practical action to change families, communities, businesses, schools, corporations, governments, etc.

There is good reason for those who hope for social transformation of a fundamental sort to turn to community psychology. There one would expect to find an adequate critique of the colonization of the lifeworld, of systems take precedence over the processes that maintain and reproduce meaning, culture, solidarity and identity (Habermas, 1984). In the case of mainstream community psychology, social spaces in which citizens, villagers, friends, or neighbors might reflect and act to solve shared problems in living in creative, generous, and courageous ways are
supplanted by extensions of the system's interests in social control and the maximization of profits. Hence, rather than being encouraged to help to shorten the work week or to create flexible schedules for parents, psychologists find funding to evaluate programs designed to train and employ those who have been systematically neglected by various social institutions and are therefore 'difficult to employ'. Rather than invitations to consult or do research on how communities might support families with adolescents as they search for enjoyable shared leisure activities, psychologists are urged to set up systems to detect potential 'school killers'.

One way of looking at the task of critical community psychology therefore is to understand it as a process of decolonizing the lifeworld. Every potential practice of the community psychologist could be scrutinized with this lens. Is this action fostering a further extension of the system's control over the forms of life we have available? Is this method objectifying or manipulating the flow of social life? Or, is this practice opening up new spaces for deep reflection on how we want to live? Is this practice helping the powerful to hear and understand the voices of marginalized populations? Extended disciplinary self-scrutiny of this sort would not only be part of building a just society, it would also breathe life into a field that threatens to collapse under the weight of its rather dull textbooks and journals.

The transformation of mainstream community psychology into critical community psychology is largely a matter of imagining and willing a different sort of society with each moment of engagement.

'Making a difference' (the theme of the conference at which these ideas were presented) thus could imply a variety of efforts within the sphere of action of community psychology:

- Shifting our energies away from systems that primarily transform disadvantaged and marginalized persons into middle class workers-consumers.
- Working from the base of both mainstream and peripheral community processes and institutions to transform the ideological, socioeconomic, political, and subjective forces that limit social wellbeing – in general, this means attending to political economy and governance as a means of altering people's life opportunities, rather than emphasizing therapeutic and educational modes as we currently do.
- Insisting on democratic participation, in every sphere of life, establishing practices of deep reflection and dialogue on our situations in place of rushed, empty selections among pre-determined options.

In short, and in summary, making a difference through critical community psychology means working from a basic commitment to those who suffer most, not only locally, but also globally, to transform the processes and structures that reproduce the domination of system requirements over lifeworld needs. This can be done in a myriad of ways, working from where one already is, but looking both outward (macrosocial) and inward (intrapsychic) much more intensely, not being overly caught up in that which is immediately present at the level of everyday life. The everyday is 'where it's at', and where community psychologists must establish a solid base, but in order to alter radically the intolerable aspects of the everyday, we need to learn the primary lesson of critical theory, that everyday misery and suffering is not a personal or local affair, but the working of an unjust and inhumane social order, driven by greed and egotism, that can only be transformed by mobilizing the latent power of the vast multitudes through what Hardt and Negri (2000) have termed deep democracy.

* Tod Sloan is a faculty affiliate of the Department of Psychology at Georgetown University. He is also co-coordinator of Psychologists for Social Responsibility in Washington, DC. He is the author of Damaged Life: The Crisis of the Modern Psyche (Routledge, 1996) and editor of Critical Psychology: Voices for Change (Macmillan, 2000). He can be reached at tss5@georgetown.edu. An early version of this essay was delivered as a keynote address at the Seventh Trans-Tasman Conference on Community Psychology in April 2001 in Melbourne, Australia.

References


Notes
Network publishes work that is of relevance to community psychologists and others interested in the field. Research reports should be methodologically sound, and papers reporting the use of qualitative methodologies will be especially welcomed. Theoretical or area review papers are welcomed, as are letters, brief reports and papers by newer contributors to the discipline. Contributions towards the four sections of the journal are sought.

**Articles**
Contributions are state of the art reviews of professional and applied areas and reviews and essays on matters of general relevance to community psychologists. They are between 4,000 and 10,000 words, or the equivalent, including all tables, figures and references.

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

**News and Views**
This section publishes commentaries on matters arising from anything published in the journal. This section also includes comments and debate on any issues of relevance to community psychologists.

**Book Reviews**
The Journal publishes book reviews of up to 1,000 words. Books reviewed relate directly to the major areas of practice in community psychology.

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

**Title Page**
Each contribution must contain a title page which has the following information: title of the manuscript, name(s) of the author(s), a contact name and address for correspondence and reprints, the word length of the manuscript, the section of the journal for which it is being submitted. If the contribution is intended for a Special Issue, clearly indicate the issue and the name of the Issue Editor.

The section area nominated will be used for editorial purposes. Manuscripts which do not contain the above information will be returned to authors.