Exploration of the Positive and Negative Effects of the Community on Mental Health of Individuals

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Abstract:
The paper gives a detailed evaluation and analysis into the factors and elements that affect mental wellbeing of individuals in community. It gives insight into the symbiotic relationship between individuals and their communities and how the bi-directional influence affects individuality and the experience of wellbeing through the community. The approach comes with an appreciation of both the cultural and physical environment's interaction with the person's individualized and internalized environment and how these intersect to give us personalized experiences, and their outcomes in mental wellbeing. Therefore, the illustration of both positive and negative ways strives to bring out a continuum evaluation to the silent aspects of society and individuality and how these should be taken into consideration in assessment of and evaluation of factors that affect people from within and outside their being.

Keywords: community, mental health, interrelations, environment, culture, individual

1. Introduction
Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Furthermore, according to WHO (2010), this is a state of psychological, physical and emotional wellbeing and not necessarily in the absence of illness. Therefore, mental health does not depend on physiology, but rather the state of mind. Community mental health is an evaluation into the ways and manner to which communities impact its natives and how the outcome influence the health-related outcomes.

Evidence from research indicates that children that are born within a family or community that is positively built develop high level of esteem that average. The basis is within the models and observation that a child associates with during the childhood years. According to Bowlby (2008) in his theory of maternal deprivation, if a child is not given appropriate motherly love, he or she may not be able to relate with others well and neither can the child be able to receive and return love to others. Thus, community plays a key role in shaping the mental functioning of its individuals. Communities that are high motivated, goal driven and achievement oriented in many instances reproduce individuals who operate within the similar framework and using the community beliefs and values as the frame of reference (Dörnyei & Ushioda, 2013).

Promoting Mental Health: Concepts, Emerging Evidence, Practice emphasizes that everyone has a role and responsibility in mental health promotion and encourages integrated participation from a variety of sectors such as education, work, environment, urban planning and community development as the best way to make the most positive improvement in people's mental health (Herrman et al, 2005). It appropriately focuses on resource-poor settings; however, money is not the key determinant to ensure good mental health. Awareness and active involvement by each member of the community often have the greatest impact (Butterfoss et al, 1993).

More so most mental illness like depression is a result of perceived inequalities and oppressions that trigger psychological dysfunctions (Desjarlais, 1996; Sheppard, 2002; Rogers & Pilgrim, 2014). Thus, communities play a fundamental role by supporting and providing the adequate infrastructure conducive to accommodate and reduce symptoms of such disorders. Evidence suggests that most people who suffer from post-traumatic disorders are usually victims of violence and aggression, therefore community is there to provide support and information to such people accompanied by the use of therapies that are community oriented with the intention of socially including these individuals (Rappaport & Seidman, 2000). Most people with post traumatic disorders need reorientation of the

psychological and emotional imbalances that may be involved in enhancing psychological instabilities within individuals. Thus, communities should provide their respective inhabitance with a sense of belonging and community resulting in enhanced perceived security for personal well-being (Rappaport & Seidman, 2000). This can be further enhanced by promoting social inclusion for people with mental health problems, improving their employment prospects and opposing stigma and discrimination.

2. Communities and Mental Health Issues

Most communities that are individualistic like the western nations that operate on the basis of capitalism have shown an increase number of reports of people suffering from depression, anxiety and stress related disorders (Karasek & Theorell, 1992). The orientation of these communities exposes individuals to isolation and internalization of social and psychological problems. However, community mental health can be enhanced through an evolution of communities that are collective and respect individual beings despite their mental states (Trickette, 2002). Communities that value relationships, dignity and potentials residing within an individual generate more positive beings. Therefore, like most communal African communities, problems are shared and dealt with at community levels before the start manifesting in the form of social problems and before the individual is in crisis.

Communities also affect mental health in positive ways through the use of prevention methods designed to deal away with the social ills that are believed to stimulate the emergence of mental illness. Through promoting the mental health of the whole community with programs such as abolishing inequalities and delivering race equality in service provision, community mental health can be enhanced positively by the community (Almedom, 2005). That is societal treatment services should not only be considerate of the majority, but should also develop and design service plans that are culture sensitive and accommodative of the existing minority groups in the community (Rogers & Pilgrim, 2002; Fernando & Keating, 2008; Friedli, 2009).

Communities can influence how people behave through various dimensions and more so through these dimensions, communities can also shape the mental health of the residence. Through accessible and available services from the primary care settings, communities can improve the mental wellbeing of its people (Almedom, 2005). Therefore, in order to improve the quality of life of mentally challenged people there is need to also address the needs of their care-givers. These are the people that directly interact and shape the behaviours of those mental challenged, therefore their wellbeing also affects the wellbeing of those at risk of mental problems and those with mental problems as proposed by Fernando and Keating (2008).

More so there is need for practitioners to divert from the use of the medical models in addressing mental health issues (Rappaport & Seidman, 2000). The medical model is based on looking for symptoms of an illness and providing treatment to deal away with the findings. This means through using this model, people are left to develop problems and when they manifest, treatment will then be employed as further illustrated by Rappaport & Seidman (2000). However, resistance on the use of this model calls for prevention of symptoms before they even manifest, thus instead of looking for ills within individuals, communities should try and locate social ills within the community that are bound to cause mental problems. For example, most poverty-stricken families have a member or some of their members portraying symptoms of mental illness; hence the solution rests in enabling them to have food on their table, peace of mind and adequate resources to help them sustain a living and also giving them an opportunity to participate in community empowerment projects so that they develop the necessary skills, knowledge and ability to fend for themselves (Almedom, 2005).

Evidence also suggests that the use of the medical model has proven helpful over the years, however with the growing technology and understanding of the various causes of mental illness, there is need to use both the medical model and other alternatives that come in the form of community based rehabilitations (De Leon, 2000). Evidence suggests that even for severe mental disorders, therapies and services offered within the home setting can prove helpful in similar ways as medication does. Consumption of pills and other solid medications has resulted in deposition of the residue into the blood leading to the development of stones. Thus, community's interventions and helping strategies divert away from creation of other problems that are not related to the initial problem of mental illness at hand (Rappaport & Seidman, 2000).

3. Childhood and Mental Health Issues

Furthermore, according to Freud (1940) supported by Erickson (1968), childhood experiences have a large bearing over the development of individuals from childhood into adulthood. Thus, most people who suffer from paranoid are believed to have not received adequate attention at the "trust versus mistrust" stage of psychosocial development, therefore these individuals do not know or lack element that enable them to trust anyone even their care-givers. They believe in looking after themselves and at times have delusions inclined towards believing that everyone is planning and plotting against them. This also goes for fixation at any of psychosexual stages of development by Freud (1940). Individuals who become fixed may experience psychological conflicts of the mind resulting in mental frustrations. This accounts for criminal tendencies from a psychodynamic perspective. Thus, communities are there to provide the love support and sense of belonging that can help its individuals move through the mile stone without problems.

Furthermore, according to Merton (1968)'s social strain theory, the development of regulations channeling ways to which individuals are to access resources can pose threat to mental wellbeing of individuals. Most people in the united states are motivated by the American dream to achieve high social valuables therefore if the means and ways are blocked they resort to unconventional ways of accessing these resources and this usually manifests in the form of subcultures that are created on ground differing from the mainstream values and norms, thus creating a social ill. Hence Allport (1930) stipulates that through increased trials to gain access to resources that prove inadequate for an individual to attain the ideal self, the gap that will exist between the real self and the ideal self will result in what is termed "neurosis", emotional imbalance accompanied by aggression tendencies. Therefore, community should be there to create an even ground for everyone to be able to access and use resources available to attain their ideal self-concepts.

The concept of Salutogenesis (generalized resistance resources) in mental health accompanied by a sense of coherence can formulate the basis of a new understanding to community mental health (Lindstrom & Ericksson 2006). That is the generalized resistance resources are biological, material and psychological factor that make it easy for people to perceive their lives as consistent, structured and understandable. These resources can be in the form of money, knowledge, experience, social support, culture, intelligence, traditions and ideologies that shape the wellbeing of the community. They are shaped and designed by life experiences and hence characterized by consistency, participation in shaping outcomes and the balance between under load and overload. Therefore, if people in the community have these resources at their exposure, there are in a better position to deal away and confront the challenges of life according to Rappaport and Seidman (2000).

Besides availability of resources, the most important aspect lies in the ability of people to use them to their advantage, the sense of coherence or rather mental health. That is these generalized resources help people construct coherent life experiences (Lindstrom & Ericksson, 2006). This sense of coherence generated within the community will establish in people a way of perceiving life and an ability to successfully manage the infinite number of complex stressors encountered on a daily basis. The salutogenic concept becomes a personal way to which an individual, thinks, acts and behaves, with a feeling of inner trust developed by internalization of the sense of coherence. Thus, our communities and the life experiences we are exposed to shape our sense of coherence, (Lindstrom & Ericksson, 2006). That is consistency, load balance (manageability), participation in shaping desired outcomes and emotional closeness which refers to the extent to which a person feels emotional bound and experiences social integration and cohesion in the different societal groupings. Thus, all these events can pose a positive effect on mental health if the individual fully comprehends them and appreciate their applicability in everyday activities, (Eriksson & Lindstrom, 2004).

4. The Mind and Mental Health Issues
High levels of mental health have been seen to manifest positively in individuals who are optimistic, hopeful, who have learned resourcefulness and constructive thinking patterns (Lahey, 2004). That is communities that generate higher sense of coherence create people who are more satisfied with their lives and consequently have high quality life styles and general wellbeing according to Eriksson and Lindstrom (2004). Therefore, social networks and intimate relationships become factors enabling development and strengthening of an individual's sense of coherence in a positive manner. They become essentials for individuals to receive and give and increase positive mental health if they are stable, deep and favorable in social support and create a climate of social integration, mutuality and social intercourse of the people involved.

Furthermore, an understanding of how communities can affect mental health lies in the sense of performance amongst individuals. People who perceive themselves as high useful and forming an integral part of the communities to which they belong develop high sense of efficacy and esteem which becomes essential element in generation of resistance and resilience to social problems amongst involved persons, (Rappaport & Seidman, 2000; Trickette, 2002). These people determine their social climates and are active in developing ways of handling social problems. They deal with social obstacles in a way that does not provoke their anxiety levels and hence they operate at minimal arousal levels. However, to develop such skills, it emerges from how their families created social realities as these individuals were growing up, people who belong to families who portray learned helplessness most of their times portray learned helplessness even in circumstances within their control. Development of resilience comes with perceive sense of control over life and its outcomes (Rappaport & Seidman, 2000). Thus, communities play a key role in making people develop these skills from early childhood into adulthood.

Evidence suggests that mental health has a large bearing on community participation and otherwise. That is most people with mental disorders and social ills are easily excluded, marginalized and disintegrated from the larger community (Choruma, 2007). Thus, people sustaining a mental illness are most likely to be regarded less human and manipulated. Furthermore, evidence from Faris and Dunham (1939) stipulate that societies that have many people suffering from mental illness are highly disintegrated. Hence this disintegration comes with increase in lonely people, divorcees, children without care giver, violence, crime and many other social ills.

5. The Religion and Mental Health Issues
Religion also plays a key role enhancing community sense of belonging and wellbeing. Most people in societies belong to various denominations and spirituality forms an integral part of their livelihood. Spirituality and the level to which one is indulged contribute to the persons' quality of life. Spirituality contributes to psychological wellbeing, social connection and meaning attached to life according to Saxena et al, (2002). Thus, religion contributes to cohesion and interrelations that exists amongst people of various races into a whole sum group united by a common goal to worship God. Thus, the principles guiding the church also affect the attitudes and perception of the church goers in a positive manner. According to Rappaport and Seidman (2000) religion has a unique access to the community with its differing resources approaches that most disciplines lack; therefore, it harnesses much power to indirectly control people through its various systems.

Besides fulfillment that comes with involvement and participation, community development capture the public's attention as it emphasizes on traditional values, for example in America this comes with participation and self-reliance (Rappaport & Seidman, 2000). Thus, its optimistic and humanistic views of possibilities of achieving consensus and cooperation are a reason why community development becomes a popular concept. Thus, the concept makes a clear appeal to its members as the goals it offers are ambiguous and moreso people have to rely on one another creating bonds of trust and companionship that enhance wellbeing and mental health stability, there is an element of assisting each other attain personal and desired goals, thus supported by Bronfenbrenner (1979)

ecological model that stipulates the interdependence that exists in most systems within a community. Thus, such coherence allows for goals, hopes and desires to be seen as potential outcomes.

6. Literacy and Mental Health Issues

The level of literacy at which the community operates has influence on the perception and behaviours of people within that community (Trickette, 2002). The community level of literacy creates social barriers to programs that seek to suppress factors prone to prevent mental illness (Choruma, 2007). Thus, the professional socialization experiences of most human services tend to make professionals put much concentration on the individual suffering and the disorder itself. This will limit the ways in which intervention is understood and conceptualized (Rappaport & Seidman, 2000). Thus, no matter how much discussion may enlighten people on the contributions of the surroundings on mental health, professionals remain conservative, seeking symptoms and solutions in a manner they are already oriented to. Thus, prevention and solutions become competitors in a mentally health communities instead of collaborators. These professionals do not understand that if prevention works out, it will create a less demand for treatment to an extent that the available resources may become adequate and effective for those with severe mental injuries in the community.

The nature of the society itself has a great influence on development of disorders. Most capitalistic communities are infested with people seeking to make a profit with everything that is available and this also includes investments in mental health (Rappaport & Seidman, 2000; Trickette, 2002). Most people who offer psychological services for money are interested in manifestations of disorders in their respective communities; this also goes for those owning pharmaceutical companies. They invest in disorders and mental illness, so large scale mental illness directly reflects increased profit and income. Thus, they will work hand in hand with psychology service providers in unethical ways to avoid fully delivering clients off their plight (Corey et al, 2014). Thus, the nature of the community is also an important dimension to understanding how communities negatively affect mental health.

Biological evidence suggests that not only do the experiences that lead to involvement and indulgent of people in mental health threatening circumstance affect the bearers. For example, those who resort to alcohol consumption and drugs to reduce the effects of their poverty on livelihood may end up suffering from Kosarkoffe syndrome, a disorder of memory and language that possesses symptoms of confabulations and delusions (Lahey, 2004). The effects can have a biological damage on offspring especially in women who consume alcohol. The consequences are seen in children born with psychological disorders like ADHD and Alcohol fetal syndrome, a disorder characterized by irritability, lack of concentration and inability to settle down. According to Rappaport and Seidman (2000) these social ills are at epidemic levels in poverty stricken communities with evidence of children born with HIV, crake babies, births to unmarried teen mothers and dumping of babies. Therefore, community structures not only affect current community mental health of the residence but it shapes the outcomes and expected future generations' mental health statuses. Thus, the population demography of communities suffering from mental illness or social illness are pyramided and with children mostly affected, this creates a cycle of mental illness and recurring social ills.

According to Altman and Stokols (1991) crime and deviance are not separate from disorders that communities face on daily basis. In their disorder continuum, they made it clear that these two aspects are proportionally linked to larger community problems and difficulties whether economically, socially, psychologically or culturally. This links particularly with other collective politically induced disorders like riot attacks to rather isolated disorders like vandalism. Hence these social problems even of smaller magnitude like street hustles and teen crake groups influence mental processes negatively. This is further supported by McKay and Shaw of the Chicago school of thought who posited on the urban ecology (Haralambos, 2006). Their model highlighted the differences in cognitive functioning that exists in societies from the rural setting into the urban settings. Their thesis as supported by Altman and Stokols (1991) highlighted that consequently in urban and suburban areas, people can be confronted with a range of disorders. Thus, there is variation in the intensity of disorder correlating with findings from the rural settings. This suggests that differences in elements that support livelihood in communities also pose differences in behaviours that affect mental health in the quest of searching for a better life.

7. Environment and Mental Health Issues

Environmental psychologists like Altman and Stokols (1991), argue that population density has a large bearing on behaviour. The mental stability of individuals can be largely affected by their surrounding environments. Most people who suffer from mental illness are those residing in the most densely populated areas were violence, crime, drug abuses and poor sanitation are situated. Thus, in these communities there is also an element of dissatisfaction with neighborhood conditions that are particular in the form of litter, garbage, vandalism and empty lots (Altman & Stokols, 1991). Thus, according to the population density theory such an arrangement of overcrowding in research done should evidence that most children who live on the ground floors of highly densely populated areas where there is noise of high magnitude are prone to suffer from auditory problems. Such areas are usually susceptible to pollution also posing threat to development of cardiovascular and respiratory disease generation. Thus, being a residence in such a community can affect cognitive abilities and performance of tasks that are regarded normal in our lives.

Behaviourism believes that aspects of maladaptation rest in faulty conditioning and channeling of individuals. Thus, if individuals are conditioned in an appropriate manner within their respective communities, the consequence of such become mentally unhealthy beings. This is supported by evidence from Ockley cited by Haralambos (2006) who stipulates that human behaviour is a product of socialization that occurs between an individual and the significant other that are close to him or her. Bronfenbrenner (1979) further supports this by stipulating that behaviours that people portray are directly linked to the interactions that co-exist between them and their respective ecological systems. Therefore, if an individual is exposed to people of maladapted nature, he or she will portray such a

behavior as highlighted by Merton in his view of the social strain theory on formation of subcultures and different social ideologies to life. Furthermore Lewin (1935) stipulates that behaviour becomes a consequence of person- environment factors that work in collaboration to bring about perceived outcomes. Therefore, communities are also there to perpetuate mental ill health for example suicide bombing that occur from time to time in Arab nations

Religion on the other hand has been seen to pose great negative influence to individual especially in countries that are in the Middle East (Post et al, 2003). Increase in suicide attempts and suicide bombs directly linked to religious beliefs have seen most people perish. Evidence suggests that religion affects reason and gives a strong excuse to which a person can cling on to commit criminal activities without feelings of guilty. Suicide tendencies are regarded as disorder and as such Islamic communities perpetuate the growth of such a disorder in the name of worship and dominance. Thus, instead of community enhancing positive values, it has now drifted towards self-destructive values attaching meaning to access of glory in the afterlife so that people will not question the motives and ideology behind these beliefs as supported by Trickette (2002). Thus, community in this manner directly affects mental health of its residence and creating social ills that will manifest even through the generation to come.

Furthermore, schools and other facilities that also play role of community form an integral part of how community in itself affects the residence. That is while teachers may agree that they are concerned with mastery and coherence, according to Lavikainen et al (2000) the major differences amongst nations on how the process of learning should take course and how ultimately the adult should demonstrate this mastery. That is in most African educational context, a well-established student; one who is regarded ideal should be obedient and docile, with this opinion shared with even the colleges and universities selection boards. However, in western society, they encourage autonomy and independence as essential element for human development and as a result, the school system only restricts a few elements but does not encourage docility although obedience is recognized (Lavikainen et al, 2000). Therefore, if an American student was to come and learn in African school setup, he or she may be regarded as a deviant, bearing in mind that mental health comes with the definition it is credited by the natives within that particular society except for common mental disorders. Therefore, community shapes people but the behaviours that will manifest if portrayed in the wrong geographic location can be seen as negative consequences of society on human behaviour. This can be best understood in terms of cultural sense of dignity, respect and obedience to authority (Trickette, 2002).

Societal allocation of power also plays a fundamental role in who gets sick and who does not. That is in most instances, individuals who are oppressed and repressed suffer mental health problems. Thus women, children and refugees are the people who are at high risk of suffering from mental problems as they are susceptible to marginalization and discrimination within their respective communities. The United Nations Special Rapporteur on the Right to Health notes that discrimination is a social determinant of health (WHO, 2001). Hence social inequalities channeled by discrimination and marginalization of particular group of people shape the distribution and prevalence of diseases and also their course of health outcomes amongst those affiliated. Thus, ill health becomes a manifestation rested in the marginalization and social oppression of other groups according to Choruma (2007). More so women are subject to discrimination in the fields of employment and other related fields, they have a glass ceiling upon them restricting them from achieving higher positions and as such they become vulnerable to domestic and sexual violence, these factors have been linked to a higher prevalence of certain mental disorders such as depression and anxiety among women. The 2001 World Health Report notes that "the traditional role of women in societies exposes them to greater stresses, as well as making them less able to change their stressful environment" (WHO, 2001).

8. Conclusion

Conclusively, communities to which individual belong pose a huge impact on their experiences as humans; hence these experiences expose people to development of poor or good mental health. Therefore, health outcomes even at individual level should be best understood from a broader scope before narrowing it and labeling the individual. Moreover, as psychologists, we should adopt comprehensive and inclusive understanding of problems from all models of treatment, to include medical, social, ecological and many other.

9. References

i.   Allport, G. W. (1930). The neurotic personality and traits of self-expression. The Journal of Social Psychology, 1(4), 524-527.
ii.   Almedom, A. M. (2005). Social capital and mental health: An interdisciplinary review of primary evidence. Social science & medicine, 61(5), 943-964.
iii. Altman, I., and Stokols, D., (1991), Handbook of environmental Psychology, New York: Wiley and Sons, Inc.
iv.   Butterfoss, F. D., Goodman, R. M., &Wandersman, A. (1993). Community coalitions for prevention and health promotion. Health education research, 8(3), 315-330.
v.   Choruma, T. (2007). The forgotten tribe: People with disabilities in Zimbabwe. CIIR.
vi.   Corey, G., Corey, M., Corey, C., &Callanan, P. (2014). Issues and Ethics in the Helping Professions with 2014 ACA Codes. Cengage Learning.
vii. De Leon, G. (2000). The therapeutic community: Theory, model, and method. Springer Publishing Company.
viii. Desjarlais, R. (1996). World mental health: problems and priorities in low-income countries. Oxford University Press, USA.
ix.   Dörnyei, Z., &Ushioda, E. (2013). Teaching and researching: Motivation. Routledge.
x.   Erikson, E. H. (1968). Identity, psychosocial. International encyclopedia of the social sciences, 7, 61-65.

xi.   Eriksson, M., &Lindström, B. (2007). Antonovsky's sense of coherence scale and its relation with quality of life: a systematic review. Journal of epidemiology and community health, 61(11), 938-944.

xii.   Faris, R. E. L., & Dunham, H. W. (1939). Mental disorders in urban areas: an ecological study of schizophrenia and other psychoses.

xiii.   Fernando, S., & Keating, F. (Eds.). (2008). Mental health in a multi-ethnic society: A multidisciplinary handbook. Routledge.

xiv.   Freud, S. (1940). The development of the sexual function. Standard edition, 23, 152-156.

xv.   Friedli, L. (2009). Mental health, resilience and inequalities.

xvi.   Haralambos, M. Holborn (2006). Sociology: Themes and Perspectives.

xvii.   Herrman, H., Saxena, S., &Moodie, R. (2005). Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organization.

xviii.   Karasek, R., & Theorell, T. (1992). Healthy work: stress, productivity, and the reconstruction of working life. Basic books.

xix.   Lahey, B., B. (2004). Introduction to Psychology, New York: McGraw Hill.

xx.   Lavikainen, J., Lahtinen, E., &Lehtinen, V. (Eds.). (2000). Public health approach on mental health in Europe. Stakes.

xxi.   Lewin, K. (1935). A dynamic theory of personality.

xxii.   Lindström, B., & Eriksson, M. (2006). Contextualizing salutogenesis and Antonovsky in public health development. Health promotion international, 21(3), 238-244.

xxiii.   Merton, R. K. (1968). Social theory and social structure. Simon and Schuster.

xxiv.   Post, J., Sprinzak, E., & Denny, L. (2003). The terrorists in their own words: Interviews with 35 incarcerated Middle Eastern terrorists∗∗ This research was conducted with the support of the

xxv.   Smith Richardson Foundation. Terrorism and political Violence, 15(1), 171-184.

xxvi.   Rappaport, J., & Seidman, E. (2000). Handbook of community psychology. Springer Science & Business Media.

xxvii.   Rogers, A., & Pilgrim, D. (2014). A sociology of mental health and illness. McGraw-Hill Education (UK).

xxviii.   Saxena, S., O'Connell, K., & Underwood, L. (2002). A Commentary Cross-Cultural Quality-of-Life Assessment at the End of Life. The Gerontologist, 42(suppl 3), 81-85.

xxix.   Sheppard, M. (2002). Mental health and social justice: Gender, race and psychological consequences of unfairness. British Journal of Social Work, 32(6), 779-797.

xxx.   Trickette, E. J. (2002). A future for community psychology: The contexts of diversity and the diversity of contexts. In A quarter century of community psychology (pp. 513-534). Springer US.

xxxi.   World Health Organisation, (2010)

xxxii.   World Health Organisation, (2001)