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ENGAGING COMMUNITY IN A CYCLE OF PRAXIS

Multicultural perspectives on personal, relational and collective wellness

This study employed an action research model known as the community wellness cycle of praxis in research with culturally diverse community members from the St Albans region (Melbourne, Australia). The major aim of the study was to gain a theoretical and pragmatic understanding of well-being from a multicultural perspective. In order to meet this aim, a qualitative study was designed to find out (1) What are the community ideals; needs; and strengths of residents of St Albans, and (2) What actions can be undertaken to improve the well-being of the community? The research involved focus groups with a total of 29 Anglo, Maltese, Vietnamese and Italian community members. The first research question was addressed by asking community members systematically about positive and negative aspects of personal, relational and collective well-being. The second research question was addressed by asking community members to generate ideas on what could be done to improve well-being and by identifying issues of concern that emerged throughout the research. The issues identified by participants offer a rich picture of community ideals, strengths and needs, as well as possible actions that could improve personal, relational and collective wellness in St Albans.

Keywords community well-being; community wellness model; community wellness cycle of praxis; multicultural; qualitative research

Cette étude utilise un approche de recherche action *connu sous le nom du* cycle de bien-être de praxis *de recherche avec des membres culturellement varies dans un banlieue de Melbourne (Australie). Le but principal de l'étude était de comprendre théoriquement et pragmatiquement bien-être dans d'une perspective multiculturelle. Dans ce perspective étude qualitative a été conçue pour identifier (1) ce que sont les opinions des groupes diverses; leurs besoins et leurs atouts, et (2) de quelles actions peuvent être entreprises affin d améliorer le bien-être de ces groupes? La recherche a utilisé 29 Anglo-Australiens, Maltais, Vietnamiens et Italiens. Les premières questions ce sont posées a propos des aspects positifs et négatifs de bien-être individuel et collectif. Ensuite des questions ont été demandé à propos des idées sur ce qui on pourrait être fait pour améliorer le bien-être et en identifiant leurs soucis. Les soucis identifiées par les participants offrent une image riche des images et des représentations leurs atouts leurs, aussi bien que les actions qui pourraient améliorer le bien-être individuel et collective.*

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Mots cléfs cycle de praxis; perspective multiculturelle; recherche action qualitative; individuel et collectif

Introduction

Praxis

This paper integrates our research and action interests through the concept of praxis. It is through praxis that we combine our theoretical interest in wellness with our practical concern for action. This is a modest attempt to illustrate how an emerging conception of wellness can be applied in a multicultural context and lead to action through a cycle of praxis.

While potentially useful, the concept of praxis has often been defined inconsistently and ambiguously. In this paper we conceptualize praxis theoretically and operationally. The paper begins with a brief review of praxis and presents a framework for informing theory, research and action. To refine and validate the model, the first author[1] conducted focus groups with four culturally and linguistically diverse groups of St Albans, Melbourne, Australia.

In Greek, *praxis* (πραξι) means action (Hionides, 1987). However, in line with Aristotle's reasoning that both praxis (action) and theoria (theory) are important (O'Brien, 1998), the term is most often used to refer to the combination of theory and action. Seng (1998) provides an informative summary of the historical basis and usage of the term:

> From Aristotle through the Medieval Scholastics, and on through Kant to Marxist philosophers of science and political economy in the 19th and 20th centuries, praxis has to various extents implied an integration of theory and practice . . . . Today, the word praxis appears often in feminist and critical discourse. It connotes activism and consciousness about one's work, drawing on the politicizing of the philosophical term by Karl Marx (1977) and Paolo Freire (1970). Key elements in the modern and postmodern historical development of the concept of praxis include integrating practice and theory, combining reflection and action, working with 'the people,' and working to cause change.
>
> (Seng, 1998, p. 4)

The idea of working with the people to bring about change is similarly reflected in *action research* as outlined by Curtis, Bryce, and Treloar (1999):

> The role of the researcher in action research is to participate meaningfully and productively in the knowledge-generating processes of the group. The development of options for change and definitions of effective change are products of collaborative action, reflection and negotiation. In action researching approaches, the participants are themselves taken to be the experts in their own lived experiences.
>
> (pp. 202–203)

Although praxis and action research are conceptually related, O'Brien (1998) suggests that praxis and action research are not the same construct. O'Brien claims that action research is a *method* while praxis is a *research paradigm*. He also claims that action research belongs, epistemologically, in a praxis research paradigm rather than in positivist or interpretive paradigms (O'Brien, 1998). While the positivist paradigm is mainly concerned with objective fact-finding, and the interpretive paradigm with the discovery of subjective meanings, praxis is about *vision* and *action*.

As implied by the name, action research can be described as 'action to bring about change in some community or organisation or program' and 'research to increase understanding on the part of the researcher or the client, or both (and often some wider community)' (Dick, 1993, p. 5). According to Dick some action research focuses more on action while in other forms research is the primary focus. In both approaches, however, it is possible for action to inform understanding, and for understanding to assist action (Dick, 1993).

McKernan (1991) posited a typology consisting of scientific–technical, practical–deliberative and critical–emancipatory to classify and review existing theories and models of action research. The critical–emancipatory form appears most related to the praxis paradigm as does the concept of 'participatory' action research. Participatory action research, according to Hall (1993), 'is a way for researchers and oppressed people to join in solidarity to take collective action . . . for radical social change' (p. xiv). Discussions regarding critical–emancipatory and participatory action research are gaining strong momentum in community psychology literature (see, e.g. Boog, Keune, Lu, & Tromp, 2003; Coenen & Khonraad, 2003; Nelson & Prilleltensky, 2005; Roberts & Dick, 2003; Valkenburg, 2003).

Action research as a method involves a cycle of various stages or steps, which begins with reflection and leads to action. Most authors acknowledge the social psychologist Kurt Lewin as the founder of action research (Dick, 1993; Kemmis, 1988; Kemmis & McTaggart, 1988; Nelson & Prilleltensky, 2005). Lewin's 1946 paper titled: 'Action Research and Minority Problems' clearly demonstrates both the use of the term action research and the method of action research as a cycle of planning and action. Lewin's system consisted of a circle of activities that could be repeated in spirals, with each circle consisting of analysis, fact-finding, conceptualization, planning, execution and evaluation (Kemmis, 1988).

Another cyclic model by Grundy and Kemmis (1981) consists of repeating cycles, with four steps (plan, act, observe and reflect) in each cycle. Another more complex model developed by Susman (1983) consists of five phases beginning with problem identification; considering alternative courses of action; selecting a course of action; studying the consequences of an action; and identifying general findings. This five-stage cyclical process is repeated until the problem is resolved.

Prilleltensky (2001) has also developed a cyclical model of action; one built on critical–emancipatory theory, the concept of wellness and praxis. According to him, praxis refers to a cycle of activity that includes philosophical, contextual, needs and pragmatic considerations (Prilleltensky, 2001). The cycle of praxis begins with philosophical considerations about values that are capable of promoting personal, collective and relational wellness. This stage probes an *ideal* vision and answers the question *what should be?* The cycle continues with research on *needs* or *what is missing?*

and *contextual factors* or *what is*? The fourth *pragmatic* stage is about *what can be done*? (Prilleltensky, 2001).

Community wellness

The community wellness model (Nelson & Prilleltensky, 2005; Prilleltensky, in press; Prilleltensky & Nelson, 2002; Prilleltensky, Nelson, & Peirson, 2001; Prilleltensky & Prilleltensky, 2003a), briefly presented in table 1, consists of three *levels of* wellness (personal, relational, collective); a series of corresponding values; and the assumption that wellness derives from the *synergy* of personal, relational and collective well-being. The authors define wellness as a positive state of affairs, brought about by the simultaneous and balanced satisfaction of personal, relational and collective needs of individuals and communities alike. These needs are satisfied by the presence of cogent values and adequate material and psychological resources. The theory posits that there cannot be wellness but in the synergy of personal, relational and collective strengths. Physical health, for example, is not tantamount to wellness in the presence of discrimination at the relational level and lack of opportunity for economic security at the collective level. Thus, there cannot be wellness but in the combined presence of personal, relational and collective well-being. The terms wellness and well-being are used holistically and interchangeably in this paper. In either case, we refer to a holistic state of affairs, as opposed to a particularistic approach to either mental or physical or economic well-being (Prilleltensky & Prilleltensky, 2003a). For us, wellness is a comprehensive state of affairs.

The community wellness project

In 2001, researchers from the Wellness Promotion Unit of Victoria University in Melbourne initiated an action research project that aimed to refine the Wellness

TABLE 1 Community wellness model: a synergy of personal, relational and collective well-being (adapted from Nelson & Prilleltensky, 2005; Prilleltensky & Nelson, 2002; Prilleltensky et al., 2001)

	personal	*relational*	collective
			
Community wellness model	Sense of control over one's life, physical health, love, competence, optimism and self-esteem	Social support, affection, belonging, cohesion, collaboration, respect for diversity and democratic participation	Economic security, social justice, adequate health and social services, low crime, safety, adequate housing and social structures (e.g. educational, recreational and transportation facilities), and a clean environment

Model by grounding it in an applied and multicultural setting; and facilitate community improvement in the multicultural western region of St Albans, Melbourne. The project involved a partnership with Good Shepherd Youth and Family Service (GSYFS) and was funded by the Australian Research Council. This project, known as the Community Wellness Project, consisted of three independent studies undertaken by student researchers over two phases. Phase one consisted of one study with professionals/service providers (Robertson, 2003) who work in the St Albans area and one study with culturally diverse community members who reside in the area (Totikidis, 2003).[2] The first phase research was exploratory and focused on ideas/dialogue for action rather than action itself, while the second stage is focused on Social Action with Youth (Morsillo & Prilleltensky, in press; see also Morsillo).[3] Only the first phase of the research, conducted with culturally diverse community members is presented in this paper.

Community wellness cycle of praxis

In an effort to operationalize the aims of the broader project, which was concerned with grounding the wellness model and facilitating action to improve well-being, Totikidis (2003) integrated Prilleltensky's community wellness model and cycle of praxis with Roth's (1990) theory of needs. This lead to the formulation of a new model referred to as the Community Wellness Cycle of Praxis. This model is presented in figure 1.

According to Roth, need (N) can be defined as the discrepancy between a target state (X) and an actual state (A) as expressed in the equation: $X - A = N$. The target state (X) in the above equation can represent an ideal state, a norm, minimal satisfactory state, desired state or expected state (Roth, 1990). Prilleltensky's (2001)

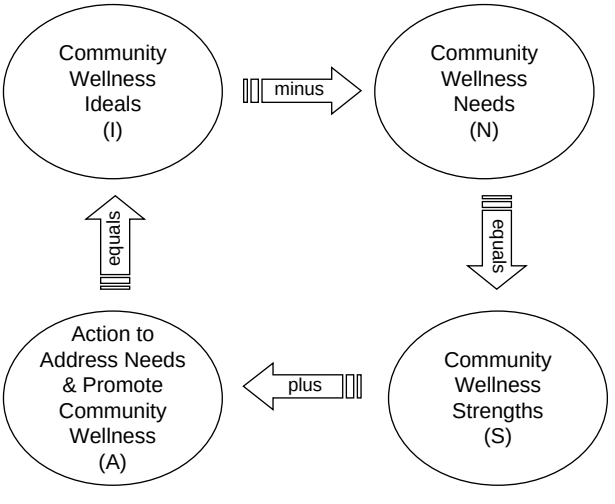

FIGURE 1 The community wellness cycle of praxis: a synthesis of theory and practice (adapted from Prilleltensky, 2001; Prilleltensky & Nelson, 2002).

cycle of praxis reflects parallel components (philosophical, contextual, needs) with the additional pragmatic or action component.

The result of the synthesis of needs, praxis and wellness theories may be expressed in two simple equations where S = I − N, and I = S + A, and where (I) are community Ideals, (N) are Needs, (S) are Strengths and (A) is Action to address needs. Needs are the negative or missing aspects while strengths are positive and existing indicators of community well-being (e.g. low crime, adequate educational facilities, good health). For the ideals (I) to be fulfilled (A) will have to be equal to or higher than (N). If Actions are less than the Needs identified, the Ideal will not be reached. Actions may exceed the level of Needs, in which case a higher plane of Ideals is reached, but if Actions fall short of meeting Needs, the Ideal state of affairs will remain out of reach. To put it succinctly, I = S + A only if A is equal or higher than N.

Aims and research questions

The major goal of the present study was to employ the community wellness cycle of praxis in research with diverse community members from the St Albans region in order to gain a theoretical and practical understanding of well-being from a multicultural perspective. In order to meet this goal, a qualitative study was designed to find out (1) What are the community[4] ideals; needs; and strengths of residents of St Albans, and (2) What actions can be undertaken to improve the well-being of the community?

Method

Participants

The research with community members consisted of two pilot individual interviews and four focus groups. Only the focus groups are discussed in the present paper. Participants for the Italian, Maltese and Vietnamese focus groups were recruited by a key person from each cultural group following communication between the first author and the key person over a number of weeks. The Anglo group was recruited from the St Albans shopping precinct with several referred by GSYFS staff. The participants included a total of 29 people (15 females and 14 males) aged between 18 and 70. The groups were selected from the four major cultural groups who reside in the Brimbank region. With over 70 languages spoken in Brimbank, the participants did not represent the cultural diversity of the region or the most needy cultural group in the community.[5] There were seven Maltese participants aged between 46 and 55 (X 47.4), eight Vietnamese participants aged 18–25 (X 21.8), seven Italian participants aged 50–70 (X 60) and seven Anglo-Australian participants aged between 20 and 47 (X 31.4).

The variation in mean age of each group was not problematic since the aim of this research was not to 'compare' responses across groups (e.g. to determine statistical significance) nor extrapolate each group's responses to the broader cultural group to which they belong. It was expected that different age groups would have some

different wellness needs, as well as some common ones (religion, education, gender would also contribute to differences).

The Anglo-Australians were all born in Australia while the other three groups migrated to Australia between 6 and 47 years ago. Participants' religions included Catholic (58%), Buddhist (19%), other Christians (10%) and 13% undecided or not stated. Nearly 10% of participants had only a primary school education, 29% attended one to five years of secondary education, 26% completed secondary school, six per cent completed secondary and some form of other training, 26% had a university degree and one person (three per cent) was undertaking postgraduate studies.

Materials

A plain language statement, consent form, a page consisting of 16 demographic and background information questions (e.g. gender, age, country of birth, culture) and a semi-structured questionnaire/focus group guide were developed for use in the research. The guide consisted of four sections or themes (A–D) and 10 questions which are presented in summary form in table 2 (see first column). table 2 also shows

TABLE 2 Focus group questions and corresponding praxis domains

focus group questions	*praxis domains*
Section A: The meaning of well-being and the lack of/or opposite of well-being	**Ideals**
1. What does well-being mean for you?	
2. *What does the lack of/or the opposite of well-being mean for you?*	
Section B: Positive things about your present state of well-being	**Strengths**
3. What is good about your present state of personal well-being?	Personal
4. What is good about your present relationships with other people?	Relational
5. What is good about the present conditions in your life and community?	Collective
Section C: Negative things about your present state of well-being	**Needs**
6. What is not so good or missing for your personal well-being at present?	Personal
7. What is not so good or missing in your present relationships with other people?	Relational
8. What is not so good or missing in terms of the present conditions of your life and community?	Collective
Section D: Actions or changes that could improve well-being in St Albans	**Action**
9. What are some of the things that you and other people who live in St Albans could do to improve well-being in the community?	Self and community
10. What could other people (e.g. health and community service workers, governments and researchers) do to help us improve well-being in this community?	Other stakeholders

the corresponding parts of the praxis cycle (ideals, needs, strengths and actions) and the research questions.

Note that the ideals of community members were addressed by asking two questions about the meaning/structure of well-being and its opposite rather than asking the question directly as: What are your ideals? This was done to ensure that all possible interpretations of well-being were acknowledged and accepted. In addition, the term 'ideals' might not be understood by those with low English proficiency or might not translate in the same way across all cultures. The terms strengths and needs could also have quite different cross-cultural meanings. In contrast, terms such as 'good' and 'not so good or missing' are more basic and general terms that capture positive and negative valences and are therefore more likely to be understood in the same way across cultures.

Procedure

Each focus group session began with informal conversation and introductions. Name-labels were distributed, and the format of the session together with matters of confidentiality, privacy and other rights were explained when participants were seated. Participants were informed that differences in opinion about well-being were common and acceptable and that well-being could mean something different to a man or woman, a younger or older person or to someone born in Australia or in another country. The questions were presented both verbally and visually using transparencies and an overhead projector to assist understanding. Brief notes of the responses were written on the transparencies during the discussion for participants to see and reflect on. A simple colourful diagram illustrating the personal, relational and collective *levels* of the model was shown to participants after the first two questions. To avoid biasing the research only the levels of the model and a few symbols such as those in table 1 were shown to participants, not the value items. The focus groups took about 60–90 minutes each and were all tape-recorded. A compensation of 20 dollars was given to each participant at the end of the discussions.

Data analysis

For the purpose of qualitative analyses, a social work student and a PhD psychology student were hired to produce written transcripts from the audiotape recordings of focus groups. All the transcripts were checked for accuracy (by means of reading and listening to the audiotapes) by the first author prior to analysis. The analysis of data was guided by the praxis model components and research questions shown previously in table 2. The data analysis therefore attempted to explicate participants' ideals, strengths and needs as well as possible actions that could improve well-being in the community.

The data analysis involved reflecting[6] on the research, listening to the audiotaped responses and reading the transcripts, notes and transparencies. Participants' responses for each of the 10 questions for each of the four focus groups were analysed, thus forming a conceptual 10 by 4 matrix overall (see Totikidis & Robertson, submitted). The analysis of data also consisted of several stages and

TABLE 3 Stage of analysis, strategy and rationale

stage of analysis and (strategy)	*why was this done?*	*how was this done?*
Discovery of community wellness ideals (matrix analysis[a])	To address the first part of research question 1: What are the community wellness 'ideals' of St Albans' community members?	Participants' responses from all sections (A–D) and questions (1–10) of the interview schedule were examined (the whole matrix), especially 1 and 2. From this, concepts or factors that could be classified as ideals were entered into four summary tables, one for each focus group.
Discovery of common ideals (thematic analysis[b])	Thematic analysis of ideals allowed further data reduction/ summarization of responses and revealed community members' ideals as a whole. The table derived allowed direct comparison to the community wellness model.	Conceptually related words and phrases from the four tables of ideals were grouped together under a common name so that most items belonged in a group. (Rather like putting objects into several baskets.)
Determining community strengths and needs (assessment of responses)	To address the second part of research question 1: What are the community wellness 'needs and strengths' of St Albans' community members?	Searched transcriptions for verbatim quotations (evidence) relating to each theme/common ideal in order to assess whether the responses to each theme were generally positive and satisfied (strength) or negative and dissatisfied (need).
Compiling actions to improve well-being (summarization)	To address the second research question: What actions can be undertaken to improve well-being in this community?	Participants' responses from section D (questions 9 and 10) of the transcripts were summarized and entered into a table.
Developing recommendations (thematic analysis)	Adds to the second research question but provides more direction and integration and is more targeted. The recommendations are a product of both the community members and researcher's thinking on what should be done.	Thematic analysis of responses on actions (section D) as well as reflection on needs, community problems and ideals identified throughout the whole research.

[a]Numerous examples of this technique are provided in Miles and Huberman (1994).

[b]Theme generation in analysis can be attributed to the ideas of Freire (1970).

strategies as illustrated in table 3. Why and how each analysis was done is also explained in the table. For greater clarity, one should return to this table after reading the findings.

Findings

Community wellness ideals

Participants' responses from all sections (A–D) and questions (1–10) of the interview guide were examined in order to address the first part of research question one: What are the community wellness 'ideals' of St Albans' community members? From this, concepts or factors that could be classified as ideals were entered into four tables, one for each focus group. Some of the factors stated as opposites of well-being were also included in the tables by rephrasing them in the affirmative. For instance, if 'a lack of self-esteem' was mentioned as an opposite then self-esteem was the ideal or affirmative. In this way, both directly stated and implied ideals could be included in the tables. We proceed to describe now the findings from the four groups.

Maltese-Australian ideals. The wellness ideals of the middle-aged Maltese-Australian group are shown in table 4. Personal well-being for this group consisted of physical health, spirituality and a wide range of positive feelings and characteristics while extended family, cultural maintenance and friendly relations with other cultural groups in the community emerged as important values for relational well-being. Some

TABLE 4 Summary of community wellness ideals in Maltese-Australian group

domains	*issues*
Personal	Physical and mental health. Positive thinking. Self-esteem. Confidence. Control. Healthy mind, body and soul. Faith/spirituality. Inner peace (vs. inner conflict). Self-acceptance. Learning opportunities. Happiness. Contentment. Authentic self. Coping ability. Resilience.
Relational	Caring for others. Feeling connected. Good relationships with partner, family and extended family. Community acceptance of cultural diversity. Relationship with God. Inter cultural cohesion and mingling (vs. cultural segregation). Community participation and protest. Responsibility. Not blaming others. Cultural maintenance or connection to roots. Respect for elders' needs.
Collective	Adequate infrastructure: education, hospitals, shops, higher education, employment, transportation, ethnic clubs and services for elders. Clean environment (no rubbish and beautification). Multicultural church. Responsive local government. Adequate parent, family and mental health support services. Adequate policing — crime and safety. [Egalitarian] government funding to community.

of the collective issues of importance to this group included adequate infrastructure, services and policing. Additionally, safety, ethnic clubs and services for elders and responsive local government were mentioned as determinants of their collective wellness.

Vietnamese-Australian ideals. The ideals of the Vietnamese-Australian participants may be seen in table 5. The table shows many positive emotions and characteristics valued by this young group of Vietnamese people. Ideals related to the personal domain included holistic health, adjustment, happiness and satisfaction with life. Relational ideals included positive relationships with friends, family and others, safety, tolerance and positive community relations. Ideals within the collective sphere included adequate opportunities for education and employment, community information and a range of community and cultural resources.

Anglo-Australian ideals. Table 6 shows the wellness ideals of the Anglo-Australian group. People in this group value health and emotional well-being, as well as a range of positive feelings and characteristics such as self-esteem, happiness, feeling safe and self-acceptance. Equality, no discrimination, kindness and respect were raised as important ideals within the relational domain. Many cultural and community issues were also discussed. The group was critical of the community that they live in (e.g. crime, poverty) and identified many crucial resources for their collective well-being.

Italian-Australian ideals.. The ideals of the Italian-Australian group are presented in table 7. This older group of people mentioned many physical factors as important to

TABLE 5 Summary of community wellness ideals in Vietnamese-Australian group

domains	*issues*
Personal	Health: physical, psychological, mental, spiritual and social. Secure (supportive) family. Not having fear. Positive sense of identity. Success. Self-esteem. Cultural integration (mental). Positive adjustment. True happiness. Satisfaction with life. Education. Hope, faith and motivation. Satisfaction of basic needs (food, rest, shelter, procreation).
Relational	Safety. Feeling accepted in the community. Supportive social group. Strong identification with friends. Tolerance. Good communications — family and others. Reciprocal relationships. Positive peer relationships. Trust. Understanding. No racism/stereotyping. Inter cultural interactions/integration (vs. cultural segregation). Part of community. Sense of belonging (community). Kindness to others.
Collective	Social well-being: being able to walk out on the street freely. Adequate meeting places. Community festivals and cultural events. Being informed about the community. Adequate opportunities (e.g. career, education). Adequate education and hospitals. Quality teaching/mentoring. Services to accommodate elders and diversity. Temples and churches. Funding to local community groups. Policy response to gambling. Information regarding services to non-English-speaking people. Employment: basic human right. Responsive/representative government.

TABLE 6 Summary of community wellness ideals in Anglo-Australian group

domains	*issues*
Personal	Health. Emotional well-being. Self-esteem. Free will. Empathy. Feeling good. Feeling safe. Happiness. Loving yourself and self-acceptance. Not being greedy. Fun. Realistic expectations. Trust. Caring.
Relational	No discrimination. No racism or racial conflict among youth. Kindness to others. Respect for everyone. 'Golden rule' [do as to others as you would like them to do to you]. Not having fear of others. Trust with partners. Compromising. Joy in watching children grow. Political participation by community. Cross-cultural communication. Community spirit. Community cohesion (vs. individualism). Connectedness. Cultural integration. Cultural reconciliation.
Collective	Employment. Equality. Safety. Adequate income. Access to free legal services. Home ownership. Drug-free kids. Staying alive in St Albans (no racial or turf wars). Awareness of global issues/ecology. Fair system. Good government. Access to support services: welfare, housing, transport. Adequate response to community issues: drugs, gambling, smoking, violence, graffiti, dental healthcare, education, GST (goods and services) burden, poverty trap, rich/poor gap, cost of living, employment.

TABLE 7 Summary of community wellness ideals in Italian-Australian group

domains	*issues*
Personal	Good health. Good life. Love. Maintaining activity levels through physical work and recreation. Not having pain. Realistic expectations regarding pain/ageing. Pleasant distractions from boredom and pain. Balance between home/external activities. Not being isolated. Coping with death of loved ones. Faith, religion and spirituality.
Relational	Family health and well-being. Understanding partner. Strong (extended) family connections. Celebrations with family. Respectful relationships. Reciprocal relationships with adult children (not being taken for granted). Caring/helping others. Friendship. Social activities. Cultural maintenance and contact with own culture. Good relationships with neighbours.
Collective	Adequate support for migrants. Safety in community. Safety on transport. Policing of drug risks to residents and crimes against elders. Adequate recreational facilities. Support/funding for ethnic elderly clubs, churches. Adequate response to vandalism. Adequate shopping facilities — variety and 'quality' shops. Education for responsible adolescence (e.g. respect, morals, graffiti, vandalism). Employment opportunities. Availability of specialist services (e.g. optometrist).

their personal well-being (e.g. health, work, activities, absence of pain) as well as a few other values such as love, faith, religion and spirituality. Relational well-being for this group meant having an understanding partner and having good relationships with extended family, friends and neighbours. Collective issues included the need for greater support services and safety. The education of adolescents regarding respect, morals, graffiti and vandalism was also raised as an issue of concern to people in this group.

Common ideals. Thematic analyses of focus groups and ancillary materials revealed 15 common ideals across the various groups. As may be seen in table 8, there are three themes classified as personal, five as relational and seven as collective. We elaborate in the discussion on the meaning of these aspirational statements.

Community strengths and needs

In the community of St Albans, items one to six in table 8 were identified as areas of strength whereas items seven to fifteen were classified as areas of need. Needs and strengths were determined by assessing whether the responses to each of one the 15 themes were positive and satisfied or negative and dissatisfied. For example, comments such as the following clearly point to strength in the Family domain:

> *Especially for the Italian people, la family, when it comes Christmas, New Year, Easter, Saturday, Sunday, must be stay together!*
>
> (Italian woman)

> *As for myself I think I have everything I need at the moment — I've got a husband, I've got two children. I have the rest of the family. We are all close to each other. If we have a problem we sort of talk it out, you know. I've got everything, I have my parents, they're in their 70's, what else, you know . . .*
>
> (Maltese woman)

The next quote illustrates the strength of Spirituality, while the one after that shows Intra Cultural Harmony.

TABLE 8 Integration of personal, relational and collective wellness ideals in four ethnic groups

personal ideals	*relational ideals*	*collective ideals*
1. Physical and psychological health	4. Family	9. Human rights
2. Positive thoughts and feelings (towards oneself and others)	5. Friendship and social support	10. Safety
3. Spirituality	6. Intra cultural harmony	11. Employment
	7. Inter cultural harmony	12. Education
	8. Community cohesion and participation	13. Community services, resources and information
		14. Community development
		15. Good government

To love one another, to help one another, is to be true to each other. That's total fulfilment I believe. I mean when you talk about religion or whatever, it's talking about being one with God, or Buddha, or who ever. It's up there at that level, above humanity, spiritual.

(Vietnamese man, age 22)

I feel that we need to come to grips to [be] fully accepting of our cultural heritage because if I don't know where I've been I don't know where the hell I'm going — you're lost. I end up confused and I'll end up passing that on to my children.

(Maltese man)

The following quotes represent community needs in the respective areas of Safety, Community Cohesion and Participation and Good Government:

The safety is very bad here in St Albans. We need more police to look around because the robberies happen all the time. For the older people, some people are scared to come into the club.

(elderly Italian man)

I don't see a community at all. I believe everyone's . . . [individual], I mean, all separate identities. . . . In our culture, your neighbours are like your family. You know everyone on the whole street. But nowadays, . . . you just say 'Hi', that's it, you leave it there. You don't invite each other for lunches, dinners, barbeques, nothing like that. I see it as breakdown of community.

(Vietnamese male)

Well like everyone talks about the transport [railway and traffic problems] in St. Albans [but] when it comes to blockade here [protests] the same people turn up. Only 20 or 30 people turn up. If more people turn up . . . you know it's not enough . . .

(Maltese woman)

And the Prime Minister of the country and the present Federal government are quite happy for the gulf between the 'haves' and the 'have nots' to get bigger, and bigger and bigger, and for people on low incomes, working class people — to be disenfranchised from the political system. Quite happy for that, and they're doing it by stealth and the opposition is just letting it happen. There's ineffective political leadership!

(Anglo-Australian male)

Actions to improve well-being

Table 9 shows a summary of issues in response to questions about improving community well-being.

Twelve recommendations emerged from an analysis of table 9 and from the issues of concern that were raised in the research with community members. To contribute to the improvement of well-being, it is recommended that:

TABLE 9 Recommendations for action by four community groups

responsibility for action self and community	*government and other stakeholders*
Maltese Address transport issues by participation in protests. Welcome newcomers. Social support for the elderly. Communication with neighbours. Visiting an elderly person.	Better monitoring by council of local services such as rubbish collection. Returning services to certain areas. More mental health services. Awareness of services. Support for families with mental illness and more activities for people with mental illness. Social support groups. Preventative community education. Policing, reduce crime and promoting safety. Address traffic problems in St Albans. Support and help for families. Funding for beautification of region. Cleaning of public areas. Community education on environmental issues.
Vietnamese Community needs to have a special day (e.g. festival) to bring people together. Extend kindness and generosity to others. Contribute to improvement of educationand hospitals.	Better educational system. Gambling issues need to be addressed to protect peoples' livelihood. Local community groups need funding. Information about services needs to be disseminated to community. Trust and friendship among communities. Language barriers need to be addressed. Better representation of community in local government. Dignity and pride of immigrants need to be protected. Sense of community.
Italian Safety needs to be improved. Security. Children need to be taught respect. Talk to neighbours. Build relationships with neighbours. Support religion.	Shopping and services need to be improved. Discount for pensioners in stores. Unemployment issues need to be addressed. Safety in general and safety on transport. Staffing of stations. Robberies need to be stopped. Graffiti needs to be stopped. More discipline in schools and education on morals.
Anglo Smile and do not judge others. Support family members and community — help one another. Community is apolitical — more people should be interested in politics. Community needs to communicate more.	Improve medical services. Address cultural integration issues. No more tokenism from government. Free dental services. Employment. Education. Cost of living for low income should be addressed. People have to have courage to speak out against bad policies. 'Ceasefire' in St Albans among youth groups. Effort from migrant groups to mix.

1 Culturally appropriate family services and support to migrants be set up in the community.
2 Information regarding existing community services, resources and benefits reach migrant communities.
3 Mental health and other services in the area be strengthened and made more accessible.
4 Strategies to curb negative inter cultural attitudes are implemented by government and services.

5 Local government, policy makers and community workers engage in ongoing consultations with the community to resolve community problems.
6 Policing of certain areas should be increased and crime prevention measures developed.
7 Strategies to enhance business and employment opportunities should be a priority.
8 Community events, celebrations and festivals be valued and encouraged.
9 Elderly clubs receive adequate support and funding.
10 Youth services, recreational activities and opportunities be improved and extended.
11 Affordable education and learning opportunities be provided to everyone in the community.
12 An ongoing community wellness group be set up and run by community members to identify emergent areas of need, initiate projects and monitor progress.

Discussion

The results of this study have implications for theory and practice. With respect to the former, the findings helped in grounding Prilleltensky's model of wellness in a multicultural context. By and large, the findings support Prilleltensky's tripartite notion of personal, relational and collective wellness (Prilleltensky, in press; Prilleltensky & Nelson, 2002; Prilleltensky et al., 2001). A look at tables 1 and 8 reveals a great deal of congruence between the original model of wellness and participants' conceptions of well-being. Many participants invoked wellness components that ranged from the personal and relational to the collective. Interestingly, participants described well-being holistically from the outset, even during the first two questions of the focus group guide, albeit with somewhat greater attention paid to the personal and relational aspects of well-being prior to the introduction of the model.

While most constituents of wellness in Prilleltensky's model were supported in the present multicultural context, the findings reinforced an aspect that was missing from Prilleltensky's original conceptualization of wellness: spirituality. Although Prilleltensky added this dimension in recent publications (Prilleltensky, in press), this component of personal wellness was missing from his initial postulates on wellness. Another component of wellness that was implicit in earlier versions of the model, but made more explicit in this research was the importance of the family. While Prilleltensky embedded family in parts of the personal and relational domains (affection, bonding, etc.) the Italian, Vietnamese and Maltese groups made it an explicit factor in the wellness formula. It is of interest to note that the Anglo-Australian group did not address family directly but the small sample size and qualitative nature of the study preclude us from generalizing this and other such findings to the broader population.

The results also provide further substance to the notion of cultural diversity. During the focus groups, participants talked about culture in terms of what happens

within their own culture (intra) as well as what happens between cultures (inter), reminding us that both components are necessary for cultural harmony in the community. This is a fine distinction that enriches Prilleltensky's conceptualization of the issue and is in line with Putnam's (2001) differentiation between bridging and bonding social capital. While the latter refers to intra cultural harmony, the former pertains to inter cultural harmony.

In addition to these general and abstract contributions to the model, research participants identified issues that are unique or particularly prevalent to their community. The plethora of issues identified by the community in tables 4–9 offer a rich picture of ideals, strengths, needs and possible actions in St Albans associated with personal, relational and collective wellness. While offering support for the wellness model introduced by Prilleltensky, there is a lesson in this research not only for theory building, but also for practice. Service providers who attend only to the personal domain of wellness may be doing a disservice to the community (Prilleltensky & Prilleltensky, 2003b, c). Based on the results of this study, community members want and expect service providers to go beyond the personal and the relational. There is a clear expectation that the needs of the collective will be addressed by the community itself and by government and non-governmental organizations.

Community wisdom, as illustrated in this research, postulates that attending to individuals one at a time may not be enough to overcome disadvantage. Numerous examples of transportation, employment and discrimination challenges were raised (Prilleltensky & Fox, in press). These belong squarely in the collective sphere of wellness that, as mentioned earlier, was deemed to be an area of weaknesses in this community. Practitioners should pay close attention to this finding, for it may call into question the concentration of person-centred efforts in health and human services (Prilleltensky & Prilleltensky, 2003c). If most needs are in the collective domain, and most strengths in the personal and relational, programmes, policies and services need to concentrate on the former more than the latter. Personal and relational strengths need to be nurtured and continually appreciated, but no amount of caring at the affective level will increase employment or educational opportunities.

It is interesting to note that the community did not expect changes to come strictly from without, but also from within the community itself. Residents do not see themselves as passive recipients of services, but as responsible participants in the solution of problems. Calls to protest the lack of public transportation, to welcome immigrants, to support the elderly and to enhance community cohesion are examples of community-initiated actions.

The research framework developed and used in this research enables the identification of local and actionable issues. For this reason, it has also served as a basis for the second stage of research undertaken by Morsillo in her Social Action with Youth work (Morsillo & Prilleltensky, in press). Indeed, the community wellness cycle of praxis may be widely applicable in local government, community development, social work and applied community psychology. The 15 common ideals may also be used to guide action and further research into the commonalities and distinctiveness of communities.

A cycle of praxis that engages community members to reflect on the meaning of well-being and on what is needed to achieve it is essential to the process of

community improvement. In our efforts to improve community, we should engage in actions that address universal and local needs, actions that maintain and enhance existing strengths and resources, and actions that strive towards a synthesis of personal, relational and collective well-being.

Conclusion

This study was designed to engage the St Albans community in a cycle of praxis to gain a theoretical and pragmatic understanding of well-being from a multicultural perspective. With respect to our theoretical interests, the results found a high level of concordance between Prilleltensky's framework of wellness and the views of our multicultural groups. Participants confirmed the validity and synergy of the tripartite model: wellness takes place at the intersection of personal, relational and collective strengths. Furthermore, the study emphasized the importance of a previously neglected category of personal wellness: spirituality. In addition, the study put family front and centre, making it an important factor in the wellness equation. Similarly, the study helped to elaborate on the notion of respect for diversity. Participants implied the need to foster both intra and inter cultural harmony.

With respect to our pragmatic concerns, the study tested the utility of a cycle of praxis based on ideals, strengths, needs and action. The current research dealt extensively with the first three domains and laid the foundations for action. The cycle of praxis proved to be a simple yet useful tool in identifying needs and capturing community strengths and capacity for action. The challenge is now for the community, health and community service workers, governments and researchers alike to keep residents involved and to remain accountable to them.

Notes

1 The research formed the thesis component of a Master of Applied (Community) Psychology for the first author under supervision from the second author.

2 Both Robertson and Totikidis undertook the research as part of the Master of Applied (Community) Psychology.

3 Morsillo undertook the second phase research for the award of Doctor of Philosophy.

4 The term 'community' is used in a geographical sense in the present context and refers to the St Albans and Brimbank region.

5 On the contrary, Anglo-Australians have the greatest number and are generally known to be the most privileged group in society, whereas Indigenous Australians are recognized as the most disadvantaged and only make up 0.003% of the Brimbank region (calculated from Australian Bureau of Statistics, 2002). Strict ethical guidelines rightly deter 'white' researchers from undertaking Indigenous research. This is because white researchers, in pursuit of their own racist agendas or for other reasons have not always acted in the best interests of Indigenous

Australians. Many also believe that white help is 'paternalistic' and that help should come from within the culture.

6 This term is used to describe the process of reflecting back on the actual focus group and recalling some of the issues raised in it, the atmosphere of the day and even emotions and gestures expressed. For example, a young Vietnamese man spoke about the importance of achieving a balance between two cultures by moving his hands closer together in front of him toward a common centre. Another Vietnamese woman had a tear in her eye when she recounted her feelings of not feeling 100% accepted in Australian society. These reflections reinforced the importance of the issues raised in the focus groups.

References

Australian Bureau of Statistics (2002). Basic community profile: Brimbank. Drawn from the Australian Bureau of Statistics 2001 Census of Population and Housing. Melbourne: Commonwealth of Australia.

Boog, B. W. M., Keune, Lu, & Tromp, C. (2003). Action research and emancipation. *Journal of Community & Applied Social Psychology*, *13*(6), 419–425.

Coenen, H., & Khonraad, S. (2003). Inspirations and aspirations of exemplarian action research. *Journal of Community & Applied Social Psychology*, *13*(6), 439–451.

Curtis, S., Bryce, H., & Treloar, C. (1999). Action research: Changing the paradigm for health psychology researchers. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 202–217). London: Sage.

Dick, B. (1993). *You want to do an action research thesis?* Thesis resource paper. Retrieved December 10, 2002, from http://www.uq.net.au/action_research/art/arthesis.html

Freire, P. (1970). *Pedagogy of the oppressed*. New York: The Seabury Press.

Grundy, S., & Kemmis, S. (1981). Educational action research in Australia: The state of the art. In S. Kemmis & R. McTaggert (Eds.), (1988). *The action research reader* (3rd ed., pp. 321–335). Geelong: Deakin University Press.

Hall, B. (1993). Introduction. In P. Park, M. Brydon-Miller, B. Hall & T. Jackson (Eds.), *Voices of change: Participatory research in the United States and Canada* (pp. Xiii–XXii). Westport, CT: Bergin & Garvey.

Hionides, H. T. (1987). *Collins Gem dictionary: Greek–English, English–Greek*. London: HarperCollins.

Kemmis, S. (1988). Action research in retrospect and prospect. In: S. Kemmis & R. McTaggert (Eds.). (1988). *The action research reader* (3rd ed., pp. 27–39). Geelong: Deakin University Press.

Kemmis, S., & McTaggart, R. (1988). *The action research reader* (3rd ed.). Victoria: Deakin University Press.

Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues*, *2*(4), 34–46.

Marx, K. (1977). Theses on Feuerbach. In D. McLellan (Ed.), *Karl Marx: Selected writings* (pp. 28–30). New York: Oxford University Press.

McKernan, J. (1991). *Curriculum action research: A handbook of methods and resources for the reflective practitioner*. London: Kogan Page.

Miles, M. B., & Huberman, A. M. (1994). *Logical analysis/matrix analysis: Qualitative data analysis* (2nd ed.). Newbury Park, CA: Sage.

Morsillo, J., & Prilleltensky, I. (in press). Social action with youth: Interventions, evaluation, and psychopolitical validity. *Journal of Community Psychology*.

Nelson, G., & Prilleltensky, I. (Eds.). (2005). *Community psychology: In pursuit of liberation and well-being*. New York: Palgrave Macmillan.

O'Brien, R. (1998). An overview of the methodological approach of action research. Retrieved October 27, 2001, from http://www.web.net/~robrien/papers/arfinal.html

Prilleltensky, I. (2001). Value-based praxis in community psychology: Moving towards social justice and social action. *American Journal of Community Psychology*, *29*(5), 747–777.

Prilleltensky, I. (in press). The role of power in wellness, oppression, and liberation: The promise of psychopolitical validity. *Journal of Community Psychology*.

Prilleltensky, I., & Fox, D. (in press). Psychopolitical literacy for wellness and justice. *Journal of Community Psychology*.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. New York: Palgrave Macmillan.

Prilleltensky, I., Nelson, G., & Peirson, L. (Eds.). (2001). *Promoting family wellness and preventing child maltreatment: Fundamentals for thinking and action*. Toronto: University of Toronto Press.

Prilleltensky, I., & Prilleltensky, O. (2003a). Towards a critical health psychology practice. *Journal of Health Psychology*, *8*, 197–210.

Prilleltensky, I., & Prilleltensky, O. (2003b). Reconciling the roles of professional helper and critical agent in health psychology. *Journal of Health Psychology*, *8*, 243–246.

Prilleltensky, I., & Prilleltensky, O. (2003c). Synergies for wellness and liberation in counselling psychology. *The Counseling Psychologist*, *20*(10), 1–9.

Putnam, R. (2001). *Bowling alone*. New York: Simon and Schuster.

Roberts, G., & Dick, B. (2003). Emancipatory design choices for action research practitioners. *Journal of Community & Applied Social Psychology*, *13*(6), 486–496.

Roth, J. (1990). Needs and needs assessment process. *Evaluation Practice*, *11*(2), 141–143.

Seng, J. S. (1998). Praxis as a conceptual framework for participatory research in nursing. *Advances in Nursing Science*, *20*(1), 37–50.

Susman, G. (1983). Action research: A sociotechnical systems perspective. In G. Morgan (Ed.), *Beyond method* (pp. 95–113). Beverly Hills, CA: Sage.

Totikidis, V. (2003). Understanding community wellness from a multicultural perspective. Unpublished Master of Applied (Community) Psychology thesis, Victoria University, St Albans, Melbourne, Australia.

Totikidis, V. & Robertson, D. (2005). Wellness and liberation in the lives of culturally diverse communities (Phase one of the community wellness project). *Network* (Official Journal of APS College of Community Psychologists).

Valkenburg, B. (2003). The development of an individual, demand driven approach in a long-lasting exemplarian action research. *Journal of Community & Applied Social Psychology*, *13*(6), 451–464.

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