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## **Yarning with the Deadly Nannas about safe practices and trauma affecting Aboriginal perinatal parents: Healing the past by nurturing the future (HPNF) research**

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*The Healing the Past by Nurturing the Future (HPNF) project aims to co-design safe, acceptable and feasible strategies for parents in the perinatal period (pregnancy to two years after birth), who have experienced trauma. An integral aspect of the project involved yarning with the Deadly Nannas, a senior group of Aboriginal grandmothers, to guide safety and the development of engagement with Aboriginal parents. A group of eight Deadly Nannas were consulted in Murray Bridge, South Australia in July 2018, utilising safe and creative methods of qualitative enquiry. Eight themes were identified from thematic analysis: a continuous trauma cycle in Aboriginal communities; service-need gap is getting wider not closing; fear of the child protection system; importance of nurturing the resilience of Aboriginal parents with support; importance of acknowledging the difficulties of becoming and being a parent; strong nannas also need care and support; parental education and learning is critical; and empowering by safe and creative engagement. Findings will inform the development of key strategies for the HPNF project to work safely and effectively with Aboriginal parents.*

**Key words:** complex, intergenerational, trauma, Aboriginal, perinatal, Nannas, parents

### **Understandings of Complex and Intergenerational Trauma**

Recently, Complex Post-Traumatic Stress Disorder (Complex trauma) has been formally recognised in the 11<sup>th</sup> edition of the International Classification of Diseases (ICD-11). This has six core symptom clusters that include issues relating to intrusions, avoidance, hypervigilance, disorganisation, worthlessness and relationships. These disturbances are also associated with significant impairment in personal, family, social, educational, occupational or other important areas of functioning (Karatzias et al., 2017).

The persistent, severe and chronic nature of complex trauma is consistent with Australian Aboriginal understandings of collective (Krieg, 2009; Ratnavale, 2007) or intergenerational (Atkinson, 2002) trauma. Trauma within Aboriginal contexts is linked to the impact of historical and continuing oppressive policies and practices. For example, Aboriginal peoples have endured frontier wars, dispossession of land, and the forced removal of Aboriginal peoples to government institutions-reserves and removal of children from their families and culture. Whilst the documented legacies of these remain, successive policies

continue to oppress and contribute to health inequalities and ongoing socio-economic disadvantage (Atkinson, 2002; Dudgeon, Wright, Paradies, Garvey & Walker, 2014; Ralph, 2010).

This is the context for other impacts of trauma including: community disconnection (feeling isolated and disconnected from ones community); identity loss/fragmentation; profound grief and loss (unresolved or unintegrated grief); suicidality, drug and alcohol abuse (Atkinson, 2008; Gee, 2016; Holmes & McRae-Williams; 2008), child maltreatment and violence (Atkinson, Nelson & Atkinson, 2010), as well as infighting or lateral violence within the community (Clark, 2017). These impacts and manifestations of trauma contribute to Aboriginal peoples' experiences of vulnerability and heightened risk of experiencing further trauma on an everyday basis (Atkinson, Atkinson, Wrigley & Collard, 2017; Krieg, 2009; Ratnavale, 2007). Consequently, Aboriginal peoples' experience of social health issues and psychological distress is proportionally higher than the non-Aboriginal Australian population (Australian Bureau of Statistics (ABS), 2021) and is relative to a high number of and types of stressors (i.e. upset by family member, housing issues and death in the family ) (Weetra et al., 2016) along with lower levels of social and emotional wellbeing (Australian Indigenous HealthInfoNet, 2020).

Accordingly, social, environmental and even biological mechanisms of trauma transmission may be passed on from generation to generation (Sotero, 2006 cited in Roy, 2019). The perinatal period is a critical time for preventing intergenerational transmission of trauma. Parental vulnerability can affect the capacity to nurture a child, respond to the attachment and day-to-day needs of their infants (e.g. breastfeeding, soothing a crying baby), and can 'trigger' trauma responses in parents (Alexander, 2016; Chamberlain et al., 2019a). As a result, children's physical, social, emotional, and psychological development can be compromised with wide-ranging and often life-long implications for their health and wellbeing (van der Kolk, 2007). Therefore, skills and strategies are necessary to promote positive development of children into adulthood to combat future self-destructive, pain-based behaviours (Atkinson et al., 2010). If not curbed, the cycle can continue from the perinatal period, in part, because it can become normalised within a culture and embedded in the collective, cultural memory of a people.

### **Healing the Past by Nurturing the Future (HPNF) Project**

The HPNF project aims to co-design perinatal (pregnancy to two years after birth) *awareness, recognition, assessment and support* strategies for Aboriginal parents experiencing complex trauma. Indigenous Research methodologies underpin the conceptual framework and guides the overall HPNF project. The framework includes core values of safety, trustworthiness, empowerment, collaboration, culture, holism, compassion and reciprocity (Chamberlain et al., 2019b; Clark et al., 2020).

The HPNF Aboriginal-led and focused community-based participatory action research (action research) project is being conducted in three Australian jurisdictions; the Northern Territory, South Australia and Victoria. An Intervention Mapping (IM) approach is used in this project to frame the co-design process. IM uses theory and evidence as foundations for taking an ecological approach to assessing and intervening in health problems and prompting community participation. The first four (of six) IM steps corresponded to four action research cycles. The first cycle included stakeholder mapping, community engagement and consultations to build strong foundations for the research. These processes occurred through active contact with key people and services, a co-design workshop in Adelaide, South Australia and consultation with a group of senior grandmothers in South Australia (*Deadly Nannas*) – a group who understand about parenting issues and initiatives, as well as intergenerational trauma.

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## Community Consultation and Engagement

Consultation and engagement with Aboriginal communities is an integral part of Aboriginal research and recommended in national and local key guidelines and protocols (see National Health Medical Research Council, 2018; South Australian Health and Medical Research Institute (SAHMRI), 2014). These documents advocate for research that is safe, respectful, responsible, beneficial, of high quality and designed to ensure ongoing connections among Aboriginal peoples and culture.

Consulting and yarning with Aboriginal Elders is often the starting point. Elders have an unparalleled role within their communities, and there is increasing recognition of the significance of story-telling and yarning as a valid research method that can lead to positive effects on practice (Geia, Hayes and Usher, 2013; Walker, Fredericks, Mills & Anderson, 2014)). Certain Elders may be more appropriate and helpful depending on the issue at hand and it is important for researchers to understand local community groups, dynamics and the inter-relationships, in order to contextualise the information and to develop a critical analysis of their own researcher processes (Smith, 2012). Koolmatrie (2010), who gained many of her research skills from her Elder Ngarrindjeri women and family within her grandmother's kitchen in South Australia, noted that once appropriate community engagement protocol is followed, researchers can feel confident that there is a place of welcome in Aboriginal communities. She identified that Aboriginal women are central to research as they have a process to talk to each other, to share information, communicate, heal and exchange skills through story-telling. This is an extension of reciprocal caring and mothering roles particularly when women give back to the community in roles on boards, committees or advisory groups (AHCSA, 2019).

## Perinatal support processes

The perinatal period (pregnancy to two years after birth) is often one of optimism, healing and emotional development (Fava et al., 2016), with the potential to prevent intergenerational transmissions of trauma (Choi and Sikkema, 2016). A scoping review found that this period can be viewed with a sense of hope and as a time for new family beginnings (Chamberlain et al., 2019a). The literature suggests that a history of trauma and childhood maltreatment in and of itself does not predict postpartum parenting quality (Sexton, Davis, Menke, Raggio & Muzic, 2017) and most parents can and do provide nurturing care for their children even when they have experienced maltreatment themselves (McCrory, DeBrito & Viding, 2010). Chamberlain et al. (2019a) highlighted various healing models and examples of social, family and professional support strategies of nurturing care to break intergenerational cycles of trauma. For example, within a life-course and intergenerational pathway model, a range of resilience and protective factors may moderate risk factors or challenges, and can increase positive perinatal parent outcomes. These protective factors include: financial solvency, access to resources, attending counselling, volunteer work, and parent training. Some of the challenges included fear of child protection agencies, lack of parenting knowledge as well as lack of trust and systemic barriers to services. Other literature relating specifically to Indigenous contexts highlight the importance of grandmothers' and communities' roles in helping to care for children by passing on culture and keeping children safe and connected, to break the intergenerational cycle of trauma and avoid family disruption and ongoing child removals by the Child Protection system (Cross, Day & Byers, 2010; Hill, 2012).

## Aims and objectives of the current study

The overall objective of this study was to gain collective advice and guidance from an Elders group to help build strong foundations for the HPNF project. The Deadly Nannas (or



Ngarrindjeri Muth:ar) were identified for this. They are a senior group of predominantly Aboriginal women who gather in Murray Bridge in South Australia supported by Moorundi Aboriginal Health Service. The specific aims of a formal consultation and yarn with the Deadly Nannas were twofold. Firstly, we aimed to learn from the wisdom of the Deadly Nannas group about the effects of intergenerational trauma for Aboriginal parents during the perinatal period and what might help or hinder a healthy transition to parenting. Secondly, we sought to pilot proposed qualitative methods to use in future research with parents and gain feedback on the appropriateness of these approaches and suggestions for improvement.

The specific research questions related to these aims were:

1. What are some of the things that need to be better understood during the perinatal period for parents who have experienced complex trauma in their own childhoods?
2. During the perinatal period, what might support the social and emotional wellbeing of Aboriginal parents who have experienced complex trauma to nurture healthy happy families?
3. Is this research approach safe for working with parents directly? And are there any suggestions about how we can make this safer, more effective and/or empowering?

## **Method**

### **Participants and Setting**

Key stakeholders for the HPNF project were initially identified during a stakeholder mapping exercise. As part of this, the Chairperson of the Deadly Nannas initiated contact with the principal investigator of the HPNF project to discuss the synergy of their work with the research. The Deadly Nannas actively work in their local community to help address the effects of intergenerational and transgenerational trauma in a culturally safe and confidential environment, particularly by assisting grandchildren to reconnect to culture and language through music. The research project was supported by the Aboriginal Health Council of South Australia (AHCSA) to facilitate further contact with the Deadly Nannas, which progressed to a formal yarning session in July 2018 at the Moorundi Aboriginal Community Controlled Health Service in Murray Bridge. The focus group consisted of six Aboriginal members of the Deadly Nannas and two senior Aboriginal community members who will be referred to collectively as the Deadly Nannas thereafter. The members ranged in age from their middle 40s to their late 60s. All were grandmothers, with extensive and rich experiences of working and/or engaging with children, parents and community.

### **Research Activities**

#### ***Procedure***

A detailed discussion group protocol and a safety framework that guided the consultation and yarning process with the Deadly Nannas was developed (Chamberlain et al., 2019b; Clark et al., 2020- documents available on request).

The research was approved by the Aboriginal Health Research Ethics Committee (AHREC) within AHCSA in June 2018 (#4-18-774)). Project information and consent forms were explained and provided to the Deadly Nannas group for signing prior to and during the session. The Deadly Nannas were informed about potential trauma responses, safety risks, strategies and resources. A HPNF psychologist from Adelaide was available to support the group along with a safety card with contact details to access other psychological support and local resources post workshop.

Creative and reflective qualitative processes were embedded into the yarn with the Deadly Nannas group to nurture safety, the relationships, conversations, strengths and positive



mood. These processes included: 1) the sharing of their strengths using strength cards (Secretariat of National Aboriginal and Islander Child Care [SNAICC]); 2) the utilisation of a fictional third person scenario of two Aboriginal parents (Mary and Tom) with trauma backgrounds (see Appendix 1); 3) developing a base landscape image (e.g. river, desert, forest with paths) to represent the parenting journey utilising natural materials and sticky notes/pens/pencils for writing and drawing; 4) the provision of cards with key themes identified in the HPNF scoping review (Chamberlain et al., 2019a) for participants to consider if any additional relevant issues should be considered.

Such indirect use of stories, activities, metaphors or analogies and cards are considered a safer, culturally appropriate and comfortable way of communicating for many Aboriginal people. Flexibility was also important because after reading the scenario, the Deadly Nannas decided to yarn about the scenario rather than engage in the planned creative ‘natural landscape’ process on the large canvas sheets. The large canvas was used instead to write notes and to summarise discussion. The change of process was not surprising given the Deadly Nannas are an established and familiar group who naturally preferred yarning, laughing and listening to each other during discussion. The two HPNF facilitators<sup>1</sup> followed the Deadly Nannas natural style of interacting with each other. The facilitators used open-ended questions to prompt discussions, focussing on “issues for parents in the present during the perinatal period” (barriers/concerns/risks) and importantly, the “things that may help” (enablers/healing factors) for the future. The discussions were recorded and later transcribed.

The Deadly Nannas were informed of the de-identified process to ensure participant anonymity and confidentiality. However, the importance of Elders’ status and wisdom needs acknowledgement (Wilson, 2008). The women chose to be identified as part of the collective of the Deadly Nannas as well as individually as co-authors in this article. At their request, their individual responses were anonymised (who said what) and preserved.

### Analysis

The transcripts and working sheets were analysed using a thematic process, to report patterns and themes in the focus group data (Braun & Clarke, 2013). This involves a rich description of the recurring (and unique) patterns from the discussion in the study via six stages: 1) familiarization with the data, by reading and re-reading the material. 2) generating initial codes and patterns, 3) searching for and identifying themes, 4) reviewing themes, 5) defining and 6) naming themes.

The material was independently reviewed manually by the two researchers involved in the consultation and analysed separately to stage three. A comparison between the two independent analyses found an initial theme consistency. For further analysis, the codes were then entered in NVivo 12 qualitative software. In September 2018, the Deadly Nannas group reviewed the findings for accuracy, interpretation and presentation style of the material. This review process generated further discussion and several adjustments to the thematic findings were made. The findings were then presented to participants in a session at the HPNF workshop two in Alice Springs in mid-September 2018 in which three of the Deadly Nannas attended and co-facilitated. The Deadly Nannas also provided feedback on the draft manuscript of this paper in October 2019 and again in May 2020.

### Findings

Thematic analysis revealed eight key themes: *a continuous trauma cycle in Aboriginal communities; the service-need gap is getting wider not closing; fear of the child protection system; importance of nurturing the resilience of Aboriginal parents with support;*

<sup>1</sup> Both researchers are of Aboriginal background and clinically trained as a mid-wife (Assoc Professor Cath Chamberlain) and an endorsed Clinical psychologist (Dr Yvonne Clark).

*acknowledging the difficulties of becoming and being a parent; strong nannas also need care and supports; parental education and learning is critical; and empowering by safe and creative engagement.* These themes overlap and are discussed in detail below along with supporting quotes from the Deadly Nannas.

### **A Continuous Trauma Cycle in Aboriginal Communities**

The Deadly Nannas group highlighted many trauma experiences and patterns that exist in Aboriginal communities. Their responses to the fictional scenario of Mary and Tom were that the couple had limited opportunities to learn about parenting, and that chronic trauma could become normalised in communities and passed from one generation to the next. The group also acknowledged that high level family support, keeping families together, and strengthening parent-baby bonding could help break the cycle of trauma:

**DN4:** *“They probably think it’s normal, the way they live, because their parents lived like that. And you can go back to the grandparents and great grand-parents who were taken away with the stolen generation...and they never got any help or anything. Kicked out of their homes and were at foster places wherever they were. They never got any help too, for them, so they didn’t know any better either...This has just passed down from generation to generation... You know grandparents lived with trauma all their lives, you know, I said, and we never got any help from anybody, you know, it’s a wonder we survived and sane like we are now.”*

**DN5:** *“This will come through the children too. I find it sad, you can only keep supporting both, not separating the family.”*

### **The ‘Service-Need Gap’ is Getting Wider Rather than Closing**

The Deadly Nannas identified the lack of support from the existing services to the Aboriginal community needs and how this contributed to a gap in health and wellbeing care. Examples included services holding back information, not providing continuity of care, and not being culturally responsive to the historical contexts and health needs of Aboriginal people. Further conversations highlighted the need for services to build trusting relationships with individuals. This was particularly relevant for young parents and those with trauma histories, especially when hospital stays are short and there is little time for engagement or assistance. The group considered that extra service supports maybe needed for those with trauma backgrounds or for members of the ‘stolen generation’<sup>2</sup>. This group may be more vulnerable and likely to find parenting challenging and confusing with insufficient direction, or support for basic parenting responses such as breastfeeding and caring for child. Ideal services were exemplified as: outreach services; holistic or family oriented; integrated; and culturally appropriate by relationship building, and being inclusive of culture, all of which could potentially improve health and wellbeing outcomes.

**DN6:** *“A big gap... it’s not closing the gap its making it wider.”*

**DN3:** *“And trust as well because they got to – a lot of people don’t realise that trust is has to be developed with anybody.”*

**DN7:** *“I think there’s a lot of information out there but it’s not culturally appropriate...to talk to a white person about Aboriginal history or anything, is very hard. I think that’s a barrier for lots of services.”*

<sup>2</sup> The term ‘stolen generation’ refers to Aboriginal and Torres Strait Islander people who were taken away from their families and communities as a result of past Australian government policies and practices.

## Fear of the Child Protection System

The Deadly Nannas highlighted that intergenerational cycles of trauma appear to coincide with intergenerational fear of the child protection system (CPS). This fear can prevent families from engaging with services as they may feel they are scrutinized and targeted, especially if they have had family experiences of child removal. Ironically non-engagement can also have consequences for the parent and child, because service personnel can sometimes make a CPS notification for non-attendances at appointments, laying blame on parents rather than addressing accessibility of the service. It could also be services failing to reflect on what they can do to reach out to families and take responsibility for their non-engagement. The Deadly Nannas also reported that once families come to the attention of a reactionary CPS, their traumas are intensified.

**DN5:** *“If you take the child away [removed by child protection (CP) agency] that makes that mother worse. It’s not going to help the mother, because what help does that mother get by taking her children instead of working with them together.”*

**DN6:** *“Yeah- because no doubt, once again, because they [the parents] haven’t engaged with the AMIC [Aboriginal maternal infant care] worker, they going to have a red mark against them for not engaging. What have you [the service] really done to engage?”*

**DN6:** *“One thing that I think that is going on with Tom and Mary at the minute is that they got this new born baby, at Tom’s parent’s house, all those issues are going on, no doubt there be risk - like notified to the Department for this infant - the newborn and even before that it would have been an unborn notification [to CP agency]...so the Department would know about it. Mary would have that fear as well- re-traumatisation. Her history is coming back. They would be very much panicking that they gonna lose their child.”*

## The Importance of Nurturing the Resilience of Aboriginal Parents with Support

The strengths and resilience of the young couple in the fictional scenario were acknowledged by the Deadly Nannas group, despite their need for considerable support. Their resilience and a new start with a baby furnished an opportunity to turn their situation around and potentially break the trauma cycle by engaging in support services and counselling to resolve or deal with some of their past traumas. It was also acknowledged that there might be parental reluctance to engage in therapeutic interventions because of the stigma of being viewed as “crazy” and a questioning of its effectiveness. Despite this, empowerment and support interventions that are inclusive of the whole family were seen as critical.

**DN4:** *“You know when you talk about send them to psychologists or psychiatrists or whatever, you know, to try and help them - they think I’m not going there - I’m not mad, I haven’t got mental problems - in fact they have, and they need help, but they’re in denial so how do you help them.”*

**DN6:** *“...the strength areas - resilience to keep going, she knows what she wants you know, she’s engaged a counsellor before - maybe that’s something that she wants to re-address and familiar with counsellors.... It would be great for her. She has got strengths there.”*

**DN8:** *“I was thinking if the baby is with Toms mum, maybe putting something in place to support Toms mum and networking, networks there. Working together to keep mum [and] Mary connected.”*

### **Acknowledging the Difficulties of Becoming and Being a Parent**

The Deadly Nannas wanted to convey a message of hope and reassurance to Aboriginal parents that even though parenting is hard, they can do it. Many of the Deadly Nannas themselves found parenting hard when they were younger. They emphasised that it is okay for parents to feel that they can't cope at times, and that could be a motivation to seek support. Moreover, they thought that parents need the courage to ask for help and not feel bad or shamed about asking for help.

**DN2:** *"Then it's getting the courage up, the confidence to go and ask for that help. You know sometimes it's really hard, they just don't want other people knowing their business... You having the same problems as what we having, maybe you don't talk, or people don't know. But to find out we sharing all the same problems and maybe that will start conversations."*

**DN4:** *"I think you need to say to them, we know how hard it was with children, you know little children, they cry all the time, when they sick and all that, we understand how tired you get, frustrated with children and that. Talk to them and tell them, you know, we weren't perfect parents when we first had children."*

### **Strong Nannas also Need Care and Support**

As trauma is intergenerational, so too is survival, support and caring. The Deadly Nannas exemplified their individual and combined strengths and their tactics to empower families and community. There was strong conviction in their caring roles and they identified themselves as a source of support and advocacy for a community of grandchildren. Many of the Deadly Nannas have volunteered their time over many years to break family cycles of trauma. Despite this, it can take a toll on them and they can experience burn-out. To lessen their burden, the Deadly Nannas also attempt to motivate and involve others in community and voluntary work.

**DN5:** *"Can I just mention it's the grandmothers that fuel it all and the grandmothers get old quick and we lose our grandmothers... too early in life and that's where the pressure goes into the grandparents ... A lot of grandparents are strength for us all you know- but it tires you."*

**DN4:** *"We look around in our community and some of our kids have got grandparents or got aunties or uncles who will take in their nieces and nephews whilst their mums and dads aren't coping properly. So that's the way we do it in our community you know, take in these children and help look after them... A lot of the kids, when I've said I drove the bus, for 10 years ... taking them to school- they just loved it. They would stand on the footpath waiting for me in the morning. Pick them up to take them to football or basketball. I guess it was just to get out of their house and go and do something that they love.... Play sport, you know a lot of them were very good at sport, because everybody praises them."*

**DN3:** *"For the future for us sitting around the table, maybe, we can encourage others out there that might want to become volunteer to work with young families, you know, cooking... helping others and volunteering, that needs to happen."*

### **Parental Education and Learning is Critical**

The Deadly Nannas identified that formal and informal education could assist Aboriginal parents to succeed with their parenting, life in general, and their ability to heal their trauma. Formal education was viewed as staying at school or returning to school, whereas informal education relates to short courses or practical learning.

The Deadly Nannas group acknowledged that chaotic and traumatic experiences in the lives of some parents meant that they didn't have role models to teach them appropriate life and parenting skills. Parents, especially young or first-time parents, could benefit from skills, such as: cooking, budgeting, health, wellbeing skills and self-help approaches. One strategy suggested by the Deadly Nannas group was to teach parents how to prepare inexpensive nutritious meals. Recipes and cookbooks were also viewed as useful.

**DN5:** *"I was looking at the education side of it all, that's been my fear for young ones, especially our own...On the education side its starting from scratch, its hard for them...Importantly its working with them together to make that good and better direction because its hard enough getting them to school...but really she's not gonna change [without any education] because her mother didn't."*

**DN3:** *"Lack of parenting, knowledge and skills. People just don't have those."*

**DN4:** *"The mums or the dads who take the kids to the kindy, they can take in a bag. Pay a couple of dollars or something, take a bag full of food home you know. You can get all your veggies, then you only need to buy some cheap cuts of meat or something. Throw in the pot and make a nice big pot of soup or something. Unless they told these things, I guess you know, somebody teaches them how to do it. Do a couple of times and then they can do it themselves.... need to learn skills- cooking food, managing finances and bills, health and wellbeing, looking after baby"*

### **Empowering by safe and creative engagement**

The Deadly Nannas shared that while they felt confident and safe to contribute to the research consultation due to their years of collective experience engaging with people and systems, younger parents may feel shame and want more privacy. Therefore, future research activities with Aboriginal parents need to incorporate processes that are safe, build trust and confidence and avoid shaming parents.

**DN3:** *"I felt safe, here I could share, like everybody has a story to share and we're our own editors. So, we edit the stories -we edit what we want to tell people."*

**DN4:** *"But then again us women sitting here we very strong women, you know we got other people out in our community who's not as forthright as us, as strong as us, so maybe they wouldn't give the feedback what we have, because we have always gotten up and spoke our minds... Because a lot of the young ones now they all shame."*

**DN2:** *"Then it's getting the courage up, the confidence to go and ask for that help. You know sometimes it's really hard, they just don't want other people knowing their business."*

The Deadly Nannas signified that research activities need to empower parents by meaningful and comfortable practices where parents can start talking about their issues and feel good about themselves. They suggested engagement methods that use distractions, incorporate sharing, have *take home* components, and involve parents receiving an incentive (i.e. gift). Distraction is when there is a focus on an activity to help regulate trauma responses whilst subtly encouraging parents to talk about their issues. This reduces the pressure for parents to tell their stories, until they are ready. Examples include weaving, cooking, making jewellery and art. Incentives could include gift packs or vouchers. Sharing for instance could be to allocate a person beforehand a role to share their account which can 'break the ice' and enable others to impart their story. Encouraging parents to be accompanied by a support person or family member may also help with their confidence. Finally, the way the questions are asked



is important and need to be invitational. If parents resonate with the process, it can lessen shame and demonstrate that it's okay to yarn about issues.

**DN1:** *"Often asking them, what can we help you with, what would you like?"*

**DN7:** *"A group activity, you know not talking straight away about issues within their home, build their trust, and then it will eventually start coming out, what people's issues are... I do a lot of activities like writing books, book making and jewellery making. Anything like that, an activity, even cooking. Having a gathering and just relaxing."*

**DN1:** *"Sometimes that might be a good idea [sticky notes] because sometimes they might think it, but they might be a bit shame, they don't want to say it, you know, so it's a good idea and then just stick it... I think from a lot of people, even if you have shared a meal with someone, well everyone brings a shared meal... and we share it around."*

**DN4:** *"So that's all you need is one of the younger mothers to start talking and then the other mothers will jump in and start talking about their problems and stuff or where they can go for help for this or that, or whatever."*

### Discussion

The thematic content provided by the Deadly Nannas was invaluable to better understand the cultural context and issues faced by Aboriginal perinatal parents as well as helping to lay solid foundations for safe and creative practices. Although many of the key themes identified in this study are consistent with findings from HPNF reviews involving parents nationally and internationally (Chamberlain et al., 2019 a; b; c), themes identified by the Deadly Nannas speak to specific issues in Aboriginal communities related to the ongoing and profound impacts of colonisation.

As highlighted by the Deadly Nannas, intergenerational trauma is a significant issue in their local community. Although complex trauma is now formally defined in the ICD-11 with six core symptom clusters (Karatzias et al., 2017), in Indigenous communities, trauma is often discussed in terms of its chronic and intergenerational nature, stemming from oppressive forms of colonialism and continued vulnerability. The consequences of intergenerational trauma for many in the Aboriginal community was linked to the Child Protection System and the gaps in services.

The Deadly Nannas confirmed that local Aboriginal parents are fearful of attracting the attention of the child protection system. They identified that this fear may be present despite the parents' capability, continually adding to trauma that the family may already be facing. This fear is warranted given the historic and ongoing overrepresentation of Aboriginal children involved in the Child Protection systems in Australia (CFCA, 2020). It also coincides with many of the stories concerning Aboriginal people in Australia, is reminiscent of the past and reflects some stories conveyed in the "Bringing them Home"<sup>3</sup> report (HREOC, 1997) where Aboriginal children were forcibly removed from families and culture causing not only trauma to the child but the parents and families that were left behind. It is possible that such fear is ongoing through the generations, may be normalised, unconscious and exacerbate the intergenerational nature of risk that can elicit the attention of the Child Protection system. Fear of Child Protection Services was also a feature in the international literature (Chamberlain et al., 2019a) but the intensity described in Indigenous communities where systematic removals have been part of political histories is evident in the narratives of the Deadly Nannas. Conversely, such fear can lead to conscious coping strategies with the avoidance of health and

<sup>3</sup> A significant report in Australia as a result of a national inquiry into the forced removal of Aboriginal children from their families and culture. It marks a pivotal moment toward healing for many stolen generation members.

other services for fear of being reported to the Child Protection system. This is ironic as the parental fear of being reported to Child Protection can also elicit avoidance and non-engagement in services and systems of support, resulting in families not receiving the potential benefits of engaging with health and social care services. Consequently, an important role played by the Deadly Nannas is to assist in keeping children in the community safe. This is consistent with the role of Elders and grandmothers in other Indigenous communities in Australia and overseas (Cross et al., 2010; Hill, 2012).

Strength and internal resilience served as protective factors for many parents and enabled parents to access resources and support. Financial resources and counselling can moderate risk stemming from childhood trauma (Chamberlain et al., 2019a). Seeking external resources therefore can strengthen the parents, family and community. This is reflected in the Deadly Nannas' practices focusing on positive community connections and support to reduce risks. One of the Deadly Nannas' particular strategies to support parental resilience was to help them understand that parenting is hard and there is no shame in asking for help. Merrit (2007) has argued that resilience related to survival has rarely been recognised in the literature as a significant source of resilience. Such resilience is exceptional and has enabled many Aboriginal people to survive by shielding against the devastating effects of colonisation and intergenerational trauma and still be here today.

The strength and support of grandparents toward parents hardly featured in the HPNF scoping reviews, with only one article that mentioned "othermothers" amongst those in foster care in which grandmothers may be included (Aparicio, Pecukonis & O'Neale, 2015, p. 50). However, there is some recognition in the literature of Aboriginal grandmothers' status, strength, resilience and survival and their ability to provide culture, help and support grandchildren and others in the community, as well as recognition of the toll this may take on grandparents and their need for nurturing care (Kilcullen, Swinbourne & Cadet-James, 2012). Indigenous American and Canadian literature discussed the caring of their grandchildren by grandparents in the child protection system to reduce intergenerational trauma. Grandmothers' "strength and resiliency" was noted along with their stressors. Despite this, the rewards outweighed the stressors providing grandparents with a sense of purpose in caring and relief in keeping their grandchildren on track and engrossed in culture (Hill, 2012; Cross et al., 2010).

The Deadly Nannas highlighted the inadequacies of the perinatal health care systems that can be both confusing and culturally inappropriate. These systems were viewed to have a lack of integrated support for families (whole of family approaches), as opposed to individualised support which predominantly focuses on the child (or children). Such an individualised service focus may contribute to a sense that the service gap is getting larger and not closing. Targets to improve the lives of Aboriginal people have been part of "closing the gap" national strategies. Whilst there has been slight improvements for Aboriginal parents in maternal and infant health over the last decade (2008 to 2018) disparities between Aboriginal and non-Aboriginal people still occur. There is an understanding that service access is a protective factor and there is a commitment by the Australian Government to grasp the inequalities and work toward change (Australian Government, 2020).

The call by the Deadly Nannas for integrated, caring, safe and culturally appropriate services are aligned with findings from the HPNF scoping review (Chamberlain et al., 2019a). This is where one can feel connected and empowered, with conscious strategies to build safe places and relationships for baby and parental protection and where parents can potentially heal and prevent intergenerational transmissions of trauma (Chamberlain et al., 2019a). In Australian Aboriginal communities current research is being translated into more sustainable and culturally responsive maternity services for Aboriginal parents. For example, models of care that focus on providing culturally safe, continuity of midwifery care are offered in various locations. That include: Victoria with the *Woman's journey: Baggarook Yurrongi, Nurragh*



*Manma Buliana* program (Judith Lumley Centre, 2020); in Queensland, the *Indigenous birthing in an urban setting* (IBUS) which looks at models of ‘birthing on country’ (Hickey et al., 2018) and in South Australia the *Aboriginal Family Birthing Program* (Middleton et al., 2016) and the *Metropolitan Aboriginal Birthing program* (Department of Health, 2020). Whilst these programs and research are at different stages of development or operation, none are currently available in the Murray Bridge area where the Deadly Nannas are located.

The Deadly Nannas identified that formal and informal education could assist Aboriginal parents to succeed in many aspects of their life. They identified returning to formal school, tertiary education, life-skills, cooking and parenting courses as all having a role in helping to break the cycle of intergenerational trauma for the whole family. A focus on social determinants of health inequality such as education, employment, child mortality and life expectancy has been recognised as part of close the gap initiatives (Australian Government, 2020). There has been headway in terms of education for Aboriginal people with improvements in early childhood enrolments and Year 12 attainment with further recommendations for improvements to other sectors in the Aboriginal community. Parents in the HPNF qualitative review indicated mixed opinions in relation to formal education and employment which was linked to seeing parenthood as a chance for a fresh start yet also challenging due to their own lack of education or employment (Chamberlain et al., 2019c).

The Deadly Nannas indicated that they felt safe in the research and were empowered in offering information to guide future approaches for working with parents. Safe and respectful practices are not an easy process to get right, especially to Aboriginal community members with past negative experiences of research and who can feel judged, misinterpreted, confused and perhaps even exploited in research (SAHMRI, 2014). Stigma and judgment also featured as an issue for some parents in the HPNF qualitative review (Chamberlain et al., 2019c). This feeling of safety can work both ways for participants and researchers and is critical in obtaining high quality data and information (Koolmatrie, 2010). The HPNF research facilitators also felt that they had a place of safety and welcome, to conduct the research in phase one, and have continued to engage with the Deadly Nannas throughout the HPNF project.

Highlighted by the Deadly Nannas was that parents have considerable resilience and strength, and this can be nurtured in a safe, caring and supportive environment especially when utilising creative methods of engagement. They advocated for engagement methods that focus on positive questions, use of distraction, sharing of stories, take home material, and use of incentives. Creative activities, such as art therapy, have been supported for use in Indigenous contexts to mitigate the impacts of trauma (Weinberg, 2018). Thus, parents can be provided with creative methods of education and skills not only to empower them but also to improve their wellbeing and abilities to raise strong healthy children. This theme corresponds with the core element of *Creating Safety*, as identified in the HPNF qualitative review. Within this theme, it was emphasised that parents can see the world as an unsafe place, may not trust others, and can use conscious strategies to build safe places and relationships to protect themselves and baby (Chamberlain et al., 2019c).

## Research Strengths and Limitations

Strengths of this study include use of a qualitative process that relies on the strength of the group and the stories they tell. Yarning with a purpose is increasingly being recognised as a valid research method and contact with such an inspiring group of women was enhanced by their familiarity with yarning and comfort engaging in research in this way. Many of the themes and findings resonate with results of other research processes and sources of information in the HPNF project.

Although many findings from yarning with the Deadly Nannas are consistent with the findings of HPNF reviews, it is worth noting that most of the studies included in these reviews did not involve Indigenous parents. The focus and content of the Deadly Nannas was specific to Aboriginal parents and their cultural values, behaviours, and histories. The Deadly Nannas offered unique insights into the experiences and needs of Aboriginal community and parents. For example, fear associated with child protection exists for many parents with histories of trauma - across many cultures - yet the intensity in Aboriginal communities may be greater due to the systematic child removal that occurred throughout much of the last century via policy and practices specifically mandated for Aboriginal people, and which is believed to still occur. Another strength of the study is that it specifically focussed on exploring experiences of trauma related to parents during the perinatal period. Furthermore, as this was a preliminary discussion seeking advice on safe approaches, it was an essential start for grounding the research and gaining appropriate cultural permissions before proceeding to work directly with Aboriginal parents.

There are study limitations that need to be noted. The Deadly Nannas are a strong group of Ngarrindjeri women from one of the language groups in South Australia. As such, the participants in our study do not represent the full breadth of diversity of Aboriginal or Torres Strait Islander language groups in Australia<sup>4</sup>. Furthermore, the consultation did not include any Aboriginal grandfathers or other Aboriginal men who might have been able to give a different insight into fatherhood and parenting. The material from the Deadly Nannas was rich and extensive and only the major themes are reported. The consolidated criteria for reporting qualitative research (COREQ)<sup>5</sup> suggest a clarification of minor themes should also be included. Despite this the study highlights important perspectives of Aboriginal grandmothers that will continue to be triangulated with other sources of information, including insights from diverse Aboriginal parents, other language groups and fathers who will also continue to also be consulted as part of HPNF research proceedings.

### **Implications for Policy and Practice**

There is limited evidence regarding perinatal awareness, recognition, assessment and support strategies for Aboriginal parents who have experienced trauma in their own childhood. Therefore, findings from this study are pertinent to policy, service delivery and public health initiatives. Perinatal care services need to be culturally responsive to Aboriginal families, understand their circumstances and reflect on their service provision rather than 'blaming the victim'. There is also a need for services to be trauma informed and aware to minimize the risk of triggering Aboriginal parents many of whom will have experienced past traumas. In this context of discussion with the Deadly Nannas, the 'triggering' responses may be in the form of the intense fear that families feel and endure when they seek services. It also needs to be recognised that the perinatal period can be one of optimism where a 'window of opportunity' exists for service providers to provide trauma and culturally specific support that empowers Aboriginal parents to thrive and disrupt intergenerational cycles of trauma.

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<sup>4</sup> There were more than 250 Indigenous Australian languages including 800 dialectal varieties spoken on the continent at the time of European settlement in 1788. Currently 13 traditional Indigenous languages are still acquired by children and about 100 languages periodically used by the older generations that are at risk of being lost when Elders pass away (AIATSIS, 2020).

<sup>5</sup> The consolidated criteria for reporting qualitative research (COREQ) is a 32-item checklist for interviews and focus groups. It can help researchers report important aspects of the research team, study methods, context, findings, analysis and interpretations (Tong, Sainsbury and Craig, 2007)

## Conclusion

Yarning, listening and learning from Aboriginal Elders is a valued cultural practice and increasingly recognised as a valid research method of engagement with Aboriginal communities. This process of Grandmother engagement assisted the HPNF research knowledge base whereby insight was gained into safety strategies for conducting research with Aboriginal parents. Insight was also gained around issues, experiences, strengths and needs of Aboriginal parents as well as the strengths and needs of the grandmothers who might support them and their children. Information gained from the study will be triangulated with other sources of information to propel the development of awareness, recognition, support and assessment strategies for Aboriginal parents who have experienced complex trauma. Such information may also be relevant for other research projects working with Aboriginal communities where it is important to start the conversation with Elders.

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## Appendix 1

### Trauma scenario *Mary and Tom*

Mary (19 YO) and Tom (21 YO) have been in a relationship for 14 months. Mary and Tom have a newborn baby girl (3 weeks old) called Kaleerah. They are living at Tom's parents place in Adelaide. An Aboriginal maternal infant care (AMIC) worker had contact with Mary on one occasion whilst she was in maternity hospital but unfortunately Mary checked herself out of hospital before their follow up visit. The AMIC worker and nurse are scheduled to visit the house next week - but they have been unable to confirm a time with Mary or Tom by a letter or by their mobile phones. Despite this, they will still visit Tom's parent's house next week. Tom is also the father of a young boy aged 20 months, from a previous relationship, but he rarely sees his other son.

Mary's background: Mary is the third oldest of 5 children and had grown up under a Guardianship of the Minister (GOM) Order within the Department of Child Protection (DCP) since she was 8 years old. She was originally taken into Care, along with 2 older siblings because of neglect and exposure to domestic violence in the home. The three children were removed after an incident where Mary's mother (Pamela) was beaten by her then partner (Joe) who is the father of the 3 oldest children. Consequently, Pamela was taken to hospital and the police were called. The children were described as extremely distressed and were taken into Care, by DCP. Since her time in Care, Mary was placed in 2 separate non-Aboriginal foster families (alone and not with her siblings). She has a pattern of running away from the foster homes (since the age of 12). This was because of conflicts in the foster homes, where Mary said that the foster carers were racist and aggressive towards her. She was placed in Residential Care from when she was 15 until 18 years old. In residential care she reported that another young female resident had sexually assaulted her. Mary received some counselling at the time, but her issues were not appropriately dealt with.

Mary went to different high schools depending on where she was living at the time, and whether the school would accept her, as she had a record of bad school behaviour. She attended a regular high school to year 10 and had done some extra schooling and courses whilst in Residential Care. Despite Mary's behaviour and School attendance, she has always been described as bright and was able to do the work when she put her mind to it.

Mary's mother, Pamela, found a new man and has two other children (Mary's younger siblings) and is now settled. Mary had some contact with her mother over the years and the early contacts were often supervised by DCP. Mary tried to make her own contact with her family (especially when she ran away from foster home) but the visits to her mother (and two younger siblings) always ended up in arguments and she ran away again and would eventually ring her social worker at DCP for help. Mary has had no contact with her father since she was 8 years old.

Tom's background: Tom has grown up within his own family and is the oldest of 6 children. Tom completed to year 9 at a regular high school but struggled academically. He then attended an alternative school for year 10 (Warriappendi) which was on the other side of town and although he enjoyed it he only attended occasionally because he had to catch two buses to get there. He comes from a large extended family and regularly hangs out with his cousins. He has

also been arrested for a few minor charges in the last 2 years when he was with his cousins. These have been for loitering and swearing in public. When he was 16 he was also a passenger in a stolen car during a car chase with police. So far, he has not been in juvenile justice or prison.

His mother (Ruth) and father (Frank) both drink (alcohol) on the weekends, are everyday marijuana smokers and are believed to take other drugs (mainly prescription drugs). They argue and fight all the time at home and the children have been exposed to family violence since they were young (including Tom).

Frank's behaviour is described as erratic, aggressive and psychotic. Frank refuses to seek help for any of his issues and blames everyone else for them. Frank grew up in a community town and is from a large extended family and maintains contact with many of them.

Tom's mother Ruth was taken away as a child and adopted by non-Aboriginal parents. She met some of her biological family (siblings) about 10 years ago through Link-up and continues some contact with them (the ones she gets on with). Ruth has tried many times to keep her children stable and tried to send the kids to school every day.

## A safe place to talk: Participant experiences and community recommendations from an Aboriginal and Torres Strait Islander youth suicide prevention program

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*Aboriginal and Torres Strait Islander young people in Queensland die by suicide at more than four times the rate of their non-Indigenous peers. As the evidence of successful suicide prevention is limited, understanding effective mechanisms is crucial. The United Health Education and Learning Program (UHELP) pilot program evaluation found a significant decrease in Aboriginal and Torres Strait Islander youth suicidal ideation. A further qualitative analysis to explore participants' experiences and perspectives to identify intervention elements contributing to the positive outcomes was conducted and presented in this paper. In total 30 Aboriginal and Torres Strait Islander young people of 54 returned their surveys about the program. A qualitative thematic analysis of open-ended questions revealed three main themes: 1) connectedness; 2) confidence; and 3) knowledge. Within the community-based participatory research (CBPR) approach, the thematic analysis results were further discussed and reviewed within the broader community. From these findings the following recommendations were made at a community level for future UHELP deliveries: 1) facilitators should be accessible for young people to connect with after the sessions, rather than implementing the content in a stand-alone approach; 2) UHELP sessions should include staff from local mental health services that participants could access for treatment; and 3) evaluate impact of UHELP on cultural identity and connectedness.*

**Key words:** suicide prevention, youth, Aboriginal and Torres Strait Islander peoples, participant experiences, community

The prolonged, systematic and institutionalised discrimination towards Aboriginal and Torres Strait Islander people continued from the period of original colonisation in Australia supports the current widespread inequalities (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; De Maio et al., 2005; Dudgeon & Wright, 2010; Griffiths, Coleman, Lee, & Madden, 2016; Human Rights and Equal Opportunity Commission, 1997; Sherwood, 2013). Disparate outcomes are seen across employment, housing, income, education, life expectancy and mental health domains (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; SCRGSP (Steering Committee for the Review of Government Service Provision), 2020). These experiences persist through cultural dislocation, grief and loss, transgenerational trauma, and social and economic disadvantage which further the disproportionate burden of mental illness borne by Aboriginal and Torres Strait Islander communities (De Maio et al., 2005; Hatcher, Crawford, & Coupe, 2017; SCRGSP, 2020; Zubrick et al., 2005). Additionally, as the

generations of dispossession, discrimination, racism and violence has led to fear and mistrust of government departments and avoidance of many services, Aboriginal and Torres Strait Islander access mental health treatment at a rate far lower than commensurate to need (De Maio et al., 2005; Eley et al., 2007; Westerman, 2010; Zubrick et al., 2005). Consequently, today Aboriginal and Torres Strait Islander people experience higher levels of self-injury, with young people acutely overrepresented in suicide fatalities (Dickson, Cruise, McCall, & Taylor, 2019).

Aboriginal and Torres Strait Islander youth in Queensland die by suicide at a rate over four times higher than their non-Indigenous counterparts and this disparity widens to almost eight times higher for those under 14 years (Gibson, Stuart, Leske, Ward, & Tanton, 2021a). Though suicide disparities have been well-documented (Queensland Family and Child Commission, 2017), the evidence of effective interventions to prevent Aboriginal and Torres Strait Islander youth suicides remains limited (Clifford, Doran, & Tsey, 2013; Harlow, Bohanna, & Clough, 2014; Ridani et al., 2015). A recent systematic literature review of suicide prevention interventions for global Indigenous Populations identified only three published studies in which interventions reported a significant decrease in suicidal thoughts or behaviours for Aboriginal and/or Torres Strait Islander young people (Leske et al., 2020). While these interventions show promise as culturally-specific, non-traditional intervention models (Nathan, Maru, Williams, Palmer, & Rawstorne, 2020; Skerrett et al., 2017; Tighe et al., 2017), there was little examination of examine causal components to understand why these interventions successfully reduced Indigenous suicidality. With limited evidence and persistently higher suicide rates, it is critical to understand intervention mechanisms which reduce Indigenous suicidality in order to develop effective suicide prevention strategies and disseminate knowledges, learnings, and programs into other Aboriginal and Torres Strait Islander communities (Dudgeon et al., 2016; Farrelly & Francis, 2009; Westerman, 2010).

### **The United Health Education and Learning Program (UHELP)**

Following several suicides by young people within the Inala (QLD) community, the Inala Aboriginal and Torres Strait Islander Elders established monthly open community meetings for Elders, health workers, service providers and community members to discuss issues related to suicide and mental illness. The goal of these meetings was reducing stigma and developing proactive solutions. The group became known as the Inala Elders' Suicide Prevention and Mental Health Program (SPAMHP). From these community meetings, the SPAMHP team decided to partner with headspace Inala to address the complex and cyclical issues which have hindered suicide prevention attempts in the community. Collaboratively, a suicide prevention program from an explicitly Indigenous worldview, based on culturally valid models of promoting wellbeing and preventing mental ill-health, was designed and implemented. The program was driven by community participation and cultural governance, with the centrepiece being a weekly group session for young people. The content of group sessions was developed through iterative reflection with Elders, young people, and community members to ensure the topic areas were conceptualised from a cultural perspective appropriate to the local Aboriginal and Torres Strait Islander community. The program content areas included: Being Healthy (physical health, self-esteem, positive outlook), Being Loved and Safe (relationships, support networks, safe environment), Personal Growth (employment, stable housing, education/professional training) and Cultural and Spiritual Healing (incorporating Elders, transgenerational trauma) (Skerrett et al., 2017). To model holistic health, including cultural and physical wellbeing, each session also included physical activity (touch football, traditional Indigenous games), or cultural activities (dancing, painting, learning about totems) and the sharing of a healthy meal with accompanying nutritional advice. The program was given the

title United Health Education and Learning Program (UHELP) by the participants of the pilot project and confirmed by the community membership.

### **Pilot Project Evaluation**

The evaluation of the pilot delivery yielded several promising results (Skerrett et al., 2017). Pre and post focus groups demonstrated that participants had more holistic understandings of health and wellbeing, increased acceptance of help-seeking, greater identification of coping strategies and increased attendance at health and support services. Quantitative results using pre and post evaluation questionnaires demonstrated reduced suicidal ideation after participation, making UHELP the first published intervention to report a significant decrease in Aboriginal and Torres Strait Islander young peoples' suicidal thoughts or behaviours (Skerrett et al., 2017). Considering the positive results of this evaluation, UHELP was listed as a 'promising intervention' in the *Solutions That Work: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* (Dudgeon et al., 2016).

An identified limitation of the pilot evaluation study design was the absence of a mechanism to elicit participants' individual perceptions of the program; participants were asked in focus groups whether they felt UHELP was beneficial and how it could be improved. However, group dynamics may have biased or limited their responses (Erickson & Kaplan, 2000; Tashakkori & Teddlie, 1998). While the study examined impact of UHELP on suicidal ideation, self-esteem, awareness and acceptance of help-seeking and health services, another limitation was that the previous evaluation did not explore why these outcomes occurred, particularly from the perspectives of the young people participating themselves.

As part of the ongoing collaborative engagement, researchers and service providers continued to attend the open-community SPAMHP meetings. In these community SPAMHP meetings, it was raised as a concern by community members that this program, which was designed to nurture future leaders and Elders, did not adequately privilege and respect young peoples' insights in the evaluation (Ford, Rasmus, & Allen, 2012). Understanding from young people if and why they believed UHELP was appropriate and effective was prioritised as other services had requested to replicate UHELP in their communities.

The current analysis aimed to further explore Aboriginal and Torres Strait Islander young peoples' experiences of participating in a culturally informed suicide prevention program and identify factors that influence the effectiveness and acceptability of this initiative to inform future deliveries of UHELP. An additional aim of this study was to outline the application and translation of the study findings into community and organisational recommendations for future projects responding to youth suicidal behaviours in Aboriginal and Torres Strait Islander communities.

## **Methods**

### **Research Approach**

As with the original evaluation, this study was developed within a community-based participatory research (CBPR) framework grounded in reciprocal partnerships, shared decision making, and shared ownership of research outcomes and disseminated products between community and researchers. Key to this framework is the acknowledgement that community members possess expertise and knowledge of the issues, possible solutions, and their implementation (Viswanathan et al., 2004). This approach has been increasingly accepted as an effective modality for research partnerships with First Nations communities (Cox et al., 2014; Salimi et al., 2012). Research materials and protocols were collaboratively developed



with UHELP facilitators, evaluators and community leaders through ongoing and reflexive discussion about key goals of evaluation. This involved allowing space to examine potential differences between community, organisational and academic priorities. Both the evaluation and the program coordination team included Aboriginal and Torres Strait Islander team members to guide implementation of the research activities to ensure cultural safety. All procedures and measures were approved by the project-specific Steering Committee within Cultural Governance protocols prior to any actions occurring. Researchers continued to participate in SPAMHP community meetings to allow community-wide cultural governance of the project, which provided a mechanism for receiving community feedback to guide changes and continually disseminate findings.

Critical to this approach, the research project is not finished when findings have been disseminated in a one-directional manner within community. Discussion and reflection within the broader community is considered a key component of the research, and the resulting community-directed interpretation, guidance, and potential translation are key project outputs. This current paper will include this component in the discussion.

Ethical approval was granted by the Griffith University Human Research Ethics Committee (GU HREC): GU Ref No: 2017/621.

### **Participant Experience Survey**

An Experiences Survey was developed for participants to complete individually and anonymously. As with the original evaluation protocol, the Experiences Survey was developed in collaboration with UHELP facilitators, evaluators and community leaders involved with young people in the local area. This process sought to identify the potential key mechanism which could explain program effects while allowing space to elicit young peoples' novel ideas and interpretations.

From these discussions the resulting survey included binary (yes/no) response items to assess if young people believed UHELP had helped them, if they learnt anything about culture, health, or help-seeking, and whether they would recommend it to other Aboriginal and Torres Strait Islander young people. Participants were invited to give open-ended free-text explanations of their responses and describe how they were helped, essential learnings, as well as any other comments about their experiences and recommendations for improvement. Experiences Survey can be viewed as Appendix 1.

### **Data Collection**

This survey was conducted within the UHELP graduation ceremonies as a part of the programs delivered between May and September 2017. To allow honest and anonymous responses, data collection procedures were performed by the program manager while the UHELP facilitators were not present. De-identified surveys were provided to AISRAP Researchers for analysis.

### **UHELP Recruitment**

Recruitment was performed by *headspace*-Inala staff, with programs delivered at local schools, community and cultural groups through the Inala community, similar to the pilot delivery (Skerrett et al., 2017).

### **Participants**

A total of 30 completed surveys (response rate = 55.6%) were received from the 54 young people attending UHELP between May and September 2017.

## **Data Analysis**

Thematic analysis of participant survey open-ended responses was conducted by the first two authors. RW is an Aboriginal senior lecturer and nurse with over 20 years' experience in Aboriginal community health promotion and service delivery, whose PhD research explored rural Aboriginal community conceptualisations of suicide prevention, and MG, a non-Indigenous researcher and psychologist who was involved with the pilot UHELP program and has over a decade of clinical and research experience in Aboriginal and Torres Strait Islander youth suicide prevention. Thematic analysis was conducted broadly following Braun and Clarke's (2006) procedural guidelines with additional community-level reviewing to enhance and substantiate the findings (Fredericks & Ward, 2014; Gwynn et al., 2015; Viswanathan et al., 2004). Initial coding, identification and defining of preliminary themes was conducted independently. Through collaborative review and analysis, themes and subthemes were further refined by the first two authors. To improve the reliability of the analysis, themes were further refined with facilitators, organisational staff and community members. Results were discussed and reflected with the organisational and community owners of the program to determine how to apply and incorporate the findings. Community recommendations for the ongoing delivery and replication of the program made from this analysis are presented following initial thematic analysis results.

## **Results**

### **Program impact**

All participants reported that UHELP had helped them. Twenty-six participants (86.7%) reported that they had learned something from the program. All but one participant (96.7%) reported that they would recommend UHELP to other First Nations youth. The one participant who reported that they would not recommend this program provided the response "mainly because I don't know other Aboriginal students that would need it". Almost two-thirds of participants (63.3%) either provided no response to this item or reported that no changes were necessary. Requests for more time with UHELP facilitators through more and ongoing sessions was suggested for improving the program.

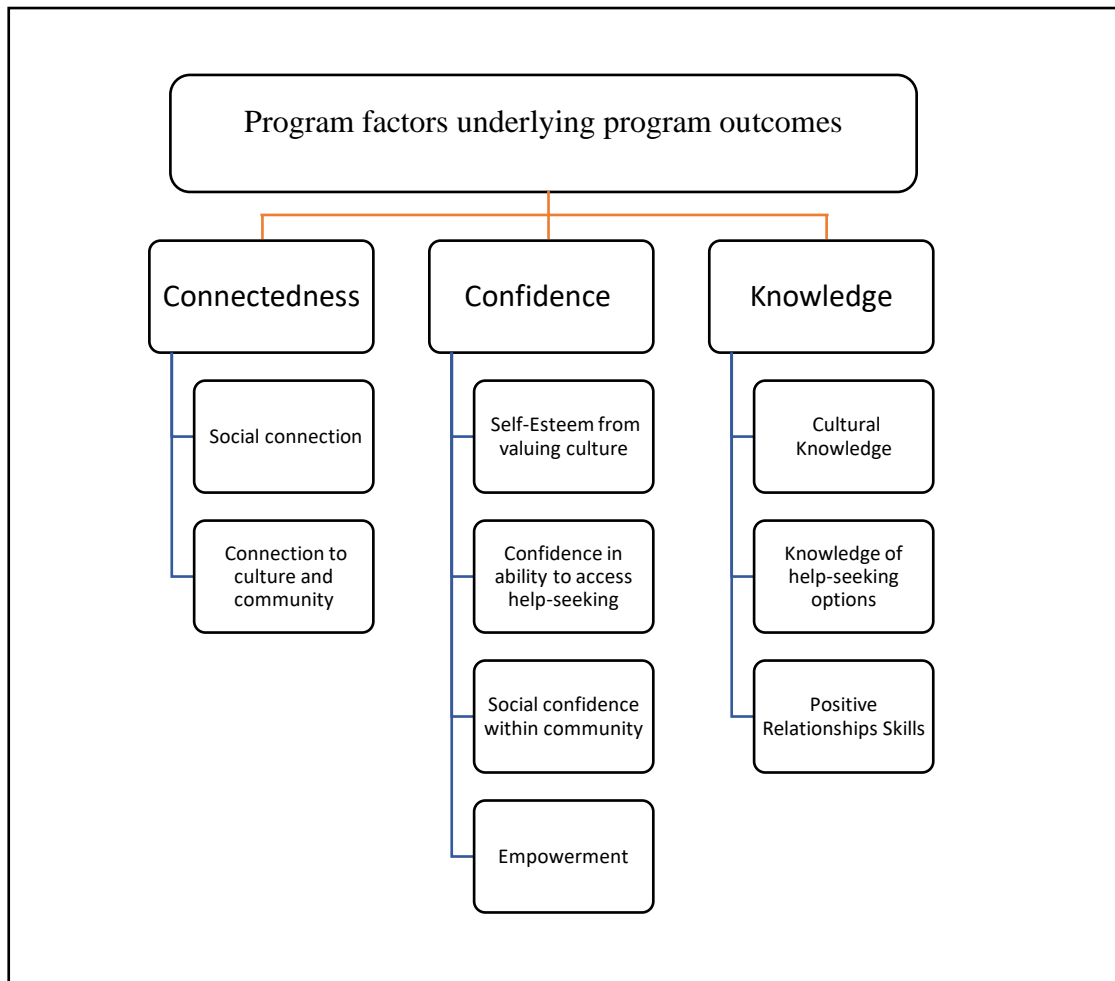
### **Program factors contributing to positive outcomes and thematic map**

Three main themes emerged of program components or factors of UHELP which underlie the positive outcomes for young people: connectedness, confidence, and knowledge. Thematic map in Figure 1 presents main themes and their subthemes.



**Figure 1**

*Thematic map of program factors underlying outcomes of UHELP from Aboriginal and Torres Strait Islander youth participants*



### **Theme one: Connectedness**

#### ***Social connection***

Having a “safe place to talk” and to develop a sense of social connection with other Aboriginal and Torres Strait Islander young people and facilitators was the most frequent answer provided by participants as to why UHELP was beneficial to them, “I have gotten to connect with other people”.

A number expanded further that the benefit was due to the ongoing nature of the relationships formed as they would now be able to connect with the people from the program for future support, “it’s been helpful because now I got people to talk to”.

#### ***Connection to culture and community***

Participants identified feeling more connected to culture and community as a primary reason UHELP helped them. Young people identified that culture had become more central to their lives and they now had greater appreciation for culture, “It has helped me learn more about my culture and where I came from”. Young people identified that they had greater appreciation

and respect for community and saw themselves as part of the community in a way they hadn't before; "I learnt that we are all connected".

## **Theme two: Confidence**

### ***Self-Esteem from 'cultural esteem'***

Participants reported that valuing culture had helped them to better understand and value themselves, "find out about your own culture as it helps identify yourself". This was the second most frequent reason cited for UHELP's positive effects. One participant reported that they had learnt "to really appreciate who I am as an Aboriginal".

### ***Confidence in ability to access help-seeking in the future***

Participants reported increased confidence in their ability to find and access support should they need help in the future as key to UHELP's effect, "I've learnt that if I need help I've got many facilities that can help me". Some expanded this further to intention to continue help-seeking even if initial attempts proved unsuccessful "there will always be support, if not from family but from organisations and friends".

### ***Social confidence within community***

Young people reported that UHELP helped them by increasing their confidence within their community, particularly their abilities to interact with their Aboriginal and Torres Strait Islander peers. "I feel more confident when talking with the other Indigenous kids"

### ***Empowerment***

While some young people articulated UHELP's primary benefit as helping them to simply "feel more confident," a sense of empowerment for future achievements was seen more broadly throughout reasons given, such as increased confidence in "setting life goals", "It has supported me and made me think about doing well in the future".

One young person further extrapolated that UHELP helping young people to feel positive and empowered towards the future, reduces suicide risk, "Suicide is not alright, a lot of people know they have lots to live for".

## **Theme three: Knowledge**

### ***Cultural knowledge***

Greater cultural knowledge and skills to perform cultural activities was identified as a primary positive component of UHELP, "It taught me important things about my culture". Some described specific knowledge or skills they had benefitted from learning, such as learning traditional painting or about their totems.

### ***Knowledge of help-seeking options***

Participants described learning which services or which people in the community they could access for help as an essential component of the program's effect, "I learnt when if I'm in trouble who I can go to for support", either for themselves or for other people in their community, "it provided information I could use to help anyone close to me". One young person explained that UHELP should continue to be delivered "because it shows people that there is help". Several expanded this further to identify specific services or people they could contact, like the UHELP facilitators, teachers or services involved in the program, "I can always go to headspace if I need to".

### ***Positive relationships skills***

Participants identified that learning how to maintain positive and healthy relationships was a key component of UHELP. This was reported across types of relationships including friendship, romantic partners, and community. “I learnt about healthy and unhealthy relationships whether intimate or friendships”. Some equated these skills with enabling them to “feel safe with [your] surroundings”. In addition to relational skills, participants reported learning about the importance of respectful relationships towards overall wellbeing.

### **Discussion and Community Recommendations**

The reasons young people identified as underlying the positive effect of UHELP were increased connectedness (to peers, facilitators, culture and community), increased confidence (in their culture, their future goals and help-seeking ability) and gaining knowledge about service providers, relationships and culture.

Ongoing social connection with facilitators and peers was considered an important factor for the program’s benefit to UHELP participants. Even the four participants who reported that they had not learnt anything still reported that they had benefitted and would recommend UHELP to other young people. This suggests that the effects of UHELP are additional to the educative content provided. These findings are aligned with previous research which confirmed that treatment outcomes are more influenced by the relationships the interventions are delivered within (therapeutic alliance) than the specific intervention factors (Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). However, further exploration to examine the impacts of therapeutic alliance in group interventions as opposed to individual settings is required (Burlingame, McClendon, & Yang, 2018). While participants did describe the educational content as beneficial, it was noticeably less prevalent than ongoing social connectedness. Requests for more time with UHELP facilitators was, by far, the most frequent request from participants.

These qualitative results are consistent with community direction throughout the years that UHELP has been delivered, namely that the ongoing relationships are part of why UHELP was effective. Similarly, previous research has found that increased connectedness is protective against suicidality for young people (Whitlock, Wyman, & Moore, 2014), however, greater research is needed to examine the effects of increasing social connectedness as a primary treatment mechanism (Pickering et al., 2018).

### **Recommendation One**

In Inala and other potential communities, the UHELP materials should not be delivered as a stand-alone program delivered without facilitators who are available for young people to maintain ongoing connection with during and after the sessions.

Having a safe place to share was observed through participants reasons for why UHELP was beneficial. These findings may reflect that Aboriginal and Torres Strait Islander youth were not comfortable to discuss their specific challenges at many youth mental health spaces as the stressors, risk and protective factors contributing to their suicidal trajectories are different than those experienced by their non-Indigenous peers (De Maio et al., 2005; Soole et al., 2014). For example, research continues to demonstrate the considerable impact of experiences of racism and discrimination on suicide risk for Aboriginal and Torres Strait Islander young people (Davison, Nagel, & Singh, 2017; Gibson et al., 2021a; Jamieson, Paradies, Gunthorpe, Cairney, & Sayers, 2011; Thomas, Cairney, Gunthorpe, Paradies, & Sayers, 2010). Previous research has found that Aboriginal and Torres Strait Islander young people often anticipate that

help-seeking services will not be welcoming or culturally-appropriate (Kendall & Barnett, 2015; Price & Dalgliesh, 2013). Unfortunately, racist and discriminatory experiences which confirm these expectations are frequently reported in health settings and reinforce reluctance to access support (Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010; Kelaher, Ferdinand, & Paradies, 2014). This finding may also reflect that it can be an atypical experience for Aboriginal and Torres Strait Islander youth to feel safe or welcomed in mainstream help-seeking or service settings.

Participants reported greater confidence in their ability to access these services as an essential factor to UHELP's effect. As Indigenous young people are more likely to die by suicide without having accessed mental health services, strategies to increase service acceptability and accessibility are crucial to reducing suicide rates (Department of Health & Aging, 2013; Soole et al., 2014). While some participants reported general increased intentions to access support, "there is always help available", most reported intentions to access the specific services provided by UHELP which was perceived as safe and accessible rather than the many other services for which contact details and information was provided. Young people's accessibility was interpreted by community members as conditional upon the formation of strong connections with service individuals. This is consistent with previous research exploring barriers to help-seeking for Aboriginal and Torres Strait Islander young people which found that without existing relationships or connection, many would not feel comfortable to access help (Price & Dalgliesh, 2013).

The clinical and cultural governance protocols throughout this project acknowledge that it would not be safe to deliver this program content (which inevitably leads to discussions of violence, genocide, and suicide) without clear referral pathways for young people who may become distressed or require mental health treatment. In response to these thematic analysis findings, community and organisational partners discussed that young people in the community may need to build rapport with service provider personnel before they need to be referred. As the program was delivered in the context of service mistrust, it was reflected that in order to safely deliver the program content it wasn't enough for facilitators to only provide contact details or refer young people who were identified as at higher risk during the program. Several community members expressed that even young people who did not participate would feel more comfortable to access these services as result of cultural vouching through community.

## **Recommendation Two**

For future deliveries of the program in Inala and other communities it was recommended that UHELP should be delivered in partnership (or at least partially attended by) people from organisations providing mental health treatment (such as *headspace*, CYMHS, ACCHOs etc.) where young people could be referred if they needed treatment in the future.

Increased cultural knowledge, connection to and value of culture were important themes to UHELP's positive effects. This is a promising result as cultural connectedness is essential to social and emotional wellbeing (Dudgeon, Bray, D'Costa, & Walker, 2017; Gee, Dudgeon, Schultz, Hart, & Kelly, 2014; Swan & Raphael, 1995) and associated with positive outcomes across domains including health, education and employment (Dockery, 2010). The number of participants providing this response was surprising to facilitators as they felt that limited time was dedicated to cultural activities or education, as compared to other topics. These components may have been more noteworthy to participants as other school-based programs also discuss psychological and physical health, but few provide cultural education.

When disseminating results at SPAMHP meetings, the most accepted interpretation by community members of this finding was that cultural knowledge has a uniquely protective effect as it strengthens and clarifies cultural identity and sense of self; As one participant aptly reported “I know I’m strong because culture is strong”. This led to discussions of not only the protective effects of increased cultural identity and connection but also the mechanisms by which cultural factors protect against suicidality. Recent analyses in Queensland found that communities with greater cultural connectedness had lower suicides rates for Aboriginal and Torres Strait Islander young people (Gibson et al., 2021b). In Canada, First Nations communities with cultural facilities, greater language use, land claims, community governance over education, health, police and child services were found to have lower youth suicide rates (Chandler & Lalonde, 1998; Hallett, Chandler, & Lalonde, 2007). The authors proposed that cultural continuity - connection to a past and future cultural lineage - reinforces connection and commitment to young peoples’ own personal futures which buffer against hopelessness and suicide risk (Chandler & Lalonde, 1998; Chandler & Proulx, 2006; Lalonde & Chandler, 2009). In an Australian context, Aboriginal men’s suicide risk was found to decrease after engaging in a traditional art program (Rasmussen, Donoghue, & Sheehan, 2018). However, no casual pathways have been explored. These findings generated the most discussion with facilitators, program authors, community members and Elders, from which it was acknowledged as a community priority for future UHELP evaluations to examine protective effects of cultural identity and connectedness. This recommendation mirrors other research exploring Elders’ advice on suicide prevention in which loss of cultural connectedness was identified as a contributor to self-harm and suicide risk (Gooda & Dudgeon, 2014).

### **Recommendation Three:**

For future UHELP deliveries, it was recommended that the evaluation methodology include components to assess the impact of UHELP on cultural connectedness and identity to further explore the protective effects of cultural factors against suicidality for Aboriginal and Torres Strait Islander youth.

The reasons young people believed UHELP worked pertained primarily to the delivery framework (time with facilitators and peers), safety procedures (connecting with service providers), and activity components (cultural activities and learnings) rather than the educative content. These results are consistent with findings that therapeutic alliance, client expectations, and contextual life factors influence young peoples’ psychotherapy outcomes more than specific intervention features and mirrors calls from researchers to further examine the context within which programs are delivered and strengths brought by young people (Shirk & Karver, 2003; Sparks, Duncan, & Miller, 2007; Wampold, 2015). Further research is needed to understand the impact on treatment outcomes of the factors proposed by young people in this study, such as ongoing relationships, cultural connectedness or the community governance context (Mohatt, Fok, Burket, Henry, & Allen, 2011; Snijder, Shakeshaft, Wagemakers, Stephens, & Calabria, 2015).

Importantly, these findings propose theoretical explanatory mechanisms contributing to the reduced suicidal ideation scores found in the UHELP pilot evaluation: 1) developing connections with people in the community and service provider staff who could be accessed for future help-seeking, and 2) increasing connection and value of culture to increase self-esteem and hope for the future.

Some limitations should be noted. As only 55.6% of program participants chose to complete this survey, the results may be biased as participants who had negative experiences may not have participated in the survey. These findings are not generalizable to all young



people who have participated in UHELP. Further, these findings are drawn from the subjective assessment of people choosing to participate in UHELP which may further influence results in this direction.

Nevertheless, including this qualitative component in future UHELP evaluations (in addition to the self-esteem, suicidality, and mental health evaluation questionnaires) will allow greater understanding of young people's experiences and opinions into effective suicide prevention programs and facilitate continual youth-directed program improvements.

### Conclusion

This qualitative study has provided novel insights into young peoples' experiences of a culturally-grounded Aboriginal and Torres Strait Islander youth suicide prevention program which has led to organisational and community endorsed recommendations for this program's continued implementation and future evaluations. This study, which privileges young peoples' voices, revealed components which Aboriginal and Torres Strait Islander youth value and prioritise in health promotion and treatment activities, namely building ongoing connections, increasing individual and collective confidence, and gaining cultural knowledge and life skills. These findings can be potentially applied in other health domains for which marked health inequalities persist (Azzopardi et al., 2018).

Traditional suicide prevention approaches have, thus far, largely failed to effectively respond to the unique suicide trajectories of Aboriginal and Torres Strait Islander young people within their broader physical, social, emotional, historical and cultural contexts (Elliott-Farrelly, 2004; Henry, Houston, & Mooney, 2004; Hunter & Milroy, 2006). The insight and experiences of young people who are best placed to both understand the needs of their community and peers and provide solutions to these issues are crucial to address these disparities (Dudgeon et al., 2016). This study also provides a 'real-world' example of translation and application of research findings which respects young peoples' views by presenting tangible recommendations informed by their advice and experiences.

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### Author Biographies

i In this paper, we refer to Aboriginal and/or Torres Strait Islander individuals as ‘First Nations’ or ‘Indigenous Peoples.’ However, it is acknowledged that significant cultural, historical and social differences exist between the many First Nations people groups in this land now called Australia.



## Mutual Efficacy and Social Cohesion: Predictors of Neighbouring and Organisational Participation

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*Mutual efficacy – defined as, “Group members’ beliefs that collective action can be successful at achieving group goals,” was designed to integrate the psychological and sociological literature on collective efficacy. In sociology, collective efficacy refers to the process by which social cohesion is activated as informal social control. In psychology, collective efficacy is a construct reflecting the perceived capability of a group. Previous research supports mutual efficacy as a partial mediator of the relationship between social cohesion and informal social control. However, mutual efficacy is theorised to be a task-specific construct. This study contributes to our understanding of mutual efficacy by examining the relationships among social cohesion, mutual efficacy, and two actions: neighbouring and participation in organisations. The mediational role of mutual efficacy is supported for both actions. Findings contribute to our understanding of the mechanisms that inform action in communities, and highlight complex – possibly reciprocal – relationships among social cohesion, mutual efficacy, and action.*

**Keywords:** Mutual Efficacy; Collective Efficacy; Social Cohesion; Neighbouring; Organisational Participation

Mutual efficacy refers to, “Group members’ beliefs that collective action can be successful at achieving group goals,” (Gearhart & Joseph, 2019). The construct was developed to establish a bridge between the sociological and psychological conceptualisations of collective efficacy. In psychology, collective efficacy refers to the perceived capability of a group (Bandura, 1997). In sociology, collective efficacy is a theoretical framework outlining the process by which social cohesion is activated as community-level actions, typically informal social control. Social cohesion is the extent of mutual trust, solidarity and shared values among community members (Sampson, Raudenbush, & Earls, 1997). Informal social control reflects community members’ willingness to enforce social norms (Sampson et al., 1997).

Collective efficacy theory is a widely studied framework associated with positive community-level outcomes (Sampson, 2012). However, the perceived capability of a group can have a significant impact on whether a group acts (Alinsky, 1971). For example, individuals are less likely to participate in informal social control activities if they believe that the police are unable to effectively address crime (Gau, 2014), and individuals are less likely to participate in civic actions if they feel that their votes do not matter (Ballard, 2014; Morrow, 2015). Prior research has demonstrated that groups with higher levels of mutual efficacy are more likely to institute informal social control (Gearhart, 2019b). Thus, mutual efficacy contributes to our understanding of how to empower communities to create change by acting collectively (Gearhart, 2019b).

Though mutual efficacy is conceptualised as a construct that can result in multiple collective actions, research on mutual efficacy is limited because it focuses exclusively on the relationships among social cohesion, mutual efficacy, and informal social control (Gearhart,



2019a; Gearhart & Joseph, 2019). This study contributes to our understanding of mutual efficacy by examining the relationships among social cohesion, mutual efficacy, and two actions: neighbouring and participation in organisations. Findings refine our understanding of the mechanisms that inform action in communities and highlight key insights for empowering communities.

## **Literature Review**

### **Collective Efficacy and Mutual Efficacy**

Within the field of sociology, the seminal study of collective efficacy (Sampson et al., 1997) used data from the Project on Human Development in Chicago Neighbourhoods (PHDCN) study. Sampson and colleagues (1997) tested the relationship between social cohesion and informal social control, and found that the constructs were highly correlated ( $r = 0.80$ ). As a result, the measures of social cohesion and informal social control were combined into a summary measure of collective efficacy (Sampson et al., 1997).

Although the summary measure of collective efficacy is associated with a variety of positive outcomes, research suggests that social cohesion and informal social control are better modelled as two constructs (Hipp & Wo, 2015). Confirmatory factor analyses consistently demonstrate that social cohesion and informal social control fit the data better as unique constructs (Barnhart, Gearhart, & Maguire-Jack, 2018; Brisson & Altschul, 2011; Gearhart, 2019a; Rhineberger-Dunn & Carlson, 2009; Wickes, Hipp, Sargeant, & Homel, 2013), and structural equation models show that the relationship between social cohesion and community outcomes are mediated by informal social control (Gearhart, 2019a; Drakulich & Crutchfield, 2013; Gau, 2014; Rhineberger-Dunn & Carlson, 2011).

Gearhart and Joseph (2019) noted that separating social cohesion and informal social control revealed the absence of an explicit measure of efficacy, defined as the perceived capability of a group, in collective efficacy theory. Social cohesion, mutual efficacy, and the willingness to perform a given behaviour (i.e. informal social control as developed by Sampson and colleagues, 1997) are conceptually and operationally distinct (Bandura, 1997; Gearhart, 2019b; Zaccaro, Blair, Peterson, & Zazanis, 1995). Thus, mutual efficacy integrates the sociological and psychological literature on collective efficacy – addressing a key gap in the sociological conceptualisation of collective efficacy, and utilising a theoretical framework to describe how the psychological construct of efficacy is activated in communities (Gearhart, 2019a).

### **Empowerment**

Though the primary goal of mutual efficacy was to integrate the sociological and psychological definitions of collective efficacy, the construct has significant implications for community psychology – particularly as it relates to empowerment (Gearhart, 2019b). Empowerment is both a process and an outcome. As a process, empowerment focuses on how individuals and groups gain greater control over their lives. As an outcome, empowerment examines how gaining more control of the decision-making process and increasing access to resources can lead people to feel more empowered (Maton, 2008; Perkins, 2010; Pigg, 2002; Zimmerman, 1995, 2000).

Empowerment occurs at multiple levels including the individual and community levels (Zimmerman, 1995, 2000). The individual level focuses on psychological factors (e.g. self-efficacy), knowledge of social issues, and the actions that individuals take to create change

(Christens, 2012; Christens, Inzeo, & Faust, 2014; Perkins, 2010; Zimmerman, 1995, 2000). The community level examines how individuals work collectively to create change (Maton, 2008; Zimmerman, 1995, 2000). As summarised by Perkins (2010), the majority of studies examine empowerment as it relates to individual psychological factors, and very few studies focus on community-level psychological factors or community-level strategies that explain how communities develop and apply power.

Studying mutual efficacy in the context of collective efficacy theory addresses key gaps in the empowerment literature (Perkins, 2010). As a construct, mutual efficacy is a community-level, psychological factor that can help facilitate collective actions in communities (Gearhart, 2019b). As a community-level theory, collective efficacy explains how communities use social resources to act collectively (Perkins, 2010; Sampson, 2012). Social cohesion can help empower communities by creating strength in numbers, developing a shared understanding of the world, and identifying mutually agreed upon goals (Alinsky, 1971; Christens, 2012; Pigg, 2002; Speer & Hughey, 1995). Fostering social cohesion can build mutual efficacy, which in turn increases the likelihood that communities will act collectively (Gearhart, 2019b).

### **The Present Study**

A limitation of previous research informed by collective efficacy theory is that it focuses almost exclusively on the relationship between social cohesion and informal social control (Gearhart, 2019b; Gearhart & Joseph, 2019; Hipp & Wo, 2015; Sampson, 2012; Sampson, Morenoff, & Gannon-Rowley, 2002; Sutherland, Brunton-Smith, & Jackson, 2013). This focus is most likely due to the fact that collective efficacy was initially developed in the field of criminology (Sampson, 2004). However, social cohesion can result in multiple forms of action (Sampson, 2004; Wickes et al., 2013). For example, Wickes and colleagues (2013) found that social cohesion predicts child-focused informal social control, violence focused informal social control, and civic engagement (e.g. voting). Though theory suggests that mutual efficacy can result in multiple actions (Gearhart & Joseph, 2019), research has yet to test mutual efficacy as a predictor of actions other than informal social control. This study contributes to the literature by testing whether mutual efficacy mediates the relationship between social cohesion and two actions: neighbouring and organisational participation.

Neighbouring is defined as activities including daily interactions and the exchange of social support among neighbours (Farrell, Aubry, & Coulombe, 2004; Unger & Wandersman, 1985). There are multiple ways that neighbours interact with one another such as discussing neighbourhood issues, loaning items, and interacting socially (Kusenbach, 2006; Nation, Fortney, & Wandersman, 2010). Organisational participation is the voluntary involvement of individuals in activities promoted by organisations (Chinman & Wandersman, 1999; Gamble & Weil, 1995). Participation in organisations is associated with multiple outcomes of interest for community psychologists including improved quality of life, well-being, empowerment, and a stronger sense of community (Nussbaum, 1999; Sampson, 2012; Talò, Mannarini, & Rochira, 2014; Wandersman & Florin, 2000).

Though neighbouring and organisational participation can have a positive impact on communities, they also play a key role in empowering communities. Frequent social interaction among neighbours (i.e. neighbouring) builds social resources that can be called upon to address neighbourhood issues (Browning, Dietz, & Feinberg, 2004; Putnam, 2000). Further, neighbouring is directly associated with positive outcomes such as a greater sense of security, belonging, connection to the community, and collective efficacy – as measured by a combination of social cohesion and informal social control (Browning et al., 2004; Burchfield & Silver, 2013). Organisations can train and support individuals and groups, as well as

influence systemic changes that empower others (Chaskin & Greenberg, 2015; Chinman & Wandersman, 1999; Wandersman & Florin, 2000; Zimmerman, 1995, 2000).

Understanding the pathways by which individuals participate in actions like neighbouring and working with local organisations is foundational to community empowerment. However, no study has examined the relationships among social cohesion, mutual efficacy, neighbouring, and organisational participation utilising the collective efficacy framework developed by Gearhart & Joseph (2019). Mutual efficacy is expected to at least partially mediate the relationship between social cohesion and both neighbouring and organisational participation. The strength of the relationship between mutual efficacy and action is expected to vary based on the action under study. Findings can increase our understanding of the processes that inform action among community members.

## Methods

### Data

The present study utilises data from the Seattle Neighbourhoods and Crime Survey (SNCS) – a cross sectional of Seattle Washington residents collected between 2002 and 2003 (Matsueda, 2010). This study will utilise data that were collected from two sampling strategies: a random sample ( $n = 2,220$ ) and an ethnic oversample ( $n = 1,145$ ). For the random sample, researchers randomly selected two block groups from each of Seattle's 123 Census Tracts. Roughly nine households per block group were randomly selected to be surveyed. The ethnic oversample is a random sample of individuals from 141 block groups with high concentrations of racial and ethnic minorities. The purpose of the ethnic oversample was to create a more representative sample of Seattle residents. A total of 558 Census Blocks were chosen from these block groups, and two households per block were randomly chosen to be surveyed. The total sample size used in this study is 3,365.

### Measures

#### *Neighbouring*

Neighbouring is measured using five items that reflect the frequency of the following neighbouring activities: (1) watching a neighbour's home, (2) borrowed tools or small food items, (3) had dinner or lunch with a neighbour, (4) helped a neighbour with a problem and (5) asked neighbours about personal things. Response options range from 1 (Often) to 3 (Never).

#### *Organisational participation*

Organisational participation is measured using five items that assess how frequently a respondent participates in five types of organisations: (1) church, synagogue, temple, or mosque; (2) recreational sports, book club, or card playing; (3) service or charitable organisation; (4) neighbourhood associations; (5) other organisations. Response options range from 1 (Often) to 3 (Never).

#### *Social cohesion*

Social cohesion is operationalised using items based on the social cohesion measure developed by Sampson and colleagues (1997). This measure assesses residents' agreement with the following statements: (1) you can count on adults in this neighbourhood to watch out that children are safe and don't get into trouble, (2) people in this neighbourhood can be trusted, (3) adults in this neighbourhood know who the local children are, and (4) people around here are willing to help their neighbours. Response options range from 1 (strongly agree) to 4 (strongly disagree).

### ***Mutual efficacy***

Mutual efficacy is measured by combining two items: (1) how effective would the following approach be in resolving major problems around your neighbourhood: small groups of neighbours working together, and (2) how effective would the following approach be in resolving major problems around your neighbourhood: organised neighbourhood associations or community clubs? Response options on each item range from 1 (highly effective) to 3 (not at all effective).

### ***Neighbourhood disorder***

To maintain consistency with previous research on mutual efficacy (Gearhart, 2019b; Gearhart & Joseph, 2019), neighbourhood disorder will be included as a covariate for the analyses. Neighbourhood disorder – defined as public behaviours that are threatening to residents such as public intoxication, and physical markers like garbage on the streets, graffiti, and abandoned buildings (Sampson, 2012). Neighbourhood disorder contributes to social issues like poor physical health, mental illness, substance use, and crime (Chappell, Monk-Turner, & Payne, 2011; Hill & Maimon, 2013; Molina, Algria, & Chen, 2012). Neighbourhood disorder can also moderate the buffering effect of protective factors like collective efficacy (Hill & Maimon, 2013).

Neighbourhood disorder is measured by combining five items that reflect the severity of problems in the neighbourhood: (1) groups of teenagers hanging out on the streets; (2) litter, garbage, or trash on the streets; (3) spray painted graffiti on buildings and streets; (4) abandoned houses and run-down buildings, and (5) neighbours causing too much noise. Response options on each item range from 1 (not a problem) to 3 (a big problem).

## **Analysis**

### ***Multiple imputation***

The data were screened for missing values using SPSS' v23 missing value analysis. The analysis showed that listwise deletion would result in losing 15.72% ( $n = 529$ ) and 16.19% ( $n = 545$ ) for the neighbouring and organisational participation analyses respectively. The four most common patterns of missing data present were: (1)  $n = 90$  people missing data on the first social cohesion item (you can count on adults in this neighbourhood to watch out that children are safe and don't get into trouble), (2)  $n = 75$  cases missing data on the efficacy of organised neighbourhood associations or community clubs item, (3)  $n = 70$  individuals missing data on the third social cohesion item (adults in this neighbourhood know who the local children are), and (4)  $n = 53$  individuals missing data on the first and third social cohesion items. No other pattern of missing data affected more than 1% of the cases ( $n = 34$ ). Bivariate comparisons found that there were no statistically significant differences between cases that had missing data, and cases with complete data.

Multiple imputation was used to account for the missing data. Data were imputed using a variance covariance model outlined by Asparouhov and Muthén (2010a). Twenty datasets were created for the present study to account for the missing data. The imputations included all variables in the analysis as well as age, gender, race/ethnicity, education, income, employment, and home ownership status. Data were not imputed for respondents who answered "don't know" or "refused" on survey items (Graham, Olchowski, & Gilreath, 2007).

### ***Structural equation modelling***

Analyses consist of two structural equation models that examine the relationships among social cohesion, mutual efficacy and two actions: neighbouring, and organisational participation. Parameters were estimated using mean and variance adjusted weighted least squares estimator

(WLSMV) because the focal variables are ordinal in nature (Flora & Curran, 2004; Muthén & Muthén, 1998-2015). Because WLSMV estimates bivariate correlations using polychoric correlations, it is resistant to violations of normality, particularly when the sample size is large (i.e.  $N \geq 1,000$ ; Flora & Curran, 2004). Despite this, descriptive statistics were examined to check for normality and outliers. Further, covariances, and correlations among latent variables were examined to assess for multicollinearity (Muthén & Muthén, 1998-2015).

Intraclass correlation coefficients (ICCs) were computed because data are nested within neighbourhoods. ICCs range from 0.05 to 0.15 for the variables included in the analysis, suggesting that clustering is present in the data (Kreft & de Leeuw, 1998). Analyses will be conducted using Huber-White sandwich estimators to account for the clustering in the data (Szpiro, Rice, & Lumley, 2010). Multilevel structural equation modelling was not feasible because of the small sample size on the neighbourhood level ( $n = 123$ ; Asparouhov & Muthén, 2010b). All analyses were conducted using Mplus v.7.4 (Flora & Curran, 2004; Muthén & Muthén, 1998-2015).

## Results

### Sample Characteristics

Table 1 presents the sociodemographic characteristics of the sample. Nearly half (48.1%,  $n = 1,619$ ) of the sample is female and 53.9% ( $n = 1,814$ ) are married or cohabiting. The average age of respondents is 48.6 ( $SD = 0.30$ ) years of age. Over three-quarters of the sample identified as white (77.8%,  $n = 2,619$ ). Two-thirds of respondents own their home (67.5%,  $n = 2,271$ ) and were employed at the time of the survey (66.9%,  $n = 2,251$ ). One-third of the sample graduated from either a college or trade school (35.4%,  $n = 1,191$ ), and 28.3% ( $n = 955$ ) either graduated from graduate school or completed some graduate school. In terms of income, most of the sample report making between \$25,000 and \$75,000 (51.9%,  $n = 1,746$ ) or over \$75,000 (30.9%,  $n = 1,040$ ).



**Table 1***Sample Characteristics*

	Mean	<i>SD</i>	<i>n</i>	%
Age	48.61	0.30		
Female			1,619	48.1
Race/Ethnicity			2,618	77.8
White			2,619	77.8
Black			318	9.5
Asian			242	7.2
Other			186	5.5
Marital Status				
Married or Cohabiting			1,814	53.9
Separated, Widowed, or Divorced			697	20.7
Never Married			855	25.4
Education				
High School or Less			485	14.4
Some College			734	21.8
College Graduate or Trade School			1,191	35.4
Some Graduate School or Beyond			956	28.4
Income				
Less than \$25,000			579	17.2
\$25,000 to less than \$75,000			1,746	51.9
\$75,000 or more			1,040	30.9
Employed			2,251	66.9
Own Home			2,271	67.5

As seen in Table 2, perceptions of social cohesion are relatively high in the sample with most respondents stating that they either agree, or strongly agree with the survey items. In terms of mutual efficacy, respondents felt more confident in terms of the effectiveness of small groups of neighbours relative to organised neighbourhood associations or clubs. The two most frequently reported neighbouring behaviours are watching a neighbour's home and helping neighbours with a problem. Asking neighbours about personal things and borrowing tools or small food items are the least common neighbouring behaviours. Organisational participation appears to be low in the sample with only 23.0% ( $n = 774$ ) of respondents stating that they 'often' attend church, synagogue, temple, or mosque; and roughly 17% stating that they 'often' participate in sports, book clubs or card playing; or participating in activities sponsored by 'other' organisations. Neighbourhood disorder is relatively low in the sample with the largest issues being litter, garbage, or trash on the streets; and neighbours causing too much noise.

**Table 2***Frequency Distribution for Focal Indicators*

Indicator	Response Options			
Social Cohesion <sup>1</sup>	1	2	3	4
Can count on adults to make sure children are safe	807 (24.0%)	1,820 (54.1%)	643 (19.1%)	95 (2.8%)
People in the neighbourhood can be trusted	852 (25.3%)	2,133 (63.4%)	316 (9.4%)	64 (1.9%)
Adults know who the local children are	631 (19.8%)	1,618 (48.1%)	962 (28.6%)	154 (4.6%)
People are willing to help their neighbours	841 (25.0%)	2,252 (66.9%)	249 (7.4%)	23 (0.7%)
Mutual Efficacy <sup>2</sup>	1	2	3	
Small groups of neighbours	1,597 (47.5%)	1,516 (45.1%)	252 (7.5%)	
Organised neighbourhood associations or clubs	1,019 (30.3%)	1,911 (56.8%)	435 (12.9%)	
Neighbouring <sup>3</sup>	1	2	3	
Watch neighbour's home	1,034 (30.7%)	1,331 (39.6%)	1,000 (29.7%)	
Borrowed tools or small food items	426 (12.7%)	1,398 (41.5%)	1,541 (45.8%)	
Had dinner or lunch with a neighbour	361 (10.7%)	1,534 (45.6%)	1,470 (43.7%)	
Helped neighbours with a problem	718 (21.3%)	2,042 (60.7%)	603 (17.9%)	
Asked neighbours about a personal thing	403 (12.0%)	1,172 (34.8%)	1,790 (53.2%)	
Organisational Participation <sup>3</sup>	1	2	3	
Church, synagogue, temple, or mosque	774 (23.0%)	609 (18.1%)	1,982 (58.9%)	
Sports, book club, or card playing	600 (17.8%)	821 (24.4%)	1,944 (57.8%)	
Service or charitable organisation	360 (10.7%)	947 (28.1%)	2,058 (61.2%)	
Neighbourhood association	275 (8.2%)	901 (26.8%)	2,189 (65.1%)	
Other organisation	583 (17.3%)	471 (14.0%)	2,311 (68.7%)	
Neighbourhood Disorder <sup>4</sup>	1	2	3	
Groups of teenagers hanging out on the streets	2,147 (63.8%)	881 (26.2%)	337 (10.0%)	
Litter, garbage or trash on the streets	1,595 (47.4%)	1,299 (38.6%)	471 (14.0%)	
Spray-painted graffiti on buildings and streets	2,170 (64.5%)	966 (28.7%)	229 (6.8%)	
Abandoned houses and run-down buildings	2,430 (72.2%)	743 (22.1%)	192 (5.7%)	
Neighbours causing too much noise	1,908 (56.7%)	1,144 (34.0%)	313 (9.3%)	

<sup>1</sup> Response options: (1) Strongly Agree, (2) Agree, (3) Disagree (4) Strongly Disagree<sup>2</sup> Response options: (1) Highly Effective, (2) Somewhat Effective, (3) Not at all Effective<sup>3</sup> Response options: (1) Often, (2) Sometimes, (3) Never<sup>4</sup> Response options: (1) Not a Problem, (2) Somewhat a Problem, (3) A Big Problem

### Model Fit

The following indices are produced to determine model fit: model chi-square ( $\chi^2_M$ ), the root mean square error of approximation (RMSEA), the comparative fit index (CFI), the Tucker Lewis Index (TLI), and the weighted root mean square residual (WRMR). Further, standardised residuals were examined for both analyses. The standardised residuals suggest that the model was properly specified and the measurement model suggests that social cohesion, mutual efficacy, neighbouring, and organisational participation are unique constructs (full results available upon request). The model fit indices are presented in Table 3. Both models meet criteria for model fit on the RMSEA, CFI, and TLI. Consistent with previous research on mutual efficacy (Gearhart, 2019a; Gearhart & Joseph, 2019) neither model meets criteria on the  $\chi^2_M$  and WRMR. However, this finding should be interpreted cautiously. The  $\chi^2_M$  is sensitive to large sample sizes and the WRMR can be inflated when clustering is present in the data (Hsu, 2011).

**Table 3**

*Model Fit Indices*

Fit Index	Neighbouring	Organisational Participation	Fit Criteria
$\chi^2_M$	436.26*	281.24*	non-significant
RMSEA	0.03	0.02	≤ 0.05 close fit 0.05-0.08 reasonable fit ≥ 0.10 poor fit
CFI	0.98	0.99	> 0.95
TLI	0.97	0.98	> 0.95
WRMR	1.96	1.56	≤ 0.90

\*  $p < 0.05$

### Neighbouring

Table 4 contains the correlations among the latent variables in the analysis focusing on neighbouring. As seen in the table, mutual efficacy has a moderate correlation with social cohesion ( $r = 0.373$ ) and neighbouring ( $r = 0.343$ ). However, social cohesion has stronger correlations with both neighbouring ( $r = 0.435$ ) and neighbourhood disorder ( $r = 0.537$ ).

**Table 4**

*Correlations Among Latent Variables, Neighbouring*

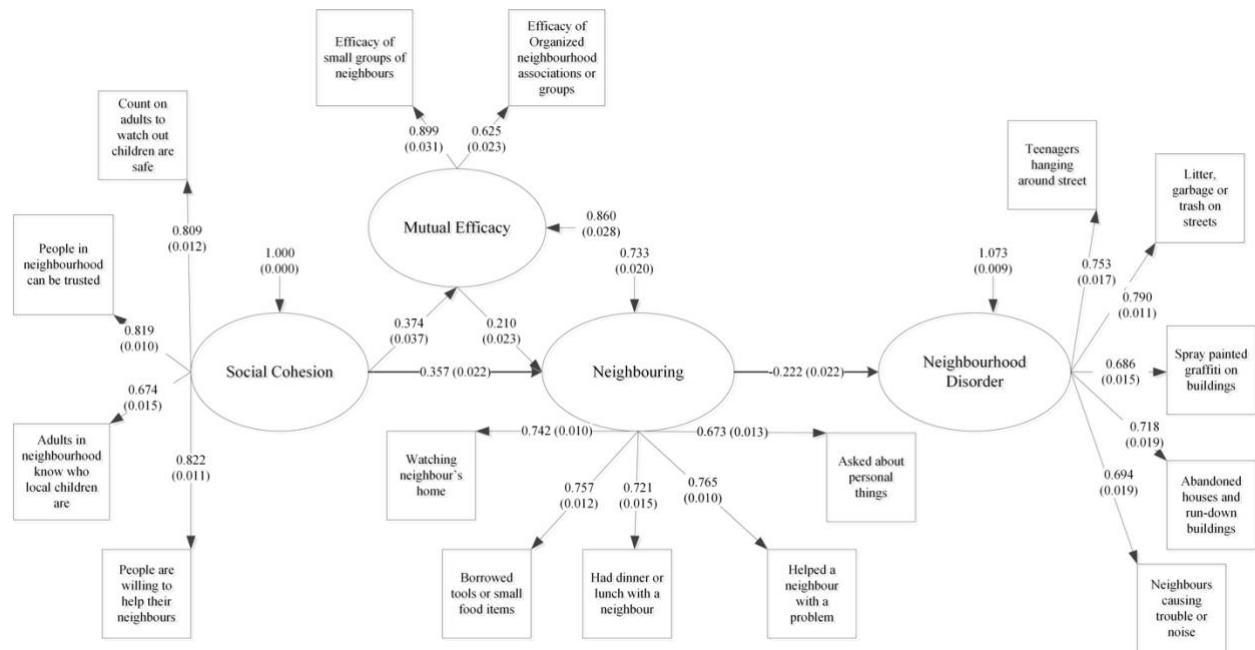
	1	2	3	4
Mutual Efficacy (1)	1.000			
Social Cohesion (2)	0.373	1.000		
Neighbouring (3)	0.343	0.435	1.000	
Neighbourhood Disorder (4)	0.160	0.537	0.054	1.000

As seen in Figure 1, factor loadings ranged from 0.674 to 0.822 for social cohesion, 0.625 to 0.899 for mutual efficacy, 0.673 to 0.765 for neighbouring, and 0.686 to 0.790 for

neighbourhood disorder. Social cohesion is significantly associated with mutual efficacy ( $\beta = 0.374, p < 0.05$ ) and neighbouring ( $\beta = 0.357, p < 0.05$ ). Mutual efficacy has a positive relationship with neighbouring ( $\beta = 0.210, p < 0.05$ ). Further, neighbouring is associated with

**Figure 1**

*Standardised Model Results, Neighbouring*



Note: Ovals represent latent variables and squares represent measured variables

lower levels of neighbourhood disorder ( $\beta = -0.022, p < 0.05$ ). The Sobel standard error test (Preacher & Hayes, 2004) indicates a significant indirect effect (estimate = 0.078,  $SE = 0.012$ ) – suggesting that mutual efficacy partially mediates the relationship between social cohesion and neighbouring.

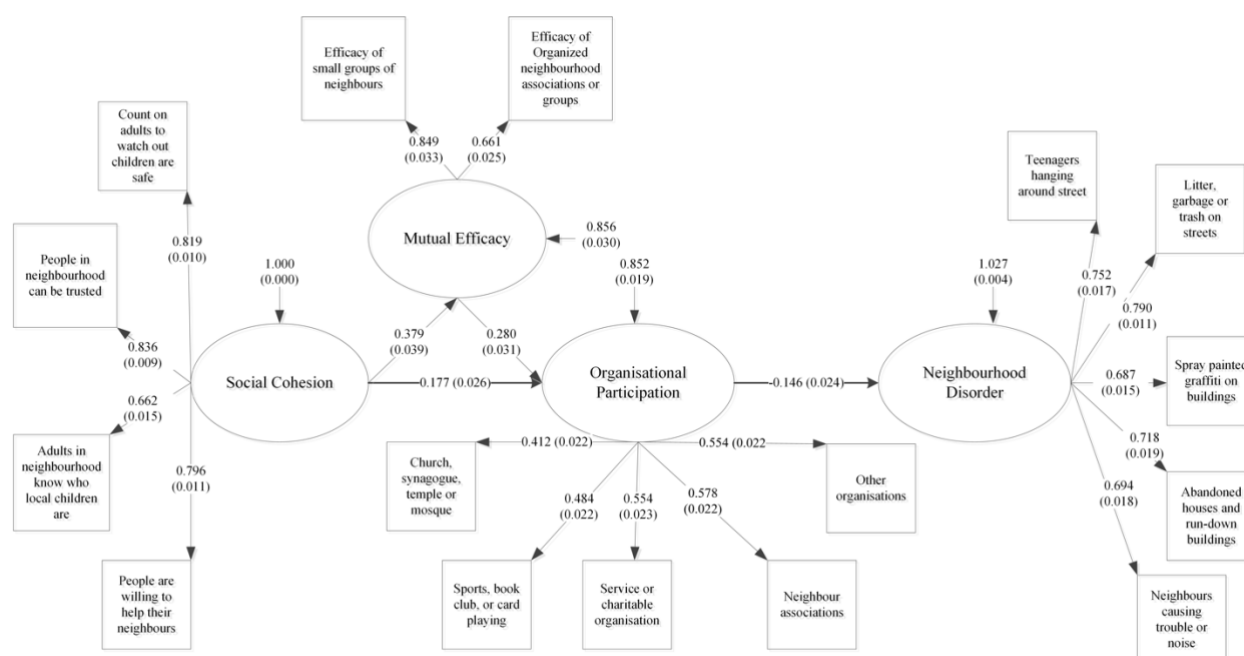
### Organisational Participation

Table 5 shows a slightly different pattern of correlations among latent variables used in the analysis focusing on organisational participation. Again, social cohesion is more strongly correlated with neighbourhood disorder ( $r = 0.538$ ) compared to mutual efficacy ( $r = 0.169$ ). However, mutual efficacy is more strongly correlated with organisational participation ( $r = 0.347$ ) compared to social cohesion ( $r = 0.283$ ).

**Table 5***Correlations Among Latent Variables, Organisational Participation*

	1	2	3	4
Mutual Efficacy (1)	1.000			
Social Cohesion (2)	0.379	1.000		
Organisational Participation (3)	0.347	0.283	1.000	
Neighbourhood Disorder (4)	0.169	0.538	0.018	1.000

Factor loadings for social cohesion, mutual efficacy, and neighbourhood disorder are similar to the analysis of neighbouring. Factor loadings for organisational participation are weak – ranging from 0.412 to 0.578. This may be due to the variety of organisations listed that may not overlap conceptually. Figure 2 shows that social cohesion is significantly associated with organisational participation ( $\beta = 0.177, p < 0.05$ ) and mutual efficacy ( $\beta = 0.379, p < 0.05$ ). Mutual efficacy is also positively associated with organisational participation ( $\beta = 0.280, p < 0.05$ ). The Sobel standard error test (Preacher & Hayes, 2004) indicates that mutual efficacy also partially mediates the relationship between social cohesion and organisational participation (Estimate = 0.106,  $SE = 0.017$ ). Mutual efficacy has a stronger association with organisational participation compared to social cohesion, which differs from the analysis of neighbouring. As expected, organisational participation is associated with lower levels of neighbourhood disorder ( $\beta = -0.146, p < 0.05$ ).

**Figure 2***Standardised Model Results, Organisational Participation*

Note: Ovals represent latent variables and squares represent measured variables



## Discussion

Findings indicate that mutual efficacy is a partial mediator of the relationships between social cohesion and both neighbouring, and organisational participation. The mediational role of mutual efficacy is consistent with previous research on the relationship between social cohesion, mutual efficacy, and informal social control (Gearhart, 2019b; Gearhart & Joseph, 2019). The results show that social cohesion has a stronger association with neighbouring compared to mutual efficacy, suggesting that – within the context of collective efficacy theory – mutual efficacy is not the primary mechanism by which social cohesion is activated as neighbouring behaviours. In terms of organisational participation, the findings suggest that individuals who have stronger beliefs in the perceived capability of the group may be more likely to work with organisations in order to create change.

The weak indirect effect of mutual efficacy on neighbouring may be due to a reciprocal relationship between social cohesion and neighbouring (Farahani, 2016). This study supports previous research suggesting that social cohesion can result in neighbouring (Farahani, 2016). However, neighbouring increases social cohesion as well (Farahani, 2016). Establishing connections among residents is a key initial step towards building mutual efficacy because cohesive groups typically have a stronger belief in the effectiveness of their actions (Bandura, 1997; Gearhart, 2019a,b). However, networks among community members must be active in order to be meaningful (Sampson, 2004). Efforts to empower communities should build relationships among members that establish social norms, identify commonly agreed upon problems, and foster the desire to act collectively (Bandura, 1997; Gearhart & Joseph, 2019; Sampson et al., 1997; Zaccaro et al., 1995).

The stronger relationship between mutual efficacy and organisational participation may be due in part because one of the mutual efficacy items focuses on the effectiveness of organised associations or community clubs. However, it is important to discuss the relationship between mutual efficacy and organisational participation because many change efforts are led by organisations (Chaskin & Greenberg, 2015; Chinman & Wandersman, 1999; Wandersman & Florin, 2000). The findings discussed above emphasise the importance of strengthening mutual efficacy through social cohesion and neighbouring. Although social cohesion can be developed without the intervention of organisations, organisations can foster social cohesion among community members directly by serving as community connectors (Fook, 2002; Mezirow & Taylor, 2009). These connections are particularly important in communities that may be lacking in mutual efficacy.

Actions that build social cohesion in communities increase the likelihood that individuals will mobilise to perform a variety of additional actions (Collins, Neal, & Neal, 2014). The findings indicate that communities with higher levels of mutual efficacy are more likely to collaborate with organisations. Thus, it is important for organisations to effectively partner with communities so that community-organisation partnerships continue to build mutual efficacy. There are multiple actions that organisations can perform to build mutual efficacy in communities including engaging residents early in the change process and placing residents at the centre of efforts to build social cohesion, identifying goals, and creating action steps (Alinsky, 1971; Bandura, 1997; Fook, 2002; Mezirow & Taylor, 2009). Organisations can also teach community members the skills and provide knowledge necessary to create change (Bandura, 1997). Setting realistic goals and achieving early successes can build mutual efficacy and increase the likelihood that community members will act in the future as well (Hipp, 2016).

As stated previously, neighbourhood disorder was included in the analyses to maintain consistency with previous research (Gearhart, 2019a; Gearhart & Joseph, 2019). However, the limited relationship between neighbouring, organisational participation, and neighbourhood disorder suggest that these actions may not be effective at addressing neighbourhood disorder. Therefore, it is important for communities to establish a clear connection between proposed actions, and the problems that they are trying to address.

Taken as a whole, the findings highlight relationships as foundational to empowering communities. Social cohesion and mutual efficacy both influence neighbouring. Though neighbouring is important in its own right, it can further empower communities by building a shared identity and demonstrating that communities can accomplish goals if they work together (Bandura, 1997; Gearhart, 2019a; Zaccaro et al., 1995). Communities with higher levels of mutual efficacy appear to be more likely to collaborate with organisations to create change. It is incumbent upon organisations to help empower communities through authentic community engagement, and allowing the community to take ownership of the change process (Alinsky, 1971; Fook, 2002; Gearhart & Joseph, 2019; Mezirow & Taylor, 2009).

### **Limitations**

While the findings of this study are informative, there are limitations worth noting. The discussion above draws on prior research and theory to highlight the complex and possibly reciprocal relationships among social cohesion, mutual efficacy, neighbouring, and organisational participation. Unfortunately, testing such relationships are beyond the scope of the SNCS data – highlighting a key area for future research. Seattle is also a high socioeconomic status city on the west coast of the United States (Matsueda, 2010). Therefore, the findings may not be generalisable beyond the SNCS sample. Future research can study mutual efficacy in other US cities and countries to determine if the findings presented here are supported in other social contexts.

Though the items used to measure mutual efficacy are a useful proxy for mutual efficacy, they do not include elements of the construct outlined by Gearhart and Joseph (2019). Mutual efficacy was also measured using two items with three response categories compared to social cohesion (four items, four response categories), and neighbouring and organisational participation – both of which were measured using five items and three response categories. Inconsistency in terms of measurement may have influenced the relationships among the constructs (Kreft & de Leeuw, 1998). Limitations in the present study highlight a critical need for research on mutual efficacy that collects primary data over time.

### **Conclusion**

Findings suggest that mutual efficacy at least partially mediates the relationships among social cohesion, and neighbouring and organisational participation. Thus, belief in the effectiveness of action is a critical precursor to multiple actions among community members. The findings presented here – combined with previous research – suggest that there may be complex reciprocal relationships among social cohesion, mutual efficacy, and actions – highlighting a need for future research. Future research can develop a more valid and reliable measure of mutual efficacy that is consistent with the measure of social cohesion and actions under study in terms of the number of items and response options. Further, the findings emphasise the importance of studying the relationships among social cohesion, mutual efficacy, and action longitudinally. The continued study of mutual efficacy can lead to the development of interventions designed to raise a community's belief in the effectiveness of their actions, which

will in turn lead to greater community engagement, community action, and by extension, positive community outcomes.

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## Recovery, Willingness and Causal Attributions: An Exploration of Trainee Psychologists' Perceptions of Mental Health

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*Psychological diagnosis, rooted in the medical model, continues to dominate the field of mental health conceptualisation and treatment planning, and attracts stigma from individuals and mental health professionals. The Power Threat Meaning Framework (PTMF) offers an alternative to mental diagnosis by providing a different way to formulate patterns of emotional distress, experiences and behaviour. The aim of this cross-sectional survey study was to use vignettes to compare 107 trainee psychologists' perceptions of a mental health client using a traditional diagnostic framework and the PTMF. Specifically, these included perceptions of willingness to work with the client, perceptions of recovery and the attributions of causal beliefs of the client's difficulties. Results indicated that participants in the diagnostic group were more likely to attribute the client's difficulties to genetic causes and a chemical imbalance, and less likely to attribute these to the client's upbringing. Participants were more willing to work with the client if they believed the client had a better chance of recovery. These findings indicate the need to change how psychology trainees are educated about diagnosis and recovery to include broader interpretations of the causes of mental health difficulties, and to see recovery as more than a reduction of symptoms.*

**Key words:** causal attributions, power threat meaning framework, psychologists, recovery, training, willingness.

Psychology education and training in Australia represents formative years where new trainees are exposed to the profession, learn the craft of practicing psychology, and develop their personal and professional identities (Pakenham & Stafford-Brown, 2012; Turnbull & Rhodes, 2019). Due to the significance of these formative years, the educational and learning process of trainee psychologists is a growing area of research interest. Past research in the area of professional psychology training has primarily focused on how to enhance the training and development of psychologists. For example, studies have focused on competency-based learning (Pachana, Sofronoff, Scott, & Helmes, 2011), the perceptions of directors of training programs (Pachana, O'Donovan, & Helmes, 2006), stress of trainees (Pakenham & Stafford-Brown, 2012) and supervision (see, e.g., Calvert, Crowe, & Grenyer, 2016; Calvert, Deane, & Barrett, 2019; Thomas, Bowie, Hill, & Taknint, 2019). Comparatively, there has been limited research on the overall theoretical frameworks that underpin contemporary post-graduate psychology training. This is significant, in light of the role of post-graduate training in assisting provisional psychologists to understand the prevailing mental health frameworks.

In the Western world, the medical model represents the predominant framework for understanding mental health (Beecher, 2009; McCulloch, Ryrie, & Williamson, 2005). Within this model, mental health difficulties are perceived as disorders characterised by impairments

in brain functioning and the central nervous system, manageable via pharmacological or physical treatments (McCulloch et al., 2005). Accordingly, the medical model aims to identify the aetiology of a disorder by selecting a diagnosis based on genetic and biological causes, subsequently providing treatment to eliminate or manage the disorder (Beecher, 2009). In psychology, the medical model underpins contemporary classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) and the *International Statistical Classification of Diseases and Related Health Problems* (10<sup>th</sup> ed.; ICD-10; World Health Organisation, 2019).

An inherent focus of the medical model relies on physical attributions and causes of mental illness. As a result, this and other subsequent classification systems have been criticised for not taking into account broader contextual and environmental factors that may contribute to the development of mental health difficulties (Bakker, 2008; Johnstone, 2018). Put simply, such approaches have been criticised for focusing on the disorder rather than the person. More recently, a shift away from the biomedical approach has seen health care professionals adopt the bio-psycho-social model which, by definition, takes into consideration the person and the illness (Engel, 1989). This model acknowledges an individual's social and environmental experiences in the development and maintenance of mental health difficulties (Borrell-Carrió, Suchman, & Epstein, 2004). Although many mental health clinicians integrate a combination of biological, psychological, and social determinants of health into their practice, studies have indicated that most implicitly focus on the biological factors (Colombo, Bendelow, Fulford, & Williams, 2003; Ghaemi, 2009). This may be particularly relevant for those trained in clinical psychology, where there is a focus on diagnosis, rather than community psychology models that emphasise social determinants of mental health (Mayers & Agnew, 2019). The medical model continues to dominate mental health throughout Western countries by means of language (e.g., “illness”, “symptoms”, “disorder”), practice (e.g., “diagnosis”, “psychopharmacology”, “hospitalisation”) and research, which continues to focus on biological and hereditary characteristics of mental health difficulties (Johnstone & Boyle, 2018). Additionally, the medical model underpins contemporary mental health treatment where classifications and diagnosis are often required for access to services.

Diagnosis is an essential component within the medical model that attempts to explain an individual's mental health difficulties. Symptoms of thoughts, feelings and behaviours have been categorised and coded as mental disorders in the DSM-5 (APA, 2013), which compares clusters of an individual's symptoms and assigns them to a particular disorder. Research into the impact of diagnosis on consumers has produced mixed findings. While diagnosis can offer individuals relief with an explanation of symptoms (Dinos, Stevens, Serfaty, Weich, & King, 2004; Jutel, 2009), it can also have long-lasting effects by altering one's perception of self. For example, a recent study by Peter and Jungbauer (2019) interviewed people (n=16) living with a mental health diagnosis. Findings indicated that shortly after receiving a diagnosis, participants reported a loss of identity coupled with overwhelming emotions, including confusion, shame and helplessness. Additionally, a multi-phase study which surveyed over 1000 members of the public indicated that lay people perceive mental health diagnosis as isolating and destructive (Holzman & Genn, 2018).

Diagnostic labels can have an impact on attributions of mental health difficulties: that is, the perceived cause of why individuals experience psychological difficulties. Research in this area has highlighted that perceptions of the causal attributions of mental health difficulties

continue to be heavily reliant on biological factors. For example, Link, Phelan, Bresnahan, Stueve and Pescosolido (1999) and Dietrich et al. (2004) utilised vignettes to evaluate participant's responses to a client with schizophrenia, with findings indicating schizophrenia is commonly attributed to stressful life events and a chemical imbalance in the brain. Biological explanations for mental health difficulties can have benefits in that they are often associated with less blame (Loughman & Haslam, 2018). However, biological attributions of mental health are also linked to increased perceptions of danger, greater pessimism, and a perceived need to distance oneself from the person with mental health difficulties (Loughman & Haslam, 2018). To date, research in this area has utilised members of the public and medical practitioners, with no studies examining the perceptions of psychologists. If these perceptions are widespread in the general public, then it is important to ascertain the causal attributions that psychologists make about mental health difficulties. These attributions may lead to the aversion of treating certain individuals with presentations of symptoms that they perceive to have a biological cause. Accordingly, this research will explore psychologists' attributions of mental health and their association with beliefs about recovery and willingness to work with particular clients.

A consistent criticism of diagnosis and the medical model approach to mental health is that it contributes to and increases stigma (Ben-Zeev, Young, & Corrigan, 2010; Corrigan, 2007; Dinos et al., 2004; Schulze & Angermeyer, 2003). Stigma can be defined as attributing negative views or stereotypes about a person whose characteristics and behaviours are considered subordinate to society and what it considers normal (Dudley, 2000). Studies have demonstrated that some mental health professionals hold stigmatising attitudes towards mental health and low perceptions of the ability of people with mental health difficulty to recover (Caldwell & Jorm, 2001; Dinos et al., 2004; Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Nordt, Rössler, & Lauber, 2006). Recovery can be understood as the process of growth through the debilitating effects of ill health in which one finds hope, re-establishes identity and self-esteem, derives meaning in life, and takes responsibility for well-being (Andresen, Oades, & Caputi, 2003; Anthony, 1993). Across the globe, studies of mental health professionals in Switzerland, Australia and the United Kingdom (UK) have revealed that mental health professionals consistently hold negative attributions and perceptions of recovery about individuals suffering from mental health difficulties, in particular, schizophrenia and Borderline Personality Disorder (BPD; Caldwell & Jorm, 2001; Lauber et al., 2004; Markham & Trower, 2003; Nordt et al., 2006). Moreover, a study by Bodner, Cohen-Fridel and Iancu (2011) found that greater clinical experience was associated with less anger, frustration, and impatience towards clients with BPD, suggesting that early career mental health professionals may hold more stigmatising beliefs than their experienced counterparts. Mental health professionals who hold lower levels of stigmatisation have been found to have greater optimism about their client's ability to recover from mental health difficulties (Knaak, Modgill, & Patten 2014; Mötteli et al., 2019), highlighting the interconnection between stigma and recovery beliefs. Given the increased stigma and ongoing discrimination against individuals with complex mental health difficulties, in both the wider community and in treatment facilities, psychologists may be less willing to work with individuals with certain diagnoses. Therefore, an important part of this research will directly address the willingness of early-career psychologists to treat an individual experiencing psychosis.

The above-mentioned criticisms have culminated in a recent United Nations report (2017) suggesting the psychology field needs to “target social determinants and abandon the predominant medical model” (p. 19). Given the recognised shortcomings of the medical model, areas such as community psychology have been utilising alternative frameworks for mental health, which are continuing to be developed and expanded upon. A recent alternative framework is the Power Threat Meaning Framework (PTMF), developed by Johnstone and Boyle (2018) in conjunction with the British Psychological Society. The PTMF offers an alternative to mental diagnosis by providing a new framework for formulating patterns of emotional distress, experiences and behaviour. The processes of the PTMF are described in relation to *power*, *threat*, *meaning*, and *threat responses*.

*Power* refers to the ability to acquire personal gains or privileges for oneself or others (Johnstone & Boyle, 2018). While power can be used in a positive way to protect individuals and groups, when used negatively, power can lead to a range of mental health problems as a result of oppression, exclusion and stigma (Holley, Stromwall, & Bashor, 2012). The PTMF aims to discover how power has previously, and continues to, operate in one's life. For example, power may operate in terms of legal issues, economic status, interpersonal relationships, and social and cultural contexts (Johnstone & Boyle, 2018). *Threats* are challenges or situations that are brought about as a consequence of the negative uses of power (Johnstone & Boyle, 2018). For example, threatening situations or challenges may present in the form of difficult or abusive relationships with others, feeling unsafe, being discriminated against and physical illness. When faced with negative operations of power, for an individual or group of people to survive, they adapt by using *threat responses*, be it emotionally, physically, relationally and/or socially (Johnstone & Boyle, 2018). Threat responses may be biologically based (e.g. fight or flight) or conscious responses (e.g. self-blame, anger, distressing thoughts or self-harm). Lastly, the PTMF seeks to understand the role that *meaning* has played in how power, threat, and threat responses are experienced and expressed (Johnstone & Boyle, 2018). When these elements are understood about a person, this can bring together a life story that explains the experience of mental distress (Johnstone & Boyle, 2018).

Theoretically, the PTMF has been posed to reduce the stigma of mental health difficulties by removing diagnostic labels and taking a humanistic approach, through considering the person, their experiences and broader context in which they operate. This framework aims to circumvent the “brain or blame” dichotomy (Boyle, 2013), which reflects common attributions of the cause of mental health difficulties. In the “brain” attribution, mental health difficulties are viewed as a physical disease in which clients are helpless and not in control (Kennedy, 2008; Pitt, Kilbride, Welford, Nothard, & Morrison, 2009), whereas the “blame” attribution views mental health difficulties as being one's fault and something within one's control (Harper, 2013; Pitt et al., 2009). In contrast to this polarisation, the PTMF aims to create a non-diagnostic and non-blaming conceptualisation of one's story. For example, a trainee psychologist that has been primarily trained within a diagnostic framework may treat a person with schizophrenia by focusing on minimising psychiatric symptoms, thus missing other relevant life experiences that played a role in the development and maintenance of such symptoms (e.g. societal and power inequality). In contrast, if provisional psychologists were trained in the PTMF, this may produce a better understanding of the individual's symptoms by assisting them to cope with the threats they have experienced and the broader systemic issues that contribute to their distress. However, no empirical studies have been conducted on how



psychologists make sense of the Power Threat Meaning framework and what capacity it has to reduce stigma and facilitate recovery beliefs.

The current study used vignettes to compare trainee psychologists' perceptions of a mental health client presented using a traditional diagnostic framework and the PTMF. Specifically, we were interested in trainee's perceptions of their willingness to work with the client, perceptions of recovery, and attributions of the causal beliefs of the client's difficulties. Due to the increased stigma associated with schizophrenia (Dinos et al., 2004; Reavley & Jorm, 2011), this study used a vignette with features of psychosis.

Our hypotheses are:

1. The presentation of the client using the PTMF will result in increased willingness to work with the client and higher perceptions of the likelihood of recovery, compared to the diagnostic framework.
2. Biological and individual causal attributions of the client's difficulties (i.e., genetic or inherited, chemical imbalance in the brain, lack of will power) will be higher in the diagnostic presented framework, compared to the PTMF.
3. Social causal attributions of the client's difficulties (i.e., the way the person was raised, stressful life circumstances) will be higher in the client presented within the PTMF, compared to the diagnostic framework.
4. Biological and individual causal attributions of the client's difficulties will be associated with lower perceptions of likelihood of recovery, whereas social causal attributions will be associated with higher perceptions of likelihood of recovery.

## Method

### Research Design

This research had a cross-sectional survey design, in which participants responded to a series of questions following the review of a clinical vignette. The survey had a mixed-methods design, with qualitative and quantitative questions utilised. A qualitative design is useful for understanding voices, views and thoughts about phenomena, and relies on trustworthiness, transparency, verification and reflexivity (Braun & Clarke, 2013; Hammarberg, Kirkman, & de Lacey, 2016). Specifically, qualitative content analysis is useful in describing characteristics of the content produced by investigating what has been said (Bloor & Wood, 2006). This systematic approach to coding and categorising data is particularly useful with larger quantities of qualitative data and is an effective way to identify trends and patterns, abundance, relationships, and structures in written words (Gbrich, 2007; Mayring, 2000; Pope, Ziebland, & Mays, 2006). Therefore, a quasi-experimental mixed methods study, using content analysis and descriptive and correlational data, was conducted to understand trainee psychologist's perceptions of working with a mental health client.

### Participants and Procedure

Participants were eligible to take part in the proposed study if they lived in Australia, were of 18 years of age or over, were proficient in English, held provisional registration as a psychologist with the Australian Health Practitioner Regulation Agency, and were enrolled in

a postgraduate psychology training program. Recruitment consisted of emails to course coordinators of 5<sup>th</sup> and 6<sup>th</sup> year Australian psychology programs and via social media posts, including a dedicated Facebook page for the research. All participants provided informed consent by proceeding through the participant information sheet at the commencement of the online survey and by checking the consent box. Prior to commencement, this research was approved to be conducted by the Australian College of Applied Psychology Human Research and Ethics Committee (552020120).

The final sample included 107 provisional psychologists which consisted of 91 females, 14 males and 2 non-binary persons. The mean age was 30.93 years ( $SD = 8.88$ ), with participants' ages ranging from 22 to 71 years of age. Of the total sample, 54 participants were in their 5<sup>th</sup> year of psychology training and 53 were in their 6<sup>th</sup> year. Sixty-nine participants (64.5%) were enrolled in a program that leads to an area of practice endorsement. Of those, the majority (75%) were enrolled in a clinical master's program ( $n = 51$ ) with the remainder enrolled in educational and developmental ( $n = 4$ ), forensic ( $n = 4$ ) health ( $n = 7$ ), and community psychology ( $n = 2$ ). A small number of participants ( $n = 4$ ; 3.7%) reported that they had received previous training on the PTMF.

## Measures

Participants were initially presented with one of two vignettes (at random) describing a mental health client. The two vignettes represented the same client and differ in how they were described. A copy of both vignettes are available in the supplementary materials. The first vignette was adapted from Link et al. (1999) and was presented through a traditional diagnostic framework. The second vignette was constructed based on information provided in the PTMF (Johnstone & Boyle, 2018) to reflect the key elements of the PTMF (i.e. power, threat, meaning and threat response). Participants then responded to a series of questions regarding this client, as described below.

### *Willingness*

Participant were asked to nominate their willingness to work with the client described in the vignette. Responses were recorded on a scale of 0 to 10, where 0 = *not at all willing* and 10 = *very willing* to work with the client. Higher scores indicated more willingness to work with the client. Following this, participants were provided with a free textbox where they were asked to elaborate on their response using their own words.

### *Recovery*

Participants were asked their perception of the likelihood that the client mentioned in the vignette would recover from their mental health difficulties. Responses were recorded on a scale of 0 to 10, where 0 = *not at all likely* and 10 = *very likely* this client will recover. Higher scores indicated that participants perceived the client would be more likely to recover. Following this, participants were provided with a free textbox where they were asked to elaborate on their response using their own words.

### *Causal Attributions*

Participants' attributions of the vignette client's mental health difficulties were assessed by responses to five Likert-type questions, as based on Dietrich et al. (2004) and Link et al. (1999). Questions presented different perceived causes of mental distress, including: (1) genetic; (2) how they were raised (upbringing); (3) stressful circumstances; (4) chemical imbalance; and

(5) will power. Participants were asked to rate the likelihood of each cause on a scale of 0 to 5, where 0 = *definitely not a cause* and 5 = *definitely a cause*. Higher scores indicated that participants attributed the relevant item to be a cause of the client's difficulties. Following this, participants were provided with a free textbox where they were asked to elaborate on their understanding of the causes of the client's current difficulties using their own words.

### ***Demographic Information***

Demographic information included the following: gender, age, stage of training (i.e. 5<sup>th</sup> year student or 6<sup>th</sup> year student), area of endorsement (if applicable), primary therapeutic orientation (cognitive behavioural, existential/humanistic, family systems, psychodynamic, other), and previous training in the power threat meaning framework.

### **Analysis**

Participants were sorted into two experimental groups: those presented with the diagnostic vignette (n = 54) and those presented with the PTMF vignette (n = 53). In order to ensure randomisation resulted in approximately equivalent groups, participants were compared on demographic variables using between-groups *t*-tests and cross-tabs. Descriptive analysis and Pearson's correlation were performed for each experimental group to determine the relationship between variables. Examination of Q-Q plots and Shapiro-Wilk's test indicated the data displayed deviation from normal distribution, thus non-parametric tests were utilised. Mann-Whitney U tests were conducted to compare willingness, likelihood of recovery and attributional causes between the diagnostic participant group and the PTMF participant group. Analyses were conducted using SPSS 22.0 for Windows.

Qualitative survey responses were coded using thematic content analysis methodology. Due to the lack of established frameworks in this area, an inductive approach was utilised. In the preparation phase, all complete survey comments (n = 50 for diagnostic participants and n = 49 for PTMF participants) were exported to the Nvivo software and read multiple times. Following the preparation phase, open coding was conducted through the addition of nodes next to each participant response, with nodes representing condensed meaning units of the text. Those nodes sharing similar content were then collated under higher order headings for the development of codes, while comparing emerging categories to each other to determine their substance and significance. The first ten surveys for each participant group were coded by both authors, in collaboration, in order to enhance dependability through mutual understanding of what constituted codes (Gibbs, 2007). The remainder of the surveys were then coded by the first author. Categories were determined based on relevance to the research question and salience across participants (minimum 20% of respondents in either participant group). Following completion of the initial coding, the first and second author then met to triangulate their observations of the codes (Palaganas, Sanchez, Molintas, & Caricativo, 2017) and data was clustered into categories. A description for each developed category was generated and key excerpts selected. The proportions of participants endorsing each theme was calculated, with these proportions examined using Chi-square tests to assess for significant differences between the two groups.

### **Results**

A series of between groups *t*-tests were conducted to examine significant differences between experimental groups according to participants age and cross-tabs were conducted to explore

any differences between the groups according to gender and stage of training. Results indicated no significant differences on these demographic variables.

Descriptive statistics and correlations for key variables can be found for each participant group in Tables 1 and 2. Across both participant groups, recovery was positively correlated with willingness,  $r(54) = .37, p < .01$  (diagnostic group) and  $r(53) = .42, p < .01$  (PTMF group). That is, as belief that the client would recover increased, participants indicated that they would be more willing to work with the client. Correlational findings from the PTMF participant group only indicated that recovery was negatively correlated with genetic causes  $r(53) = -.33, p < .05$  and chemical imbalance  $r(53) = -.36, p < .01$ . That is, as attributions of genetic and chemical imbalance causes increased, beliefs about the likelihood of recovery decreased. Additionally, recovery was positively correlated with raised/upbringing,  $r(53) = .55, p < .01$ , indicating that as attributions of 'way client was raised' increased, beliefs about the likelihood of recovery increased.

**Table 1**

*Descriptive Statistics and Correlations for participants in diagnostic group (n = 54)*

Variable	Mean	SD	2.	3.	4.	5.	6.	7.
1. Willingness	7.06	2.33	.37**	-.05	-.04	.20	-.04	.06
2. Recovery	6.57	1.80	—	-.10	.20	.22	.01	-.03
3. Cause – genetic	4.93	1.49		—	.20	.24	.55**	-.04
4. Causes – raised / upbringing	3.61	1.55			—	.42**	-.01	.07
5. Cause – stress	5.43	1.34				—	.17	.00
6. Cause – chemical Imbalance	4.69	1.75					—	.12
7. Cause – willpower	1.43	0.74						—

\*  $p < .05$ , \*\*  $p < .01$

**Table 2***Descriptive Statistics and Correlations for participants in PTMF group (n = 53)*

Variable	Mean	SD	2.	3.	4.	5.	6.	7.
1. Willingness	7.23	2.40	.42**	-.16	.21	-.09	-.10	-.06
2. Recovery	6.77	1.68	—	-.33*	.30*	.07	-.36**	.07
3. Cause – genetic	3.55	1.53		—	-.21	-.05	.64**	-.02
4. Causes – raised / upbringing	5.36	1.61			—	.55**	-.22	.15
5. Cause – stress	5.75	1.36				—	.04	.18
6. Cause – chemical Imbalance	3.94	1.74					—	-.00
7. Cause – willpower	1.64	0.96						—

\*  $p < .05$ , \*\*  $p < .01$ 

The Mann-Whitney U test indicated that there was a significant difference in scores on the attributional cause of genetic factors between the two groups. Specifically, participants in the diagnostic group were more likely to rate ‘genetic’ as a cause for the client’s mental health difficulties ( $Mdn = 4.0$ ) than those in the PTMF participant group ( $Mdn = 3.0$ ),  $U = 734.50$ ,  $z = -4.49$ ,  $p = .000$ . There was a significant difference in scores on the attributional cause of chemical imbalance between the two groups. Specifically, participants in the diagnostic group were more likely to rate ‘chemical imbalance’ as a cause for the client’s mental health difficulties ( $Mdn = 4.0$ ) than those in the PTMF participant group ( $Mdn = 4.0$ ),  $U = 1081.50$ ,  $z = -2.23$ ,  $p = .025$ . Lastly, there was a significant difference in scores on the attributional cause of ‘upbringing’ between the two groups, with participants in the diagnostic group less likely to rate ‘the way client was raised’ as a cause for the client’s mental health difficulties ( $Mdn = 4.0$ ) than those in the PTMF participant group ( $Mdn = 6.0$ ),  $U = 652.00$ ,  $z = -4.98$ ,  $p = .000$ . All other comparisons were non-significant, with no group differences in willingness to work with the client or perceptions of recovery, contrary to our first hypothesis.

Thematic content analysis produced four themes for willingness, recovery and causes of the client’s difficulty respectively. As can be seen in Table 3, participant’s reflections on their willingness to work with the client primarily focused on expressions of hesitancy, expressions of willingness, references to benevolence as a motivation and references to symptoms of psychosis/schizophrenia. Chi-square tests indicated no significant differences in the proportion of individuals endorsing each theme, however, there were nuanced differences in the language used by participants across the groups. Whilst both participant groups indicated they were equally as willing to work with the client, participants in the PTMF group used more confident language (e.g. “I would be very prepared and comfortable”) compared to participants in the diagnostic group (e.g. “I would be willing to have a go”). Furthermore, when referencing symptoms of schizophrenia in their rationale for being willing/not willing to work with the client, participants in the diagnostic group were more likely to use the term ‘schizophrenia’ itself, whereas participants in the PTMF primarily referred to symptoms of psychosis.

Participants’ perceptions of the clients’ likelihood of recovery, as seen in Table 4, focused on beliefs that recovery was likely and/or unlikely, the role of medication in



determining the likelihood of recovery, and the role of support in determining the likelihood of recovery. Chi-square tests indicated no significant differences in the proportion of individuals endorsing each theme. Again, there were nuanced differences in the language used by participants across the groups. When describing the likelihood of recovery, the diagnostic group used more tentative language when expressing the perception that the client will recover (e.g. “may show improvements”) and more definite language when reporting the client may not recover (e.g. “never recover”).

Participants' perceptions of the causes of the client's difficulty, as seen in Table 5, focused on biological attributions, the role of traumatic experiences, the role of stress and the impact of interpersonal relationships. Chi-square tests indicated there was a significant difference in the proportion of participants endorsing biological causes, with participants in the diagnostic group more likely to reference biological causes than participants in the PTMF group,  $X^2(1, N = 99) = 20.15, p < .001$ . There was a significant difference in references to traumatic experience, with participants in the PTMF group more likely to reference trauma than participants in the diagnostic group,  $X^2(1, N = 99) = 30.58, p < .001$ . There was a significant difference in references to interpersonal causes, with participants in the PTMF group more likely to reference interpersonal difficulties than participants in the diagnostic group,  $X^2(1, N = 99) = 4.38, p < .05$ . There was no significant difference in references to stress between the two participant groups.

**Table 3***Content Analysis of Willingness to Work with the Client*

Themes	Diagnostic vignette (n = 50)		Power threat meaning framework vignette (n = 49)	
	Number endorsing (%)	Examples (Participant number)	Number endorsing (%)	Examples (Participant number)
1. Hesitant to work with client	25 (50%)	<p>“I would be concerned about my level of training and experience to best support him.” (12)</p> <p>“My concern is that it may be outside my area of competency at this time.” (19)</p>	18 (36.7%)	<p>“I am hesitant because I do not feel I have the competency to work with John at this stage in my career.” (20)</p> <p>“I don't feel I have enough knowledge or experience to confidently work with such a complex presentation.” (48)</p>
2. Willing to work with client	20 (40%)	<p>“I would be willing to have a go and develop my experience with working with John.” (46)</p> <p>“I would be willing to learn and work with John within my abilities.” (24)</p>	12 (24.5%)	<p>“I feel I have adequate training and experience in the right areas of psychology to be competent and able to help John.” (14)</p> <p>“I would be very prepared and comfortable supporting a client like John.” (41)</p>
3. Good will	14 (28%)	<p>“He's a good person who wants and deserves help.” (6)</p> <p>“I think everyone deserves a chance to get treatment.” (37)</p>	18 (36.7%)	<p>“I would want him to believe that there is hope and a way forward through all of this.” (38)</p> <p>“I feel empathy for John and want to support him through and out of this difficult phase of his life.” (32)</p>
4. Schizophrenia	9 (18%)	<p>“I would prefer to work with a client without such a complicated diagnosis.” (42)</p> <p>“Schizophrenia is difficult to work with.” (4)</p>	11 (22.4%)	<p>“I am not sure I would be the best fit for John, considering the complexity of his case and the current severity of his disorder.” (35)</p> <p>“I would be mostly not willing to work with John because I understand the difficulties that might be presented in psychotherapy with a seemingly psychotic patient.” (44)</p>

**Table 4***Content Analysis of Recovery*

Themes	Diagnostic vignette (n = 50)		Power threat meaning framework vignette (n = 49)	
	Number endorsing (%)	Examples (Participant number)	Number endorsing (%)	Examples (Participant number)
1. Recovery likely	22 (44%)	<p>“John may show improvements but he may continue to experience these symptoms of psychosis on and off.” (1)</p> <p>“He will likely make gains and recover.” (3)</p>	25 (51%)	<p>“I believe with the right approach John could recover from his condition.” (18)</p> <p>“I believe that John is very likely to recover from his current mental health difficulties.” (38)</p>
2. May not recover	14 (28%)	<p>“Client can never recover.” (30)</p> <p>“He will never recover as there is no cure for schizophrenia.” (7)</p>	7 (14.3%)	<p>“Psychosis is often not fully curable.” (12)</p> <p>“I’m wondering whether his symptoms are along the lines of schizophrenia and thus as far as modern treatment full recovery is not likely.” (22)</p>
3. Role of Medication	14 (28%)	<p>“Schizophrenia appears to rely heavily on medical intervention for significant change.” (18)</p> <p>“Schizophrenia is commonly a chronic condition that can be controlled by medication.” (24)</p>	9 (18.4%)	<p>“John will likely be able to better manage his symptoms with a combination of both medication and therapy.” (4)</p> <p>“I do not know much about medication for psychotic symptoms, but if this could be effectively delivered as an adjunct to therapy then I believe it would also improve his prognosis.” (43)</p>
4. Role of support	11 (22%)	<p>“With the right support and therapy, I believe it is highly likely that John will recover.” (28)</p> <p>“With the right combination of support John will be able to “recover” from his difficulties.” (23)</p>	9 (18.4%)	<p>“He may well recover with appropriate treatment and support.” (39)</p> <p>“With the right support...around him, recovery is possible.” (46)</p>

**Table 5***Content Analysis of Causes of the Client's Difficulty*

Themes	Diagnostic vignette (n = 50)		Power threat meaning framework vignette (n = 49)	
	Number endorsing (%)	Examples (Participant number)	Number endorsing (%)	Examples (Participant number)
1. Biological	43 (86%)	<p>“An underlying genetic predisposition.” (15)</p> <p>“May have had predisposing factors such as a chemical imbalance in the brain that he had a genetic propensity for.” (43)</p>	21 (42.9%)	<p>‘There is potential for John's presentation to be a genetic or predisposed biological issue’ (20)</p> <p>‘Possible chemical imbalance’ (3)</p>
2. Traumatic experience	10 (20%)	<p>“A history of adverse experiences growing up.” (11)</p> <p>“Childhood trauma may play a large role” 17)</p>	37 (75.5%)	<p>“John’s complex developmental trauma has likely predisposed him to being vulnerable to mental health difficulties.” (14)</p> <p>“Trauma - loss of significant family member and ongoing abuse from caregiver.” (15)</p>
3. Stress	27 (54%)	<p>“Perhaps a particularly stressful life circumstance triggered his first psychotic episode.” (19)</p> <p>“Acute or chronic stress may have led to John's difficulties.” (51)</p>	19 (38.8%)	<p>“Changes in symptoms and functioning may indicate stress/other life events” (6)</p> <p>“The current episode may have been triggered by a stressful situation.” (35)</p>
4. Interpersonal	9 (18%)	<p>“John's withdrawal from his social networks ...as he no longer has access to any support structures he previously had in place.” (51)</p> <p>“John's difficulties largely stem from his social interactions.” (48)</p>	18 (36.7%)	<p>“Lack of social support (especially during his childhood and teenage years) leading to withdrawal to social life.” (102)</p> <p>“Difficult relationships in his life.” (7)</p>

## Discussion

This study aimed to use vignettes to compare trainee psychologists' perceptions of a mental health client using a traditional diagnostic framework and the PTMF. Contrary to our hypothesis, the participant groups did not differ in terms of their willingness to work with the client or their perceptions of the likelihood that the client would recover. This indicates that the presentation of the client using the PTMF or diagnostic framework alone may not have influenced willingness to work with the client or perceptions of the likelihood that they would recover. Rather, it was the interpretation of the causes of the client's difficulties that held most weight. Our research design presented one client vignette, and measured willingness and recovery perceptions using single item scales. Thus, participants may have responded differently if given a choice between multiple clients and asked to rate their willingness and perceptions of recovery on validated multiple item measures. Although there were no statistically significant differences between the groups according to Mann-Whitney U and Chi-square tests, there were notable differences in language used by participants in the qualitative findings, with the diagnostic group participants using more tentative language when describing their willingness to work with the client and perceptions that they would recover. Further research using a qualitative design, such as focus groups or interviews, may assist in unpacking these potential differences further.

Results of the Mann-Whitney U tests indicated significant between group differences on the causal attributions of mental health difficulties, with participants in the diagnostic group more likely to endorse genetic causes and chemical imbalance, and less likely to endorse upbringing, than participants in the PTMF group. Thus, the presence of a diagnostic label (schizophrenia) was associated with biological causes. The PTMF vignette which displayed the same symptoms without a diagnosis present, was most commonly attributed to the client's upbringing. These results align with previous findings regarding the 'brain or blame' dichotomy; with diagnosis known to attract 'brain' attributions (McCulloch et al., 2005).

Correlational findings indicated that participants in the PTMF group who endorsed a greater causal attribution to genetic causes, or a chemical imbalance had lower perceptions of the likelihood that the client would recover. While there is a strong genetic basis for the development of psychotic symptoms (Lichtermann, Karbe, & Maier, 2000), these results are concerning, given that mental health professionals who are less optimistic about recovery are more likely to hold stigmatising beliefs about their clients (Mötteli et al., 2019). Additionally, stigma has the ability to cause distress, prevent people from disclosing their difficulties, affect how a psychiatric diagnosis is accepted, whether treatment will be adhered to and may reduce opportunities for recovery (Dinos et al., 2004; Pitt et al., 2009).

The association between biological causes of mental health difficulties and low perceptions of recovery, highlights the need for further education on contemporary recovery frameworks. For example, this could include information on personal recovery, including consumers stories of their own recovery process from conditions such as schizophrenia. Unlike clinical recovery, which is based on a reduction of symptoms, personal recovery is a subjective process which focuses on the development of a meaningful life with or without the presence of mental health difficulties (Ballesteros-Urpi, Slade, Manley, & Pardo-Hernandez, 2019). Through this lens, psychologists may focus less on the symptoms the client is experiencing and more on the person in front of them. Given that the PTMF takes a humanistic approach that



considers the person, their lived experiences, and the broader systems in which they operate (Johnstone & Boyle, 2018), education on the PTMF may be one way of facilitating a broader recovery-oriented perspective with psychology trainees.

Perceptions that the client would recover increased when participants in the PTMF group attributed the client's difficulties to their upbringing. This assumption is aligned with current research, as disorders such as schizophrenia have been linked to childhood trauma (Khavari & Cairns, 2020). In addition, for all participants, perceptions that the client would recover increased with willingness to work with the client. That is, trainee psychologists reported that they were more willing to work with the client if they perceived that the client had a better chance at recovery, or vice versa. Within the qualitative findings, more therapists exposed to the diagnostic framework reported that they were not as willing to work with the client and this was primarily attributed to a lack of competency. Therefore, psychology training programs need to not only focus on broadening perspectives on recovery, but also to incorporate trauma-informed practice which may reduce stigma and facilitate psychologist's willingness to work with complex presentations.

The PTMF offers a unique way to conceptualise trauma through the concepts of "threat" and "threat responses" (Johnstone & Boyle, 2018). In the qualitative findings, there was a significant difference in the frequency of trauma as a reported cause/attribution of the client's difficulties. Within the PTMF participant group, 75.5% of the sample noted the role of traumatic experiences in the development of the client's mental health difficulties, compared to 20% of the sample in the diagnostic group. These results support the utility of the PTMF in highlighting the role of trauma as a cause of mental distress. Moreover, the utilisation of the PTMF, particularly in the treatment of culturally diverse groups, provides psychologists with a framework where such threats can be explicitly incorporated as part of the perpetuating factors that may be contributing to an individual's mental health presentation. While certain responses to threats may be seen within the medical model as "symptoms", clustered together to form a diagnosis (e.g. schizophrenia), the PTMF steers away from diagnosis to recognise that all people experience reactions to threats and employ survival strategies (Johnstone & Boyle, 2018). Trauma-informed approaches promote recovery and prevent further trauma through creating safe environments and relationships that facilitate this (Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). The medical model and associated interventions undervalue the impact of meaningful relationships, which play a vital role in minimising the impact of trauma (Van der Kolk, 2005). However, the PTMF can support trauma-informed care by providing a framework in which psychologists ascertain "What has happened / is happening to you?", rather than the traditional, "What is wrong with you?".

This research is not without its limitations. Currently, there are over five and a half thousand provisional psychologists in Australia (Psychology Board of Australia, 2020), making our sample size relatively small by comparison. Our sample was predominantly female (85%), reflective of the Australian psychology workforce (Psychology Board of Australia, 2020). Future research should aim to capture a wider audience of trainee psychologists. The cross-sectional design of the research methodology also limits the results to a static time point in each participant's training. The use of single-item measures for beliefs about recovery and

willingness to work with the client is recognised as a limitation of the design of this study; however, no appropriate scales were available at the time.

The utilisation of a vignette design is limited to measuring intent, which does not equate to a behaviour being performed, as people often engage in self-preservation of their identity (Carraro & Gaudreau, 2013; Conner, Gaston, Sheeran, & Germain, 2013). There were also subtle differences between the vignettes which may partially account for participants' responses. For example, the vignette presented to the diagnostic participant group included the statement, "Up until a year ago, life was pretty okay for John". This may imply an absence of adverse childhood events and/or trauma, potentially influencing the likelihood of participants endorsing upbringing as a potential cause of the client's difficulties. Additionally, the vignettes presented were limited to one type of mental health presentation, based on a male with schizophrenia. As current theories into the causes of psychosis suggest that there is an inherited genetic vulnerability for this disorder (Carr & McNulty, 2016), results may have differed if another set of symptoms were presented that have less of a genetic loading, for example, depression or anxiety (Bienvenu, Davydow, & Kendler, 2010). Taking this into account, future researchers could implement a design with a larger sample size that compares trainee psychologist's perceptions across different diagnoses and multiple types of mental health presentations utilising a gender-neutral vignette.

Despite the above limitations, this research is the first of its kind to explicitly explore Australian trainee psychologist's perceptions of mental health from the perspective of the PTMF. Findings indicate the need for psychology training programs to broaden their education on recovery and to incorporate trauma-informed care as part of their practice which may reduce mental health stigma and support mental health professionals working with complex presentations. The PTMF may offer one way in which trainee psychologists may be encouraged to shift their focus from the biological causes of mental distress and consider the wider contributing factors of mental health.

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### Supplementary Material

#### Vignette A – DSM Diagnosis Presentation

John is a 24 year old Caucasian man with a secondary education. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. John started hearing a female voice even though no one else was around. The voice told him that he was dirty and evil. He has been living this way for six months. John recently sought help from the local mental health service, and received a diagnosis of schizophrenia.

#### Vignette B – PTMF Presentation

John is a 24 year old Caucasian man with a secondary education. John had a happy childhood until his father died at age eight. Following this, John moved in with his mother, who was verbally and physically abusive. John felt powerless in the presence of his mother, and did not feel able to confide in anyone. John left home at the age of sixteen and started an apprenticeship. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. John started hearing a female voice even though no one else was around. The voice told him that he was dirty and evil. This seemed to express how the abuse made John feel, and it also reminded John of things that his mother said to him. He has been living this way for six months.

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Teola London is a Registered Psychologist and Clinical Psychology Registrar who completed their Master's degree at the Australian College of Applied Psychology under the supervision of Dr Elly Quinlan. This study is an extension of their dissertation. Teola currently practices as a psychologist within a university research clinic and a hospital setting. Teola's research interests include child behaviour management, stigma of mental health, and recovery based approaches.

Elly Quinlan, PhD, is a senior lecturer in the Discipline of Psychological Sciences at the Australian College of Applied Psychology. Her research focuses on professional psychology training, tolerance of uncertainty, mental health carers, recovery based approaches, interpersonal problems, experiential avoidance, role-play and gaming.

## Help-seeking for mental health services among Afghan Hazara women from refugee backgrounds in South Australia

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*Little is known regarding help-seeking for mental health services within refugee populations, especially for women who may be at higher risk for poor mental health outcomes and face multiple barriers to service access. The participants were eleven Afghan Hazara women (aged 18-60 years) with refugee backgrounds living in Adelaide, South Australia. Qualitative, semi-structured interviews were conducted to examine existing formal and informal help-seeking patterns as well as to investigate how Afghan Hazara women conceptualise mental health issues, and whether this influences help-seeking behaviours. Thematic analysis was employed to analyse the data. Findings suggest that women of all ages from the Afghan community may face multiple social and cultural barriers to help-seeking including stigma, differences in cultural conceptualisations of mental health, domestic violence, and language and communication difficulties, and that these may be pronounced for older women. Future research should include the voices of older women in the community – and particularly those with lower levels of English. The study points to key recommendations, including women-only education sessions and English classes with mental health and domestic violence related information, outreach education and mental health teams, incorporating mental health information into religious practices, and mental health services that enhance protective social support networks.*

**Key words:** barriers, help-seeking, mental health, Afghan, women, refugees

There are currently over 25.9 million people classified as refugees, who have been forced to leave their home countries due to persecution or conflict (UNHCR, 2019). Of these, approximately 2.7 million have fled Afghanistan, most recently as a result of years of conflict (UNHCR, 2019), including the Soviet-Afghan war during the 1980s, civil wars, invasion by the United States, and political instability. In August 2021 this included the Taliban taking control of Afghanistan once again, as America (and allied forces including Australia) withdrew from the country. In particular, the Shi-ite Hazara minority endured increased levels of violence during the theocratic rule of the Taliban from 1996-2001 (Saikal, 2012), and it is anticipated that Afghan Hazara people – and particularly women – will once again be the target of discrimination and potential genocide under the new Taliban regime from 2021. Indeed, refugee numbers from Afghanistan are already increasing with several countries agreeing to take hundreds, if not thousands, of people already attempting to flee the country (UNHCR, 2021).

The 2016 census indicated that there were over 46,000 Afghanistan-born people living in Australia, of whom over 10,000 were Hazara (Department of Home Affairs, 2016). Although people with refugee or asylum seeking backgrounds (defined for brevity here as refugees) often show extraordinary strength and resilience in the face of extreme adversity (Hutchinson & Dorsett, 2012), systematic reviews suggest that refugee populations suffer poorer mental health status when compared with other groups of migrants and the general

populations of host countries (Fazel, Wheeler, Danesh, 2005; Kirmayer et al. 2011; Lindert, Ehrenstein, Priebe, Mielck, Brahler, 2009; Porter & Haslam, 2005). Although few studies have assessed mental health outcomes among Afghan refugees resettled in Western countries specifically, of those that have, results consistently suggest high levels of mental health disorders, ranging from 25.4-35% for Post-Traumatic Stress Disorder (PTSD) and 54.7-57% for depression (Gernaat, Malwand, Laban, Komproe, & de Jong, 2002; Gerritsen et al., 2006). A recent Australian study found that 44% of a sample of 150 Afghan refugees presented with clinically significant PTSD symptoms, and 14.7% had symptoms of depression (Slewa-Younan et al., 2017).

Poor mental health outcomes amongst refugee populations more generally have been linked to pre-migration trauma (including torture, loss of family members, witnessing or participating in conflict, and imprisonment), the migration pathway itself, and post-migration stressors (adjusting to a new culture, racism and discrimination, resettlement stress, and loss of social support) (Alemi, James, Cruz, Zepeda & Racadio, 2014; Porter & Haslam, 2005), and a meta-analysis of Afghan refugees' mental distress supports this (Alemi et al., 2014). Many Afghan women have experienced human rights violations under the Taliban regime (Scholte et al. 2004), with one cross-sectional survey finding that Afghan women living in Kabul or refugee camps during the Taliban rule in 1998 reported significant symptoms of major depression (97%), and anxiety (86%) (Rasekh, Bauer, Manos & Iacopino, 1998). Women may then be at particular risk of psychological distress due to extra risks they face on their journey to a resettlement country, including sexual violence, rape, unwanted pregnancies, harassment, health issues, and separation from children and loved ones (Kastrup, 2006). In addition, after arrival in a resettlement country, mental health issues may be heightened due to the erosion of traditional and cultural values within the family and the negotiation of gender and social roles in host countries particularly for elderly women (Alemi et al. 2014).

Despite the reported high levels of psychological distress in refugees and asylum seekers, these populations are profoundly underrepresented in relation to the utilization of mental health services in resettlement countries such as Australia (Minas et al., 2013; Posselt, McDonald, Procter, de Crespigny, & Galletly, 2017). Although there is a growing body of literature addressing health and mental health service utilisation by non-English speaking people and immigrants (McDonald & Steel, 1997; Trauer, 1995, Hassett & George, 2002; Boufous, Silove, Bauman & Steel, 2005), few Australian studies have specifically investigated contributory reasons behind the apparent low up-take of mental health services in culturally diverse refugee communities. This gap warrants an examination of community factors influencing help-seeking behaviours (defined as "any communication about a problem which is directed toward obtaining support, advice or assistance in times of distress"; Gourash, 1978, p. 413) and uptake of services. This is particularly important since previous research has identified low rates of help-seeking amongst people with refugee backgrounds in resettlement countries such as Australia (Kayrouz et al., 2015), including for refugees from Afghanistan living in South Australia (Slewa-Younan, 2017).

In a systematic review of the literature concerning the impact of primary health care delivery for refugees in resettlement countries, Joshi et al. (2013) identified strategies that improved access to services, which included using teams of multidisciplinary staff, use of interpreters, outreach services, free transport to appointments, more generous consultation times, and gender-sensitive health providers. Additional barriers identified in broader literature include: lack of services that take into account cultural knowledge and healing (Ellis et al., 2010); discordant health beliefs and divergent expectations of healthcare systems (Pavlish, Noor & Brandt, 2010); difficulties regarding interpreters and lack of trust of services (Colucci,

Minas, Szwarc, Paxton & Guerra, 2012); language difficulties (Colucci, Minas, Szwarc, Guerra & Paxton, 2015; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006; Franks, Gawn & Bowden, 2007); and institutional racism (Summerfield, 2016; Fernando, 2017). Specifically for Muslim immigrants, identified barriers include social stigma surrounding mental health problems and cultural mistrust of mental health workers (Amri & Bemak, 2012). Identified barriers to help-seeking for immigrant and refugee women include gender hierarchies within the family and relationship dominance, as well as precarious visa status (O'Mahony & Donnelly, 2013). Specifically for Afghan women with refugee backgrounds, lack of awareness of services, husbands as gatekeepers, access to interpreters (Rintoul, 2010), and low mental health literacy (Yaser et al., 2016) have been identified as potential barriers. Only minimal research thus far has examined how cultural beliefs and culturally specific concepts of mental illness may affect help-seeking in this population.

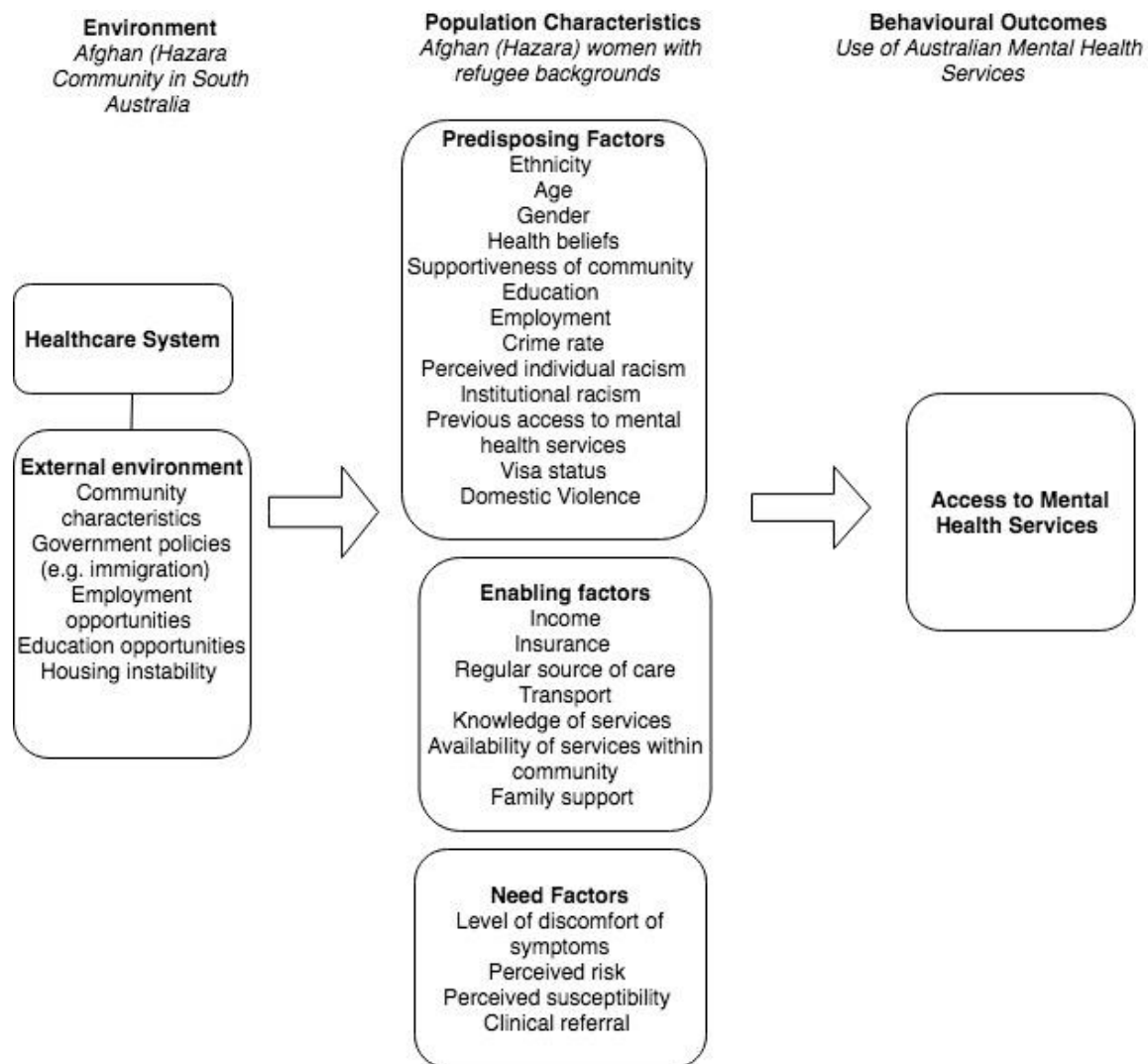
Using qualitative research methods, this study will explore help-seeking within the Afghan refugee community in South Australia, with a focus on women and those who identify as Hazara, given the persecution this group has faced and their subsequent representation in humanitarian migration to Australia as noted above. Specifically it aims to: 1) contribute to the literature concerning culturally specific knowledge about conceptualizations of mental health within this population, 2) explore preferred strategies for coping with mental health problems, and perceived efficacy of Australian mental health services, and 3) better understand and recognise barriers to help-seeking behaviours.

### Theoretical Perspective

Andersen's model of health service utilisation was used in this study as an interpretive lens to examine any social inequalities in access to health services (Andersen, 1995). The model addresses the concern that minority groups may receive less health care provision compared to the rest of the population (Andersen & Newman, 1973). It conceptualises access to services as a result of decisions made by the individual, which are constrained by their position in society and the subsequent level of accessibility and availability of health services (Andersen, 1995; Andersen & Davidson, 2007).

An individual's likelihood of access to health services is considered to be a function of three individual and contextual characteristics. *Predisposing factors* are socio-cultural characteristics that include demographic factors, social structure, and health beliefs. Social characteristics include how supportive the community is towards health and access to health services, educational level, ethnicity, employment level, and crime rate, as these are existing conditions that predispose people to engage in or disengage from service use (Andersen, 1995). *Enabling factors* are the logistical aspects of obtaining care, including whether an individual has a regular source of care, ability to transport oneself, health insurance, and knowledge of health care services. It also includes whether there are available health facilities within their community (Andersen, 1995). *Need factors* are functional or health issues that promote the need for access to health care (e.g. level of discomfort of symptoms). Need factors are considered the most immediate cause of service use and are the conditions that laypeople recognise as requiring healthcare (Andersen, 1995). Figure 1 presents an adapted model of Andersen's (1995) Model of Health Service Utilisation based on the likely factors affecting Afghan women's service use in relation to previous literature.



**Figure 1***Adapted version of Andersen's Model of Health Service Utilisation (Andersen, 1995)*

The model has been employed as a theoretical basis for studies investigating health-seeking behaviours in refugee populations by numerous international researchers (Ruiz-Rodriguez, Lopez-Moreno, Avila-Burgos & Acosta-Ramirez, 2006; Portes, Kyle & Eaton, 1992; Seagal & Elliott, 2012). However, there are as yet no Australian studies that use the Andersen model to consider barriers to help-seeking for mental health services for Afghan women from refugee backgrounds.

## Method

### Participants

Participants for this study were 11 Hazara women with refugee backgrounds from the Afghan community who lived in Adelaide, South Australia. Participants were recruited through responses to posters and fliers (in English and Dari) distributed around South Australian universities, a Technical and Further Education institute (TAFESA), community centres, and organisations. A combination of convenience and snowball sampling was used to maximise participation. Eligible participants had to have been in Australia for more than three months to ensure some level of familiarity with the Australian health care system, and be over the age of 18. It was not a requirement for participants to speak English, as interpreters were offered in whatever language women felt most comfortable speaking. The mean age of participants was 30 years and the mean length of time spent in Australia was 6.8 years.

**Table 1**

*Participant demographic information*

Pseudonym	Age	Visa Status	Time spent in Australia	Language	Occupation
Parisa	30	Temporary Protection Visa (785)	4 years	Hazaragi, English	Student
Laila	18	Permanent Protection Visa (866)	4 years	Dari, English	Student
Jamilah	59	Permanent Protection Visa (866)	4 years	Dari	Unemployed (Stay at home mother)
Qamar	31	Woman at risk visa (204)	4 years	Dari, English	Student
Naila	60	Woman at risk visa (204)	4 years	Dari	Unemployed (Stay at home mother)
Giti	23	Permanent Protection Visa (866)	9 years	Dari, Urdu, Hindi, English	Student
Mahlia	32	Australian Citizen	11 years	Dari, Hazaragi, Urdu, English	Student and childcare worker
Saba	21	Australian Citizen	10 years	Dari, Irani, Hindi, English	Student
Rana	20	Refugee Visa (200)	5 months	Dari and Persian	Student
Lila	18	Australian Citizen	16 years	Dari and English	Student
Azadah	18	Australian Citizen	9 years	Hazaragi, Urdu, English	Student

### Procedure

Qualitative, semi-structured, face-to-face interviews were conducted between October 2016 and May 2017 by the first author. On average, interviews lasted 60 minutes and were conducted at locations that were convenient for the participants. A \$20 shopping voucher was gifted to each participant upon completion of the interview in appreciation of their time. Written consent was obtained from each participant. The project was approved by The Adelaide University Ethics Committee (H-2016-130).

Initially, efforts were made to recruit female community leaders in order to triangulate the data. However, it proved difficult to find women who identified as community leaders. Instead, two female Afghan bi-cultural workers were consulted to formulate research questions and provide relevant cultural information. Of the community-member participants, nine had a

competent level of English, and two women did not speak English. The two women who could not speak English were offered professional interpreters but preferred to have a female family member interpret for them.

An interview guide was used that included questions such as ‘What do you think are some of the difficulties that women face in your community?’, ‘When women in your community feel unhappy how do they get help?’, ‘What kind of things might stop women from getting help in your community?’. This guide served as an aide memoire, and participants predominantly guided interviews facilitated by prompts from the first author.

### **Ethical considerations**

Refugees and asylum seekers have been classified as a hard-to-reach, ‘vulnerable’ population (Liamputtong, 2010). Accordingly, research must be designed and conducted in a way that empowers, respects and ‘does no harm’ to communities (Birman, 2006; Block, Warr, Gibbs & Riggs, 2012; Ellis, Kia-Keating, Yusuf, Lincoln & Nur, 2007; Hugman, Pittaway & Bartolomei, 2011; Ziaian et al., 2018).

In the current study, women were recruited from multiple institutional and community sources, creating multiple starting points from which to snowball in order to ensure a diverse sample (Bloch, 2007). Moreover, clear protocols and referral pathways for participants were established at the beginning of the research process so that there were guidelines to follow if participants became distressed or re-traumatised by interview questions (Ziersch, Due, Arthurson, & Loehr, 2017).

It was made clear to participants that participation was voluntary (Mackenzie, McDowell, & Pittaway 2007), as those from more collectivist cultures may be reluctant to decline their participation in order to benefit their broader community (Ellis et al., 2007). In an effort to balance the power dynamic, and to build rapport between researcher and participant, author RBR spent time having casual conversations before beginning the interview (Mackenzie et al. 2007).

### **Data Analysis**

Braun & Clarke’s (2013) six-stage thematic analysis was used to analyse transcripts verbatim. After familiarization with the data, interviews were initially inductively coded. Codes related to factors contributing to mental distress and barriers to help-seeking were sorted into themes and codes for barriers to help-seeking were condensed into two broad, overarching themes. The codes within these themes were then deductively analysed using Andersen’s model, and identified as either ‘predisposing’, ‘enabling’, and ‘need’ factors, with discussion provided about this categorization throughout each of the inductively identified themes.

Overall, two main themes were identified, and within these, multiple sub-themes were described. The overarching theme of ‘social & cultural’ factors includes the sub-themes: stigma, cultural conceptualisations, domestic violence, husbands often acting as gatekeepers, and informal help-seeking preferences. The overarching theme of ‘structural & organisational’ factors includes the sub-themes; lack of knowledge of services/lack of appropriate services, English language proficiency, financial concerns, and transportation problems. With regard to the latter theme, structural and organizational barriers have been well-documented in previous literature (Colucci, Minas, Szwarc, Paxton & Guerra, 2012; Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006; World Health Organization, 2018; Franks, Gawn & Bowden, 2007; Chuah, Teng Tan, Teo & Legido-Quigley, 2018). Therefore, this paper will focus on the

more unique findings of social and cultural barriers to help-seeking for mental health services for Hazara women with refugee backgrounds.

## Findings and Discussion

### Social and cultural barriers to help-seeking

#### *Stigma*

Family reputation was described as highly valued in Hazara culture, with women responsible for caring for her children and husband. As a result, a woman's reputation also reflects her family's reputation within the community. Participants indicated that where women were perceived to be derelict in fulfilling this role, she may be at risk of social disapproval, often in the form of gossip. For example, Azadah (18 years old) said:

*They will think oh if everyone else in the community finds out, what will they say about me? [...] our family will have a bad image [...] the question is what will people say? [...] How will the community react to my condition, or to my health issues.*

Expressing personal problems may be detrimental not only to a woman's social status but also that of her husband and children. Participants reported not wishing to cause undue stress for their children, or not wanting to be a burden on other family members due to the stigma and social repercussions that may ensue from seeking help for their mental health concerns. In these accounts women's identity is equated with that of the family's – they are intricately linked. This may cause a woman to reconsider seeking help, as may risk reflecting poorly upon her family members, with Parisa (30 years) saying:

*Other people will not blame that girl, they will blame the family.[...] that's the thing that stops people to go to any service or anywhere to help them.*

As such, having a mental health issue and seeking help from a professional may be viewed as controversial within the community, as it would likely involve discussing family matters or marital issues. For fear of the social consequences, women may therefore choose to remain silent. For example, Parisa continued on to say:

*They will think that if they go to any service for help, other people will think wrong about her and her reputation will be very bad in my community. For example if people see that this woman is going to the other service they will think why she going? Is she mad? [...] people backbiting about her. That's the reason to stop women from going to any service.*

#### **Cultural conceptualisations of mental health**

In addition to (and sometimes contributing to) stigma, were cultural understandings of mental health, with age playing a key role. In particular, participants reported that older women in their community thought the act of visiting a psychologist was extreme, and that a person would have to be 'mad' or 'crazy' to do so, again reflecting the stigma often associated with understandings of mental health:

*Afghani people talk 'if you go to the psychologist' the Afghani people say 'you are mad, you are crazy' and maybe they can't make friend with you [...] if my mother go there people said my mother is nuts or crazy and the meaning of crazy and mad in my culture is very bad.[...] the psychologists has very bad name in my culture (Rana, 20 years).*

*You know in my country some people are going to mental health they say oh this is crazy because mental health is just for crazy people and their brain is not working (Qamar, 31 years).*

Beliefs about mental health are predisposing factors (Andersen, 1995), and as such, cultural conceptualisations of mental health (and mental illness) as “mad[ness]” or “crazy[ness]” are likely to lead to low levels of help-seeking.

While younger women reported that mental illness was seen in a negative light in their community as presented above, they noted that views on mental health within their generation were gradually changing. This was predominantly due to younger women in the community growing up in Australia, being aware of available services, and receiving education about mental health, as well as forming support networks within the broader Australian population. Azadah (18 years) said:

*I don't think I would care about what the community thinks because in this generation no one really cares anymore, in this younger generation. The longer you stay here, or the more educated you are, you'll think that way. But it also depends on the family you come from so if you're a bit more uneducated or if your family isn't as open minded, maybe you won't be willing to talk about it.*

Finally, mental distress was often related to physical symptoms such as headaches. Medical treatment was reported as being a preferred treatment for some women rather than talking therapies or counselling:

*In Afghanistan [...] they will say oh I'm not feeling well, I'm sick, I'm headache I need someone to talk to they will say oh you're okay take this medicine you will be okay. Like even they don't know what the medicine is, they have to take it (Parisa, 30 years).*

These reports are consistent with previous literature that highlight the frequency of refugee women in general (Kastrup, 2006), and specifically Afghan women resettled in Australia (Rintoul, 2010), presenting with emotional distress that manifests as non-specific somatic complaints such as headaches and pain. However, women in the current study also noted that these physical complaints were conceptualized by some within the Hazara community as contagious, and that those who physically exhibited symptoms may therefore be further isolated, as Lila (18 years) explained:

*They think like if this person has a mental health tomorrow I will I get in the same situation, [...] like I get mental health tomorrow, so they think like that. Sort of like flu you know.*

Overall, then, participants' accounts in interviews supported Andersen's (1995) stated predisposing factors in relation to help-seeking, highlighting that negative conceptualizations of mental health and illness related to culture are likely to inhibit help-seeking for individual women, who may feel stigmatization were she to seek help, particularly professional help.

### **Domestic Violence**

Participants in the study noted that the violence towards women that occurred in Afghanistan was a significant factor that predicted mental health issues for many women community members. Importantly, domestic violence (or violence more generally) was not explicitly asked about in interview questions; however, violence was often brought up spontaneously by participants when asked what the most significant issues for women were, or what would stop



a woman from seeking help, as seen in the extract from Saba (21 years) below, in response to a question about causes of any mental health issues Hazara women face:

*In my country the way that they experience is probably cos abusement and violent and mens there they don't care about if you get [...] killed in general. Or if you get [...] a disease or a mental health problem, they just don't care about you. So whatever they do to you is like pleasure for themselves, it's different cos most of those mental health problems are from abusement and from hitting.*

Previous research indicates that gender-based violence is not uncommon in Afghanistan, with studies with women in shelters in Kabul identifying experiences such as subjection to violence when attempting to leave abusive relationships, inability to leave the house without supervision from men, forced virginity exams, and threats of honour killing (Stokes, Seritan & Miller, 2016). Many of the accounts of women in the current study also point to the cultural differences and changes in gender roles that women experienced in Australia. For example, Saba continued on to say:

*They were treated really badly like they would be violent, they would be hitting them. Try to fight with them. So we had no quality as womens [...] there was no actual value for womens as here cos here we are same as men, we have the same rights whereas they have no rights. You cannot be standing next to a man's right. You'll be always down, you'll be always second. So we had nothing there like women were valued as nothing. They were just valued as something like an item, whenever they like to use it they use it, when they are done with it they just throw it away or trash it.*

Nevertheless, participants did recount experiences of domestic violence in their community in Australia. These experiences and the associated mental health issues were spoken about as something that many women were expected to endure, and remain silent about:

*If they are facing domestic violence, they will keep with themselves, they will not go for help to go to the police, to go to the doctor or any other service that will help them, they will never go. [...] if something happened to my mum she would never raise her voice because she has grown up in that environment – like you are brainwashed. She will never go to police, she will never go to any other person. She will like keep it with herself. (Parisa, 30 years).*

Related to the earlier sub-theme of stigma in relation to mental health issues, participants highlighted that seeking help for domestic violence also remained highly stigmatized, and would attract significant opprobrium from the community, as further noted by Parisa below:

*If for example an older woman go all through this, they think oh yeah maybe sick, maybe has something wrong with her, they will not say something. But for example if a woman has been through all domestic violence and she has raised her voice then people will say something about her.*

### **Husbands often act as gatekeepers**

In addition to threats posed by domestic violence, husbands were often perceived more generally as potential barriers to help-seeking. Participants mentioned that a spouse would most likely perceive a woman seeking help for mental health concerns as a negative reflection upon them, their relationship, or their family life.

*Their partner – unless there has been problem they don't appreciate them to go share, because they would definitely stop them. The partner would think if you share that they have this problem and it may look probably unusual for others because they think your woman's crazy [...] think you would be a joke. (Mahlia, 32 years).*

Importantly, there were differences in the way that participants discussed the issue of husbands as barriers or gatekeepers to services, which were based upon the age of both the participant and the men they were discussing:

*If the husband be young maybe he lets her for going to the psychologist but if her husband is old man maybe not let because old men is for a long time be in the Muslim country and there isn't any psychologists in there and maybe different between the old woman and the young woman. (Rana, 20 years).*

In general, then, participants highlighted that older men were more likely to impede help seeking for women than younger men. Andersen's model has been used to predict help-seeking for family and domestic violence (e.g., Fleming & Resick, 2017), however this study points to the possibility for extension of Andersen's model to consider family and domestic violence – and indeed in some instances the role of intimate relationships themselves - as pre-disposing factors.

### **Language and Communication**

As previous studies with refugee communities have illustrated (Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; Colucci, Minas, Szwarc, Guerra & Paxton, 2015; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006) lack of English language proficiency remains an enduring barrier to help-seeking for mental health services. Notably, in this study there appeared to be a paradoxical challenge for women with no English skills in relation to help seeking. That is, while women were required to attend English classes, mental distress restricted their ability to learn English, which in turn limited their ability to seek help for mental health. Notably, the two older women in the study reported having headaches, thinking about traumatic past experiences, worrying about separated family members, and finding it difficult to concentrate during English classes. Both women dropped out of classes within one year and stated that they had not attempted to learn English again.

*When I talk to them they say we can't learn at this age, and then I say you can! [...] But they are negative, they said we can't. And I guess they cannot because their minds are not here. [...] See my mum is here, her mum is there, she thinks about her. [...] She thinks about her past. She thinks, what is happening there? (Laila, 18 years on behalf of her mother, Jamilah, 59 years).*

*When she's going to the class she is getting headache, her foot is not well, one of them is hurting, and she went language class one year but did not learn anything [...] she's saying it's not like I'm not concentrating exactly, I will be thinking ohh what happened at home? Lots of things going in her mind [...] it's hard for her to concentrate, I think it is not time for her to study. (Giti, 23 years interpreting for Nailia, 60 years).*

These findings align with those of another study with Iraqi refugees in Australia (Slewa-Younan et al. 2015), which highlighted the impact that psychological distress may have on refugees enrolled in English language classes. The predisposing factors of ethnicity, in this case Afghan (Hazara) and English language skills were both pre-disposing barriers to mental health service use (Andersen, 1995). In participants' examples here, their low levels of English and

lack of ability to engage in English language classes compounded their ability, opportunity and subsequent decision to access mental health services.

### ***Informal help-seeking preferences***

Aligning with the aforementioned literature (Fleury, Grenier, Bamvita, Perreault & Caron, 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik, Eaton, & Bradshaw, 2009), participants in the current study reported a preference for relying on various informal support options rather than seeking professional services. This included particularly their existing social supports and – particularly for older women – religion). In relation to social support, women reported that discussing shared experiences including being separated from family members would relieve some emotional distress, as Rana (20 years) said:

*They find their friend or woman like herself and talk together and remove the bad events in their mind or anything that had effect in their memory.*

Participants also reported turning to family members for help, and older women in particular relied primarily upon on their adolescent or adult children. Some younger participants spoke about the stress that this carer role can cause:

*It's basically the kids who help the parents in terms of when they find a health issue or anything that is happening with their parents because they might be having depression. (Mahlia, 32 years).*

Religion was also reported as an informal help-seeking preference. There is research showing that religious belief can encourage an internal locus of control (associated with well-being), and may have positive effects such as enhancing acceptance and resilience (Behere, Das, Yadav, & Behere, 2013). This aligns with reports from women in this study, where religion was mentioned as a coping strategy - particularly for older women:

*My mum has always told me that if you have a problem, go pray. Pray because that connection with God will really help you. If you have a stronger faith that will really help you. And she says that if you turn to God He will always answer your questions. (Azadah, 18 years).*

On the other hand, younger participants who had grown up in Australia questioned the effectiveness of turning to religion for support with mental health. For example, whilst Azadah reported above that her mother drew strength from religion, she felt that “talk[ing] to someone” was also important:

*Maybe that faith will help you but at the end of the day I think you need to approach someone, you can't just rely on God. Sure he will help you, he'll answer your questions but he won't say something to you, you know what I mean? Maybe that faith, that connection will make you feel as if he's there for you and he's looking out for you but in reality you need a person if you really want that help, you have to approach someone, you have to talk to someone.*

Andersen's (1995) model includes social support and religion as pre-disposing factors for help-seeking, and in this study they mostly appeared to act as barriers. However, it is important to note that their effectiveness and value is not to be dismissed. Aligning with previous research with refugee populations regarding resilience and coping strategies, women drew strength and positivity from their social connections within the community (Correa-Velez & Gifford & Barnett, 2010; Schweitzer, Melville, Steel & Lacherez, 2006) and their strong faith in their religious beliefs (Schweitzer, Greenslade, & Kagee, 2007; Khawaja et al., 2008; Sossou, Craig, Ogren & Schnak, 2008; Lusk, Terrazas, Caro, Chaparro & Antunez, 2019).

### Discussion and Recommendations

The result of this study suggested that interconnected, complex social and cultural barriers to help-seeking exist in varying degrees dependent upon predisposing (Andersen, 1995) and demographic factors for women from the Hazara refugee community in Australia. Overall, Andersen's (1995) model appeared to be useful in relation to predicting help-seeking, with age in particular identified as a pre-disposing factor, together with stigma, cultural conceptualizations of mental health, social support, religion, and English language proficiency. However, this study also found that the women discussed high levels of domestic violence, including husbands acting as gatekeepers to help-seeking, which extends understandings of Andersen's model for use with the Hazara refugee community. Here, we discuss these findings and outline recommendations for best-practice.

Notably, participants' age seemed to influence reported experiences and perceptions throughout every theme. Older women were reported to be most disadvantaged in terms of service access, due to the increased likelihood that they face barriers such as low levels of English, isolation, stigma surrounding mental illness and domestic violence, and restrictive gender roles. A potential explanation for this is that age could be acting here as a proxy for education levels, whereby younger participants – like those from many cultural backgrounds – may be more aware of mental health and illness. There is less research with older women from refugee backgrounds from other age groups – and in this study accounts were often from younger women recounting their mothers' or other women's experiences. There are contradictory reports about age and its influence on help-seeking in Afghan culture more broadly (Slewa-Younan, Rioseco, Guajardo, & Mond, 2019) and thus this is an important area for future research.

Although domestic violence is a phenomenon in all cultural and faith groups (Devries et al., 2013), in this cultural context, due to the reported high levels of stigma, domestic violence issues appeared to be a key restraint to women's help-seeking for both domestic violence support and mental health concerns. Previous research indicates that there are complex intersecting factors associated with domestic violence for people from refugee backgrounds that may inhibit help-seeking including migration pathways, traumatic pre-arrival experiences, social isolation and resettlement stressors (El-Murr, 2018). More generally, previous research has suggested that women from culturally and linguistically diverse backgrounds (CALD) face inter-linked and overlapping barriers to access support for experiences of domestic violence including limited knowledge of rights/services, lack of cultural safety in those services, and family and community factors such as those noted above (Ghafournia, 2011; Harris, 2018; Vaughan et al., 2016). It is important for family and domestic violence – and the role of some husbands – to be recognized as a pre-disposing factor for help-seeking for mental health for women in this community. Moreover, it is important for service providers in this area not only to understand the general barriers to service access for this population but also that women from refugee backgrounds may be affected by experiences of domestic violence in different ways that subsequently influence help-seeking strategies (El-Murr, 2018).

The study also echoed findings of previous research pointing to various cultural understandings of mental health – including somatization or explanations of mental health in physical terms – as a potential barrier to help-seeking for women. Importantly, such differences in cultural understandings of mental health risk being interpreted as low mental health literacy, and therefore interventions may focus on education concerning mental health. However, Western notions of mental illness may make little sense in the context of the lives of many women with refugee backgrounds from Afghanistan, particularly older women. Nadeau and Measham (2006) suggest that working with clients, family members, and cultural brokers

to develop a *shared* understanding of mental health and wellbeing is therefore necessary. The results of this study further support these recommendations and highlight the need for service providers to understand the unique cultural ways in which individuals think about and prioritize mental health concerns in their lives. This may be particularly important for General Practitioners (GPs) who are the front-line services that most women will initially engage with. If GPs are not adequately aware of how women may discuss mental health, they may not make appropriate referrals to mental health support (Due, Green & Ziersch, 2020)

Utilising social support networks was a preferred strategy to seeking professional help from services, aligning with previous literature reporting that higher levels of social support are often correlated with lower service use for mental health services – although this may be because people are adequately supported rather than support being a barrier per se (Faccincani, et al. 1990; Fleury et al. 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik, Eaton, & Bradshaw, 2009; Sherbourne, 1988). For women in the current study, social support may include coping and healing strategies that are deemed ‘informal’ within Western psychological settings, but which could operate as formal healing practices within communities. Previous studies have recommended developing community-based mental health services that work to maintain and enhance the protective effect of individuals’ social support network (Faccincani et al. 1990). The social support networks that women reported using spoke the same language and often shared a collective experience of seeking refuge. If women more easily trust and relate to people of their own culture, then training community members as mental health professionals would ensure that Afghan – and particularly Hazara - women have the option of choosing services that are more culturally appropriate and that they may feel more comfortable attending, with less attached stigma.

Given the barriers that many women reported regarding language and communication, it is likely that outreach English language classes and mental health support may be more effective than the current model in Australia. Necessarily, these services would require teams of teachers, bi-cultural workers, mental health workers, and interpreters with appropriate, culturally responsive, training. Importantly, English language classes could be an avenue for teaching women about helpful services for mental health and domestic violence support. Women-only, group sessions for education and therapy may be more effective in this regard, given the collectivist culture and frequent gender-segregated practices of much of the Hazara community (Gondek et al., 2015; Felsman, 2016). Similarly, given the fact that the Muslim faith was portrayed as being highly significant in many participants’ lives, there may be an opportunity to incorporate mental health literacy into religious practices or Khutbahs (Islamic sermons) to draw attention to, educate about, and reduce stigma surrounding help-seeking for mental health services.

While this study has provided important information concerning mental health and help-seeking for women with refugee backgrounds from the Hazara community, it is not without its limitations. A small sample size and snowball sampling within a tight-knit community means that results may not be generalizable. Instead, these findings should serve as a basis for future research, particularly concerning family and domestic violence. The use of family members as translators may also be problematic. Although we chose to respect participants’ preferences for family interpreters, this may have meant that they felt uncomfortable to discuss certain topics. For future projects of this type a research team, including bi-cultural workers and interpreters, is required to ensure that the voices of those who do not speak English are included. Indeed, as this research suggests, older Hazara women with no/low English proficiency may be those with the greatest unmet needs.



## Conclusion

This study highlights the importance of understanding the unique situation of the lives of many women from refugee backgrounds, both from a theoretical and applied standpoint. The study points to a range of barriers to mental health help-seeking, including differences in ways of conceptualising mental illness, husbands acting as gate keepers, and stigma surrounding mental health. The study also points to the complex interactions of what are considered pre-disposing variables (Andersen, 1995), including the ways in which social support and religion may act as barriers to access to professional services, while also offering protection from mental illness. Importantly, young women in the study expressed concern that their mothers and grandmothers did require further support.

In relation to family and domestic violence specifically, the National Plan to Reduce Violence against Women and their Children (Commonwealth of Australia, 2016) and the Intimate Partner Violence in Australian Refugee Communities review (El-Murr, 2018) highlight the issue of domestic violence in CALD communities and the importance of early intervention and for services to practice in a culturally safe manner. Considering this, as well as the findings of the current study, it may be necessary for women from this group presenting with mental health issues to any service to always be assessed for family conflict or domestic violence. In general, however, the study points to the need for training and resources to reach out to women who may be isolated to offer support and assistance that is culturally safe and responsive to their own living situations, beliefs, and past experiences.

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# Learning through Life Narratives in Environmental and Community Psychology

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*This project was conducted as part of pedagogical process designed to engage community psychology students with the stories of community psychology researchers and practitioners in the field using oral histories. The oral history in this project is that of an environmental psychologist, provided in conversation with a community psychology student to explore the intersection of community psychology and environmental psychology. The project aimed to connect classroom learnings with greater understandings of current work being done in the field, offering an opportunity to witness the narrative of a practitioner and to reflect on the relevance of the story to hopes and ideas for future practice. In analysing the information from the oral history, two major themes were generated: resource-collaboration and values-led practice. These themes are considered as they relate to community and environmental psychological work, and reflections are offered from the student perspective pertaining to implications for future learnings, praxis, and social change.*

**Key words:** community psychology, environmental psychology, oral history, storytelling, pedagogy

In my experiences as a student of the Master of Applied Psychology (Community Psychology) course at Victoria University, I am particularly intrigued by the intentional and values-driven approach to practice. For me, this course is building upon my previous and current participation in spaces which focus on equity, connection, continued learning, and adapting to meet individual needs – such as my work in a community health setting, my previous research on the psychology of climate change, my participation in community psychology events, and my connection with a group of psychologists interested in the gendered issues relating to women and psychology. I am grateful to have connected with a remarkable network of supervisors and mentors to guide me through the application of community psychology frameworks, such as reconsidering power structures, maintaining a social justice focus, and considering interactions of societal and individual systems.

As I develop my understanding of these community psychology approaches and theories, I am finding that they are being integrated with my ongoing interest in the psychology of climate change. I am curious about the role that community psychology as a discipline could have in this space, and the ways that a coalescence of community and environmental psychology might manifest in practice. As an avenue of exploring these emerging questions, I decided to speak with an environmental psychologist as a part of my coursework, alongside an oral histories project undertaken with my cohort in the community psychology course.

## Method

### Project Aim

The broader oral histories project aimed to gather stories of community psychology to explore the diversity of research and practice in this field, and to summarise and critically analyse key

experiences and various influences that have shaped the journeys as shared by key informants. Community psychology students were given the opportunity to interview psychologists who had worked in the field of community psychology in order to learn about the everyday realities of research and practice in the profession we would soon be entering, and the potential applications of the theories and frameworks we had learned. We were invited to explore areas of interest and curiosity as they pertained to community psychology and our personal/professional journey. We considered who might be key informants best positioned to answer questions about being and becoming a community-engaged practitioner, researcher, and change agent.

In seeking a psychologist who shared my interest in community and environmental psychologies, I connected with Susie Burke, who has worked in this area for many years in a range of organisational, community, and clinical practice settings, using her knowledge and experience around disaster recovery, transitioning to a climate-safe future, speaking with children about climate change and how to help people cope with existential climate grief. I hoped that in speaking with Susie and hearing her story that I could develop greater insight into her experiences in this space of community and environmental psychologies, particularly to gain a deeper understanding of what practical environmental psychology entails, and the ways that community psychology contributes to Susie's work in a challenging yet vitally important and ever-changing field.

### **Oral History Methodology**

The power of storytelling and life narratives has been documented in a range of contexts, including in teaching and learning (Landrum, Brakke, & McCarthy, 2019; Stovold, 2014). Oral history is a method of knowledge production that encourages engagement and reflexivity with narratives of lived experience (MacKay, 2016), so was chosen for use in this project. The democratic and collaborative nature of oral histories are well-aligned with community psychology research, as are the processes of critical reflection and resituation encouraged by this praxis (Llewellyn & Ng-A-Fook, 2020; MacKay, 2016). Mulvey et al. (2000, p. 885) wrote that "stories allow shifts across time and context, while facilitating contextualized, multilayered understanding of personal identities, social relationships, and cultural landscapes". This methodological process is well-aligned with the aim of the combined oral histories project, which was to engage in conversation and to bring together classroom learning with the journeys of psychologists, academics and others in order to develop a better understanding of the field and associated theories, methods, practice and roles. Within my project with Susie, I aimed to engage in the oral history process to witness her story of working at an intersection of environmental and community psychologies, and to reflect upon relevance to my own journey beginning in this space.

### **Project Design**

In preparing for and designing the project, I first contacted Susie Burke via email to explain the project and to allow her to consider her interest in participating. Consent to participate was received through an affirmative email response and verbal consent at the time of the interview. There was no formal ethics application for this interview due to its place within a classroom exercise. The interview schedule was created with a focus on exploring the pathway to Susie's current role, and the effect of community psychology theories and approaches on Susie's practice. This schedule was not negotiated with Susie ahead of the interview; it was developed with the intent of guiding the conversation to meet the project's aims rather than as a prescriptive tool, allowing for organic conversation throughout.

## Data Collection and Analysis

The interview with Susie was arranged for a mutually convenient time and lasted around one hour. This interview was conducted over video conferencing software to allow for myself and Susie to adhere to social distancing and COVID-19 lockdown requirements at the time of the project, and to reduce the constraints of time and distance that affect face-to-face meetings. Research indicates that face-to-face and video conferenced interviews do not substantially differ in regards to relationship, rapport and disclosure of information (Jenner & Myers, 2019). I feel that this generally aligns with my own experience in speaking with Susie, as we were able to speak quite freely and I felt I developed a good sense of her journey and her practice, as much as is possible in a relatively short time frame. The interview was recorded with consent and used to create a verbatim transcript. A categorical-content analysis approach was adopted for data analysis, in which the content of a narrative is analysed and explored for clusters of meaning through repeated reading and re-reading of the transcript (Hiles & Cermak, 2011; Langridge, 2007). Through this approach, emergent categories were determined through their frequency, significance, and relevance to the topic. These emergent categories were then analysed to explore overarching themes which were determined and revised to ensure they appropriately met the project aims. Given the personal nature of storytelling and oral histories, this project aimed to emphasise the shared authority of Susie's oral history and the manuscript by requesting feedback from Susie at key points in writing, to ensure that her story was not being misrepresented and for Susie to be comfortable with the information being shared. At each point of contact, Susie affirmed that she did not have reservations about her story as it was represented, and was comfortable with further dissemination.

## A Summary of Susie Burke's Oral History

This section summarises the key aspects of Susie's oral history, and is interspersed with quotes from Susie to illustrate her thoughts and retain her voice. In speaking with me about her work at an intersection of environmental and community psychology, Susie shared her journey as it began in a clinical psychological setting. Whilst Susie completed her masters and PhD in clinical psychology, her focus – on social support and stress in women with breast cancer – drew upon her interest in group work and community psychology-aligned considerations of transformative change and holistic wellbeing.

During her time at university, Susie was introduced to the group Psychologists for the Prevention of War (later called Psychologists for Peace), which she describes as a key point in her professional journey. Susie's discussion around this group indicated that her membership, the connections with other psychologists involved, and the immersion within the broader theme of peace psychology, were key in forming Susie's work and career path; Susie later became the national convener. This group provided a space for Susie to do work that she was "drawn to", on "finding the underlying points of connection as being a way to transform conflict". This work was also crucial to Susie's role within an ecovillage she lived in, wherein she facilitated groups and provided education and support for conflict resolution.

Susie spoke about her connection with Psychologists for Peace and with influential members as key in leading to her next roles at the Victorian Parenting Centre and then the Australian Psychological Society (APS), where she stayed for 17 years. Susie's time at the APS was spoken of fondly, and it was clear that Susie found great meaning in the work focussed on community psychology/societal issues, such as: homelessness and issues of housing security, disaster recovery, Indigenous issues, parenting issues and family violence prevention. Over time, the team grew to create a "lovely team" of community psychologists who together had a wide range of professional interests that let them work on many projects for the benefit of APS

members and the general public. In this work, Susie created many tip sheets and resources for the public, and enjoyed using her ability to adapt “incredibly dry academic, pedantic language into user-friendly language”. Susie also spoke of her excitement and delight when she was able to work with a community psychology student on placement who shared her interest in the psychology of climate change. This led to the creation of the Climate Change Empowerment Handbook (Australian Psychological Society, 2019), using Susie’s knowledge translation skills and climate change research to distil the literature into eight psychological strategies for engaging with climate change.

When Susie reflected on the skills she used in creating these resources and of her knowledge of environmental psychology, she considered the importance of an informal mentor-mentee relationship. Susie learned about environmental psychology from an expert in the field, who had studied environmental psychology in the USA where it is given a more robust focus than has been seen in Australia. This working relationship embodies Susie’s self-identified “upward orientation”, which she describes as an inclination to seek people who she “trusts and respects” and are more established, knowledgeable, or “expert” (Susie also explained the contrasting “downward orientation”, involving an inclination to work with people who are more junior in order to teach and inspire).

Susie reflected on more recent changes to her career, particularly the effects of a transitional stage at the APS and the subsequent changes to the work that she had been able to do autonomously, for the public good, with the colleagues that she had enjoyed working with. Susie spoke of her decision to leave the APS and pursue further meaningful work as a decision made in line with her values – appearing to be a strong moment of integrity – and with one of her personal rules: that she will only work with people that she believes share her values. These strongly held values were mirrored in other transitional decisions in Susie’s journey, both in relation to her professional workplaces and her activist practices.

Currently, Susie draws upon many of her past projects, roles, and learnings to inform her work in private practice as a registered generalist psychologist, as a consultant in environmental psychology for local organisations and councils and as a facilitator for holistic case discussion in a Balint group with local GPs. Susie describes herself as an environmental psychologist to reflect the many years of work and learning she has done in the realm of climate change mitigation and response, and when considering her identification with environmental psychology, she reflected on the importance of diversity within broader psychology, particularly for social issues. Susie spoke of the paradox of critical issues – especially climate change – receiving such limited attention within Australian psychology, despite these specialisations or disciplines “booming” in other parts of the world. Susie described finding great meaning in being able to use and share her knowledge and experience in environmental psychology and climate change mitigation and response. Susie speaks about her work in this area being driven by her knowledge of the importance of addressing this existential threat, almost as a calling that lets her incorporate her values, such as peace, integrity, and responsible action, with the knowledge and skills developed over her career.

In the future, Susie hopes to continue with her private practice and consulting whilst enjoying the time spent with her children while they are still living at home. Susie also plans to further develop her work in climate activism, noting specifically a “Ground Hug Day” campaign, in which people dedicate one day per week to climate emergency work. It is clear that Susie will continue to be driven by her values, to promote peaceful and climate-safe futures.



## Key Themes

In analysing the information from Susie's oral history, themes and subthemes that became apparent were: *resource-collaboration* (in mentorship, and in groups); and *values led practice* (sustaining practice and informing transitions).

### Resource-Collaboration

Susie spoke not so much of key experiences in her career, but of key people and influential collaborations, with Susie summarising: "pretty much everything that I work on always has an acknowledgement of the importance of working together with other people". Susie's role and the approach she takes to her practice appear to be aligned with the resource-collaborator ("scholar-activist") role described by Nelson and Prilleltensky (2010), characterised by strong collaborations with others, especially with community groups, using these collaborations to develop and share resources, as opposed to the traditional applied psychology role of expert ("scientist-practitioner").

### In Mentorship

Susie spoke of the significance of her ongoing collaborations with key people in informal mentorship roles. Susie often linked these mentorship collaborations with her self-described "upward orientation", reflecting her valued relational experiences of learning from and being inspired by "cleverer" and "more expert" people. Susie also was "delighted" at the chance to work with a community psychology student on placement, a relationship in which she presumably adopted a more supervisory and guiding role.

Many of Susie's key relationships have been sustained across many years, across geographical distance, workplace changes, and many, many projects. These collaborations played a large role in Susie's practice of developing and sharing resources for community benefit.

### In Groups

Susie's inclination to work with groups has been evident throughout her journey, beginning with her PhD on therapeutic and social support groups for women with breast cancer. Susie's role within her shared home in an ecovillage encapsulates community-led resource-collaboration; Susie assisted in conflict resolution as needed whilst also sharing her knowledge of the psychology of conflict resolution, supporting others to apply the model as it made sense in the community. As Susie explained:

*[Conflict resolution skills] became a real feature of what we were all learning to do, share resources, share this space together and deal with people that wanted to have cats and dogs, which is where most of the conflict in intentional communities comes from apparently.*

Whilst this was not a professional role, Susie used her knowledge in a way to support the community to have the skills it needed whilst avoiding assuming a hierarchical, expert position.

Collaboration within like-minded groups and teams has been a consistent and central component of Susie's professional practice, particularly with the Psychologists for Peace group and with the social issues department of the APS. While resource creation and sharing was a major component of Susie's work in these groups, these resources took a more expert position. This may have been related to the sources of the information (i.e. scientific literature), or the due to the broad nature of dissemination acting as a barrier to community collaboration. In this

work, Susie acted as a bridge between the “impenetrable scientific language” of research and the audience, who benefited from Susie’s skill in translating, simplifying, and disseminating resources that were previously largely inaccessible.

### **Values-Led Practice**

Susie evidently lives and works in accordance with strong values. Her projects, therapeutic work, and ongoing professional connections with respected colleagues reflect guidance from her values: from a focus on peace, as explicitly identified by Susie, and from integrity, collaboration, courage, respect, sustainability, and hope for collective and ecological wellness. Collaboration and collective wellness are both identified as core values in community psychology (Kloos, Hill, Thomas, Case, Scott & Wandersman, 2020). Susie’s focus on collective and ecological wellness also relates to an argument posited by Prilleltensky (2001) that psychologists often pay greater attention to individual and relational wellness than collective wellness, and that this imbalance ought to be addressed through phases of praxis beyond reflection and research to incorporate social action. Susie also indicated her hopes that psychology as a discipline would continue to develop a greater focus on the potential for transformative change in the social issues space.

Susie’s strongly held value of peace influences both her professional practice and her activist relationships and methods of activism. The influence of this value in Susie’s work parallels the message conveyed in work by Rose (2004) – that too often actions of the present are excused in pursuit of an imagined ideal future, which then paradoxically becomes unattainable. While Rose wrote this specifically in relation to moral engagement with the ethics of decolonialism, the broader concept of *the ends justifying the means* is one that Susie has also explicitly countered as it relates to non-violent direct action, in line with the deeply held value of peace.

### **Sustaining Practice**

Susie’s work has predominantly entailed working in the psychology of social issues that are important to her, particularly related to environmental psychology and climate change. Susie spoke of significant challenges in her practice, particularly in the face of the global and existential threat posed by the climate crisis. Susie’s discussion of being true to her values indicated that her values-led practice fosters a sense of meaning, motivation, and empowerment. Having these qualities in her professional roles serves to sustain her practice in the areas most important to her.

### **Informing Transitions**

Susie spoke of key transition points in her career, and of her inclination to be guided by her values in determining her future steps. Susie would evaluate the values most important to her that she wanted most to uphold in her practice and her workplace and consider how she could shape her career to be true to these. In many instances this process involved competing values, which needed intense reflection and deliberation in a difficult decision-making process.

### **Reflections**

In witnessing Susie’s oral history and in reflecting on the links to my own interests and questions, I consider my understanding and naming of this space as an intersection of community psychology and environmental psychology. Although Susie identifies herself as an environmental psychologist with general registration, I understand her environmental psychology practice as being informed by community psychology theories, frameworks, and approaches. A focus on resource-collaboration, values-led practice, and transformative change

of social issues are not inherent to environmental psychology, however have been crucial aspects of Susie's work.

An aspect that arose during this project for me was the unmaking and rebuilding of psychological contributions to communities from a collaborative and non-hierarchical standpoint, rather than from the expert vantage point. This arose particularly in Susie's discussions of her work creating resources for communities and providing community-led support. I am in the ongoing process of unlearning the expert role as psychology's default, and was reminded of my first community psychology placement, at Daughters of the West (a holistic health promotion program set in the western suburbs of Melbourne, Australia). Working in this community setting needed me to shift away from the expert role into something more helpful for that space. Through supervision and reflection I considered what the expert role can provide – and how as a provisional psychologist, in early career stages, the familiar structure of this expert role may act as a comforting guide for new practitioners who are uncertain or unfamiliar with other options. I found the intention and meaning in the decision to move away from this default expert approach to be crucial in balancing the discomfort of moving away from the familiar. In Susie's discussions of her varying experiences of sharing and developing resources, I was prompted to consider the importance of tailoring the approach to the situation and the community.

I find myself curious about the upwards- or downwards-orientation discussed by Susie, as in some ways this seems to reinforce hierarchy. However, this could also be an acknowledgement of contextualised differences in experience and knowledge. When speaking about the concept of being upwardly-oriented or downwardly-oriented, Susie said that people tend to identify with either one or the other, and encouraged me to consider my own preference. Initially I related to the upwardly-oriented experience that Susie described, as I also appreciate the opportunity to learn from people who are more established and that have the "teaching and inspiring" skills associated with being downwardly-oriented. This is potentially more related to my current environment and roles as a student and as a provisional psychologist on placement; I currently do not have many opportunities to work professionally with people in a teaching and inspiring capacity, and instead find my most influential professional relationships are with peers and supervisors who are equally or more established in community psychology than I am.

Given the importance of group collaborations in Susie's journey, I was reminded of Bronfenbrenner's social-ecological systems model (1979), which I considered in relation to Susie's work. It is apparent that Susie has found groups to be useful across multiple levels. When working with an individual, or in small group settings, Susie spoke about the considerations she gives to broader level influences, such as social support networks, the role of stressors of family and work life, and of cultural and planetary systems influences – particularly of climate change. Susie also works with these broader macrosystems as an explicit focus in producing resources and in advocating for positive social change. I found these links between theory and practice to be an interesting illustration of community and environmental psychology praxis, particularly due to the varying levels that Susie works in – an approach to practice which also resonates with me and my hopes for my future career.

Susie's discussion around the importance of finding the group Psychologists for the Prevention of War (Psychologists for Peace) indicates that this was a clear cornerstone of her career and prompted me to consider the importance of the people I am learning from in my current community psychology course. I consider myself fortunate to be making the connections and to have the opportunities for learning and practice that I do within community

psychology and I can see this being a similar cornerstone. Many of my colleagues have shared interests and approaches to psychology and I am hopeful that we will have similar longstanding relationships as Susie found in Psychologists for Peace.

Susie's practice was clearly informed by strongly held values such as sustainability, integrity, courage, respect, and peace. I reflect upon how my own journey in community psychology is emerging as informed by my own values, particularly relating to social justice and equity. Susie's recognition of the importance of collaboration also resonates with my hopes for my future practice and my preferred approach to learning and working. In considering how Susie used her values to inform key transition points, I can see the importance of clearly knowing and evaluating one's own values in a reflective and ongoing process, a learning which I am sure will also be important in my future work. I see the relationships between values-led practice and social change in community psychology as relating to a call by Cornish, Campbell and Montenegro (2018), for community psychology to embrace a politics of hope, rather than despair, as a part of reinvigorating community psychology's contribution to scholar-activism.

### Conclusion

This project was immensely rewarding and valuable for exploring my interest and curiosity in community psychology and environmental psychology, and for considering the relevance to my own experiences and future practice. I have found witnessing and reflecting on Susie's oral history to be useful in understanding the ways in which people may navigate and create their psychological practice, whilst facilitating greater learning about my own ways of being and becoming a community psychologist. Through Susie's story, the prominent themes of resource-collaboration and values-led practice are an attestation to the influence of community psychology approaches in practice. These reflect Susie's valued collaborations, particularly with mentorship relationships and with groups, and reflect the role her values play in sustaining her practice and offering guidance in transition points. The role of connection and hope have been reinforced as central to mitigating burnout and stagnation whilst affirming the role of the scholar-activist/resource-collaborator. Susie's approaches to her practice resonate strongly with how I hope to practice in the future, across multiple social-ecological levels and in areas where community psychology can contribute to transformative change in social issues. I am hopeful that in working in a values-driven way in environmental psychology, as Susie has done, I will be able to support healthy and just communities in ways that are meaningful to me personally and professionally.

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