Journal of Modern Education Review, ISSN 2155-7993, USA
April 2014, Volume 4, No. 4, pp. 242–252
Doi: 10.15341/jmer(2155-7993)/04.04.2014/002

http://www.academicstar.us

Socio-cultural Imperatives and Basic Theory in Applied Research

Robert Kleiner[1], Tom Sørensen[2], Paul Ngo[3], Andreas P. S. Sørensen[4]

(1. Department of Sociology, Temple University, Philadelphia, USA; 2. Division of Mental Health and Addiction, Institute of Clinical Medicine, University of Oslo, Norway; 3. St. Norberth College, USA; 4. Division of Research, North Coast Psychiatry, Norway)

Abstract: This paper focuses on the origins of a theoretical and practical research perspective that developed from a series of community studies. They sought to understand the impact of socio-cultural and structural properties of a community on quality of life in mental health promotion projects in communities in North-Norway. Different types of observations and research methods were used depending on purpose, time, place, and analyses needed to be made; including quantitative surveys at the start of community interventions and in follow-up studies, field notes during intervention period, characteristics of populations, interviews with local resource groups at follow-up times, evaluations of projects by project director, and physical descriptions (including pictures) of community changes. This perspective has evolved from research done in different disciplines concerned with basic research and/or clinical/applied interests. Critical in conducting the project and understanding what was taking place, has been the impact of three types of realities occurring and interacting at the same time, i.e., objective, social-cultural, and psychological realities. Research activities in real communities required focusing on cultural and/or sub-cultural milieus influencing issues like socialization, educational policies and strategies. This perspective leads to new problems that need to be defined and dealt with. Paradoxically what may emerge is a new more comprehensive theoretical model.

Key words: basic and applied research, multiple realities, social cohesion, local community, interdisciplinary

1. Introduction

This paper will present a more explicit integrated perspective of the total program we have been developing and their ramifications for socialization, education, community integration programs and their role in enhancing psychological health, In addition, it will include a discussion of some of the problems that have emerged in the process. Our perspective derives from the writings of important figures from different disciplines, e.g., Lewin

Robert Kleiner, Ph.D., Professor Emeritus, Department of Sociology, Temple University; research areas: psychiatric epidemiology (communities), community/social psychiatry (social support, social cohesion, migration), mental health promotion (local community), quality of life (psychiatric patients, general populations), mental health service research (decentralized/community psychiatry). E-mail: robert.kleiner@verizon.net.

Tom Sørensen, Ph.D., Professor, Division of Mental Health and Addiction, Institute of Clinical Medicine, University of Oslo; research areas: psychiatric epidemiology (communities), community/social psychiatry (social support, social cohesion, migration), mental health promotion (local community), quality of life (psychiatric patients, general populations), mental health service research (decentralized/community psychiatry).

Paul Ngo, Ph.D., Associate Professor, St. Norberth College; research areas: research methods in social science, adapting analytical methods to new demands in social science research.

Andreas P. S. Sørensen, Research Assistant, Division of Research, North Coast Psychiatry, research areas: local community studies.

(Psychology), Leighton (Anthropology and Psychiatry), Durkheim (Sociology), Parker (Anthropology), Kleiner (Psychology and Sociology), Weinman (Psychology), Dalgard (Psychiatry), and Sørensen (Psychiatry). (References will be cited later in text.)

Historically, the basic and applied research activities of the current authors were carried out together or in overlapping collaborations. In the 1960s and 1970s, when our work began, Kleiner (USA), Dalgard (Norway), and Sørensen (Norway) were relatively new researchers, influenced by the prevalent biases, theoretical ideas, and methods of that time that still influence, to a considerable degree, our disciplines today. It is useful to give a brief description of how a serendipity or unexpected event could lead to new research methods and hypotheses that radically changed our focus from important epidemiological studies of mental illness to a focus on the importance of factors that may relate to their "causal" role in mental and psychological disorders, and their relevance for new innovative intervention and treatment programs.

In the 1950s and 1960s, the literature in the social sciences seemed to show conclusively that mental illness was higher among international migrants than natives in the host country. Two explanatory "logically compelling" models were developed to explain these findings that were called the "Culture Shock" and "Selective Migration" Hypotheses. The first emphasized the intrinsic role of conflict and stress between aspects of the culture of origin and the culture of destination. The second was predicated on the idea that the migrants were more emotionally disturbed than the natives in their community of origin due to problems of social isolation and mal-integration there, that made them more prone to migrate and escape these problems. The issue of internal migration was seen as a different phenomenon because the natives of an area in a given country and internal migrants in that country presumably shared the same culture therefore explanations based on cultural differences couldn't apply in the same way.

However, in that period, a number of studies in the United States and Norway by some of the researchers here published data raising serious questions about the presumed generality of the earlier findings and the relevance of the explanatory hypotheses given above (Parker & Kleiner, 1959); Dalgard (1969); and Sørensen (1979). Kleiner and Parker (1959) and Parker and Kleiner (1966) showed that natives in a major American city had higher rates of mental illness than migrants to that city. Dalgard (1969) showed that, in Norway, natives in a major city and urban migrants to that city had higher rates of mental illness than rural migrants. Sørensen (1979; 1991) showed that, in Norway, psychological problems among daily and weekly migrants (commuters) were a function of their ties to and integration with their communities of origin. In addition to affecting the male commuters themselves, their wives and even other people in areas with a high proportion of long distance commuters were affected. Such studies were discounted because they weren't studying international migration. However, the fact remained that these studies were raising questions about the generality of the earlier findings for both types of migration that had to be dealt with.

Reevaluation of the concepts used in the research at that time showed that (1) migratory status was always defined in terms of "Birthplace", (2) the different study populations were aggregates of large numbers of individuals who varied widely in social experience and demographic characteristics, (3) such aggregated individuals had no known relationship to each other, and (4) analyses of the explanatory demographic characteristics were based on assumptions about the meaning and implications of categories based on education, status, income, sex, etc. and their effects on people's views of themselves and others.

Migratory status was re-defined in terms of place and content of socialization in the first sixteen years of life and experience after the individual migrant's migration had occurred. The pattern of rates of mental illness and

psychological problems now varied in ways very different from before; and new explanations were required. The social structural, interpersonal and intra-personal properties of the particular communities of origin from which people came and the comparable properties in the communities of destination and their joint effects on psychological health had to be studied. In the process, it has become clear that the causes and risks of psychological problems had to be found in the communities of origin and destination.

2. Major Themes as Points of Departure

We are developing a strategy for mobilizing the resources of a community to deal with the stresses and strains in that community that impact on the mental health of its residents, This requires a causal model for understanding what the stresses and strains are, how they occur, what their effects are, and how to deal with them. Our approach demands that the model (1) provide an understanding of the interacting impact of three types of reality on mental health, (2) must be cognizant of the fact the perspective is necessarily interdisciplinary and involves different sub-specialties in each discipline, and (3) needs to know and understand the simultaneous relevance and usefulness of both basic and applied research efforts.

2.1 Types of "Realities"

To deal with the complex challenge of community psychiatry, especially with the increasing emphasis on community properties and their significance, we needed sophisticated models of the total reality to use where action is to occur. The point of departure for the mental health promotion projects in the seven Lofoten local communities was Leighton and his collaborator's studies that argued for the validity of a causal relationship between socio-cultural integration of a local community and mental disorder (Leighton et al., 1959). Adding to this perspective, and an integral part of how to understand the results of the Lofoten studies we focused on Lewin's Field Theory (Kleiner et al., 2006a; Kleiner et al., 2006b) and its concepts of life space, social space, and planned change (Cartwright, 1951). This led to the conscious emergence of the multiple realities perspective. The focus of field theory is the mapping of the totality of objective, social and psychological factors that may determine human and social behavior. In action research, it requires analyzing the total situation and choosing the best variables for changing the situation, and creating a stepwise change (unfreezing) model. Hence, the perspective for both understanding practice and research strategies was provided by the Multiple Realities Model derived from the Field Theory approach to science.

We tend to define the "reality" of a given discipline in terms of the data collected in the given discipline. Thus, for example, in social psychology, its reality would be the responses given to interviews, diaries, written responses, etc. about the world as they see it, based primarily on individual's perceptions of their reality. If we don't have the responses of collectives of individuals linked to each other in some way, we don't know their social reality. "Linkage" may be defined in terms of family ties, integration with school, neighborhoods, work situations, etc. Without such collective data, we can only depend on individual data. If we have both collective and individual data, we have two realities, the social and psychological realities. They may differ in some ways or be the same. Thus, the combined realities and their effects are different from the effects of the realities taken separately. Similarly, what is objectively true can be different from the first two realities, i.e., to what extent are the individual and social realities objectively correct, and what are the effects of the incongruities between them. These issues must be dealt with if one is to know causes of outcomes and how to change or eliminate such outcomes.

Thus, in dealing with the causes or antecedents of behaviors and the ways one can change those behaviors,

one has to have a complete or holistic view of the situation which can vary from a simple situation to an extremely complex situation. Any given situation includes what is objectively true, how do each of relevant social networks, reference groups, or social frames of reference collectively perceive and evaluate the situation, and how do each individual in the situation perceive and evaluate the situation. In general terms, these refer to different types of realities that we may call objective, social, and psychological realities. We would say that causal explanations of any given behavior must make use of at least two of these realities. For our purposes, they may be defined simply as follows:

The objective reality refers to what the community context and its properties really are. This requires a model of what the relevant objective properties are and how we can measure them (if possible). Social reality refers to how a specific collective of people evaluates their community and its properties. This requires defining the relevant collective groups, what needs to be measured, and how to measure their evaluations of these needs. The psychological reality refers to the way an individual perceives and evaluates one's community, its properties, its relevance to him/her and his/her motivation in that context. This also requires defining what aspects of the individual are important to look at, and how to measure them.

In reality, it is quite probable, that a person or a group will be part of more than one objective reality, more than one social reality, and more than one psychological reality. Several of these realities may be operative at the same time or at different points in time. Our analytic methods need to be able to separate out the influence of each reality and their interactive effects. The causal dynamics derive from the degree to which these different realities are congruent, different, contradictory, or complementary to each other. What is crucially important is that the concept of "community" is central to each reality and the interaction between them as well.

2.2 Meaning of "Interdisciplinary"

Each discipline usually defines its subject matter, its range of variables, its research problem areas, and its appropriate research and analytic methods. But in the present context, limiting oneself to a particular discipline is inapplicable and provides impoverished analyses and limited understanding. If we limit ourselves to one discipline, we are eliminating from the discussion, variables from other disciplines that may also act in an important way on the issue. This approach guarantees probability statements about whether the observed findings are due to chance, but not causal statements.

Variables from different disciplines are simultaneously or sequentially relevant to each of the realities in a given community. These variables interact with each other within each reality and between the realities, and have differing effects on the community, depending on their role and importance to the community. Clearly, this situation is more complex because it also requires integrating the theoretical insights and research methods of different disciplines into a single macro-theoretical paradigm.

2.2.1 Meaning of Sub-specialties

It is also true that different sub-specialties in a given discipline may contribute to the problems at hand. For example, from Psychology, clinical psychology, social psychology and cultural psychology may influence our thinking. Similarly, from Psychiatry, general psychiatry, neuropsychiatry, and social psychiatry may also influence our thinking. The same can be said for sub-specialties in Anthropology, Sociology, Economics, Political Science, etc.

2.3 "Basic" and "Applied" Research

Historically, there has tended to be (but not always) a separation between "basic" and "applied" research, i.e.,

they differ in their relevance to basic theoretic issues and practical problems. The manifestations of this distinction, shows itself in many ways: the kind of problems each deals with, the kind of theory each generates, the locus of their research, and the relevant methods they use. The distinction has also led to different organizations, different educational curricula, separate journals, separate meetings, and separate grant agencies. The implicit assumption is that although they overlap, they should be treated as different areas of activity.

In the context of our own research, our experiences and findings from both types of approaches are relevant and necessary to know; and we need to know how each contribute to our understanding, strategy, findings, and policy issues.

In the discussion to follow, we will illustrate the importance of these themes in our research. Because of the complexity of the situations we are working in, conceptual thinking and empirical activity frequently lead to problems and issues that may confuse the findings and conclusions. These always have to be dealt with.

2.3.1 Collective Disciplinary Origins

Early research based on epidemiological studies has been in need of explanation of their findings. Important contributions to the theoretical origins have been:

(1) EMIL DURKHEIM — relationship of properties of social categories or groups to deviance (Sociology) (1893; 1897)

(2) KURT LEWIN (and students and colleagues) — application of Field Theory to social sciences, development of group dynamic theory and research, and effects of social and social psychological factors on psychological and group problem behavior (Social Psychology and Ecological Psychology) (1947; 1951).

(3) ALEXANDER LEIGHTON (and students and colleagues) — Impact of community integration and change in community integration on mental illness (Psychiatry & Anthropology) (1959).

(4) ROBERT MERTON — relation of properties of social structure to deviant behavior (Sociology) (1957)

(5) HERBERT HYMAN — effects of reference group structure and dynamics on social and individual behavior (Sociology and Social Psychology) (Hyman & Singer, 1968).

(6) CLYDE MITCHELL — relationship of ethnic social networks in different cultural contexts to social behavior (Anthropology) (1969).

(7) KAREN HORNEY — role of competitive social group values in development of mental disorder (Psychiatry) (1941).

(8) ERIC FROMM — social structural variables as causing mental disorder (Psychiatry) (1941).

Over the years, our Research Methods have included all of the following:

(1) Laboratory Experiments

(2) Field Experiments

(3) Surveys

(4) Ecological Methods

(5) Historical and Archival Methods

(6) Case Histories

2.3.2 The Structural Dimensions of Each Reality

(1) Motivation — guiding values, aspirations, goals and expectations

(2) Initiative — origins of personal and social initiatives and availability of such initiatives

(3) Cohesion — interpersonal and intergroup attraction

(4) Consensus — degree of personal and community agreement about issues and actions

(5) Cooperation — interpersonal and intergroup cooperation

(6) Role Definition — clarity of roles and adherence to role demands

(7) Leadership — availability of leadership and utilization of leadership

2.3.3 Urban-Rural Focus

In earlier work, we concentrated on studying populations living in large urban centers such as New York, Philadelphia, Oslo, etc. In such studies, the size of the population and the complexity of the areas in which they resided required us to use sampling statistical methods. Such methods led to a dependency on inferences and generalization based on samples of individuals that were assumed to represent the population from which the samples were drawn. This did not allow for studying aggregates, universes, or systems of interacting individuals who were related to each other and in actual contact with each other in their life experiences. As our research developed, we moved into less urbanized areas and into more rural areas where we could interview close to the universe of people living in the rural community. This allowed us to develop ways of identifying systems of interacting individuals and determine the nature of their interpersonal interaction and integration. As our research became more cross-cultural and cross-sub-cultural, two problems emerged that we have to deal with. In order to make generalizations from our findings, we had to be concerned with the problems involved when dealing with similar research done in different cultures and sub-cultures, i.e., different populations. At the same time, we had to be concerned about generalizing across countries that differed in their "natural" environments, in their societal forms, in their degree of industrialization, in their educational system, etc. In view of the increasing population shifts to urban environments, operational definitions and measures of community have to change, with reduced dependency on administratively defined areas, community names, and physical boundaries.

We will illustrate the paradigm with experience in two of seven rural communities in Northern Norway, differing in population, social structure and community culture. This required us to change our strategy to fit each community. We had to learn what successes there were and what failures there were in each community; and why these outcomes occurred.

3. The Lofoten Studies

The setting: The Lofoten region in North Norway has about 24000 inhabitants, and consists of a series of islands stretching out into the Gulf Stream north of the Arctic Circle. The region is composed of six municipalities. The main income of this region has historically come from the Norwegian Arctic cod fisheries in the wintertime. Work connected with the fisheries has been important in all of the local communities we have studied. In the last years of the 1980's, the usual migration of cod that come to spawn along the coasts of Lofoten in February-March failed to occur. The authorities introduced limiting quotas for each boat. This put the fishermen, boat owners, and the land-based fishery companies in an economically impoverished situation. The mental health promotion project derived from this fishery crisis.

3.1 Community Psychiatry

From the early 1980's, a proximal community model for psychiatric services called "The Strategic Network Model" (Sørensen & Sandanger, 1989) was developed in Lofoten. The evolving structure focused on co-operation among a wide range of local personal and social networks, including people from health and social services, schools, local political structures, the administration, private enterprises, and ultimately the general population; all working toward enhancement of mental health of the total population.

3.2 Mental Health Promotion

The coming together of the regional crisis situation in the fisheries and this local-community-focused psychiatric specialist service, evolved into a mental health promotion project. The first stages of the project were planned in meetings between local political leaders, health officers and administrators representing the Lofoten municipalities, and the initiators from the Psychiatric out-patient clinic in Lofoten. From these activities, a group of mental health promotion projects named “Liv Laga i Lofoten” were carried out during the 1990’s. The design for carrying out the projects was a product of a comprehensive community psychiatric model for prevention of mental problems and promotion of mental health (Sørensen et al., 1996). The model has roots that stem from many origins in the literature, but with different names (e.g., Lewin, 1947; Caplan, 1964; Kleiner & Parker, 1976; Leighton & Murphy, 1987; Medly & Acan 2008). Leighton (1959), being both anthropologist and psychiatrist, shows clearly the disciplines that contributed to his concept of socio-cultural integration-disintegration, anthropologists/anthropology was central to his understanding community function (Hughes et al., 1960). A common denominator for many of these roots would be the concept of social cohesion in the Lofoten project (Sørensen et al., 2013).

3.3 Socio-cultural Integration

Historically the perspective of societal disorganization causing personal disorganization was put forward by the French philosopher Comte (Bastide, 1972). A research starting point could be Durkheim’s (1883, 1997; 1887, 1997) description of a cohesive society, i.e., a society characterized by a multitude of mutual moral supports, which do not depend on individuals’ own resources, but leads them to share their collective energy and mutual support. Durkheim defined the cohesive society in terms of mutual defined and agreed upon role expectation and goal directed behavior which would lead to positive mental health. Tonnie’s (Harris, 2001) division of social groups into “gemeinschaft” and “gesellschaft” is also a forerunner of the concept of the “cohesive community”. Leighton (Sørensen et al., 2004) emphasized that increased economic and educational opportunities were not enough to bring about a turn for the better in a disintegrated community. One needed the development and enhancement of social important processes: leadership, followership and practice in cooperatively working together, thus enabling people to gain confidence that they could do things to better their lot. Also social capital (Putnam, 1993) emerges as a meaningful concept because it embraces individual (internal) and social (external) resources, the degree of socio-cultural integration, and the interaction of both types of resources. The relationship between social capital of a community and mental health has also been shown by Almedon (2005). A geographical defined community is socially integrated or cohesive to the degree that it has internal and external social capital, and high level of social cohesion has been seen to negate the effects of small-area deprivation on mental health (Fone et al., 2007).

3.4 The Mental Health Promotion Project

The Lofoten mental health promotion model emphasizes the mobilization of the citizenry and intrinsic social resources for a higher quality of life, for the present and the future. The Lofoten community projects had a combined focus on material disadvantage and social capital, as well as developing effective leadership and effective community organizations to carry out the local plans. The main questions asked in the project were: (1) What are the properties of a local community that secure the mental health of its inhabitants; (2) how can one influence such community processes; and (3) what are the requirements for an enduring development of a socio-cultural integrated cohesive local community.

Seven local communities took part in the project activities that occurred over a 3–4 years period. In each of these communities, surveys were carried out to acquire information from residents to be used in the community development programs, as well as data to evaluate possible changes in both the properties of the community structures and of personal qualities of life. The first surveys took place in the first months of the community activities, and there were two follow-up surveys, 6 and 16 years after the end of the project period respectively. In addition to analyzing the three surveys (for each community), detailed notes were kept and audio tapes were made during the entire process, and at all community and committee meetings. Priority lists were made of ideas for change, and newsletters reporting on the activities and progress of the projects were published in the same period. After the projects terminated, and after having analyzed the follow-up surveys, there were systematic meetings/interviews with groups of key persons in each community to give feedback about their experiences during the in intervention project and concurrent community activities during the follow-up periods. The project coordinator for the total project was interviewed systematically about the project and other developments in each of the communities during the entire 20-years period. During the total project and during the follow-up periods, pictures were taken to illustrate the material condition of each of the seven local communities, as well as changes that may have occurred.

These different sources of data forced us to evaluate the research/analytic methods so as to provide us with a comprehensive map of what took place based on input from a multiple reality perspective on the requirements for an enduring development of a socio-cultural integrated and cohesive local community. This can be seen most clearly by contrasting the development and experience of two of the project communities (Kleiner et al., 2012; Sørensen et al., 2012). The populations of both communities, Bridge Haven and Utmost Port, evaluated themselves most positively in the first survey than most of the other communities on how their community functioned and their own quality of life. Bridge Haven became more negative over time on these indicators, especially from the first to the second follow-up surveys. Utmost Port, on the other hand, showed a continuous increase in their positive evaluations on these indicators in the same period. These divergent changes could be seen most clearly in the collective evaluation of two of the core-community integration dimensions (social reality), “Initiative & Co-operation” and “Leadership”, and in one of the individual defined quality of life dimensions, i.e., “Experience and Interpretations of Social Support” (psychological reality). These descriptions of the changes taking place in the two communities were supported by interviews with local resource people, the project coordinators’ evaluations and the concrete changes that show itself in pictures taken through the 20-years period.

A main asset in Utmost Port was a very strong collective leadership group, evolving from the local school. Thus, this aspect of the social reality perspective in this community was not dependent on one person making the project work. They were open to their community, i.e., to also include new members of their community in the continuous community development. In contrast, the leadership in Bridge Haven leaned heavily on one person and a few members of her network. When this group had personal difficulties or moved out of the area, others did not take their place to continue the activities. Our pictures show how few of the ideas generated in Bridge Haven were completed, whereas in Utmost Port, one can see an enlarged harbor, renewed school area, new buildings and new social meeting places.

4. Concluding Reflections

Action research: The Lofoten mental health promotion project has been an action research project deriving

from studies that showed that community work could increase the social cohesion, the socio-cultural integration of a local community, and the community's mental health. The Lofoten-surveys used indicators measuring dimensions of socio-cultural integration (Sørensen et al., 2013), and showed that such an approach can demonstrate the changes that occur in the project communities. The practical implementation of the projects in Lofoten is in debt to Leighton and Lewin and their students; especially as they laid the early foundation for understanding change in social situations (Lippit et al., 1958; Marrow, 1969; Schein, 1992). Lewin's model of planned change utilizing field theory, group dynamics, and action research in a stepwise change model has helped to understand the community-individual interaction processes during the project period and in the follow-up periods (Lewin, 1947; Medley & Acan, 2008).

Interdisciplinary: The practice within the community model in the Lofoten psychiatric out-patient clinic evolved to be, in a very broad sense, interdisciplinary. The network for mental health enhancement did not only included people from the health and social service, but also reached out to teachers, employment office, police, and in Lofoten a very important group, the fishery organization, etc. Also one had a close relation to political bodies; all groups that had an extensive contact with a broad range of people, often in crises situations. The contact consisted of meetings, supervision and education, and also local newspapers and other media were often used. The design of the mental health promotion project was also done within an interdisciplinary context. The first stages of the project were planned in meetings between local political leaders, health officers and administrators representing the Lofoten municipalities, and the initiators from the Psychiatric out-patient clinic in Lofoten. Together with a researcher experienced in psychiatry, mental health survey research, and the concept of socio-cultural integration, the "Liv Laga i Lofoten" — project was put into action. Also the practical work in local community projects was in every respect an interdisciplinary cooperation. The project leaders had background in psychiatry, medicine, history, education and organizing. The local; participants represented all aspect of community resources: teachers, fishermen, farmers, shop owners, social and health workers, politician etc. Also the researchers analyzing the data represent an interdisciplinary group; sociology, psychiatry, social psychology, epidemiology, statistics and history.

Multiple realities: The emphasis on "multiple realities" emerges from Lewin's theories of life-space (psychological reality) and social-space (social reality) (Cartwright, 1951; Kleiner, 2006). In the Lofoten project the main information about psychological and social realities would be the three series of surveys where people report on their state of subjective quality of life and their evaluation of how their respective local community functions. The experience of personal social support, nervous symptoms, and level of well-being, reflect the person's psychological reality. In addition, in fairly small and visible communities, people's lives are affected by the functioning of their local community (social reality); hence, taken collectively, one may talk about shared "subjective quality of life" on the community level.

The project communities in Lofoten are fairly small, surveyable, and it is possible for people to know about each other and what takes place in their community; hence, their community evaluation, represent valid indicators of the social reality. To the extent objective realities can explain the states of -, and change in social and subjective realities in the project communities, would be hypothetical, and not provable causes (as shown in an experiment). However using the multitude of types of observation in the project, one can argue for causal relations.

An important element in the objective reality for Bridge Haven was the building of a new bridge, connecting the community to the municipality center, e.g., making the central school there accessible. This resulted in the closing of their local community school, thereby moving this service and related activities out of the area. In the

latest follow-up study, there was a major decline in the population, especially the loss of active teachers who moved out. In contrast, Utmost Port showed a population increase and enlargement of their school. Traditionally, teachers have been major social resources. The stable cohort of teachers in Utmost Port and the loss of the same type of people in Bridge Haven have clearly contributed to the diverging community developments. Additional important determining aspects of the objective reality in the two local communities were the differences in the systems of work (fishing/farming) and ownership of homes and land. For example, in Utmost Port, it has been possible for new people to buy houses and start small businesses, whereas in Bridge Haven, people who have moved out of the community continued to own their properties, hence, preventing new (young) people from having places to live in.

Distinguishing between objective and social realities in a project like "Liv Laga i Lofoten", can be a complex task. Some factors like condition of harbors, farmland, closeness to fishing resources, and technical levels of boat and land transportation are clearly objective realities, but the processes leading to or using these assets, may be the result of the influence of social realities in a community and the subjective realities of strategic community members. For example, whether a school is located in a local community, or if children have to travel to another (more central) community is an objective issue, but the community that succeeds in keeping its local school could be the result of the quality of the leadership structure, i.e., a reflection of the social reality.

Applied and basic research: The Lofoten project also demonstrates how applied and basic research interacts, and alternately, changes the focus of the research process. The practical mental health promotion design came from community intervention by Leighton and co-workers in Nova Scotia (Leighton, 1965) building on their theory about the relationship between socio-cultural integration in a local community and the mental health of the actual population, hence starting as applied research. However the community descriptions and evaluations in Nova Scotia were done by trained anthropologist. In Lofoten, the community assessments had to make use of questionnaires in a more sociological approach. This method revealed the multi-dimensional aspect of the integration concept, and could later show how these dimension differed to their effects on how people evaluated their personal social support (Sørensen et al., 2002). Also the findings that different dimensions of socio-cultural integration can vary in their sensitivity to change in a community intervention project, have a basic relevance, as well as applied when indicators of socio-cultural integration are to be used in future practical mental health promotion projects.

Context: Thus placing the project activities in the real community required focusing on the respective cultural and/or sub-cultural milieus of communities that influence such issues as socialization, educational policies, and strategies. New observations have to be made continuously, and need to be evaluated and dealt with. Paradoxically, such applied strategies may lead to new fundamental theoretical understanding and actions.

References

Almedom A. (2005). "Social capital and mental health: An interdisciplinary review of primary evidence", *Social Science and Medicine*, Vol. 61, pp. 943–964.

Bastide R. (1972). *The Sociology of Mental Disorder*, London: Routledge & Kegan Paul.

Caplan G. (1964). *Principles of Preventive Psychiatry*, London: Tavistock.

Durkheim E. (1893, 1997). *The Division of Labor in Society*, New York: The Free Press.

Durkheim E. (1887, 1997). *Suicide: A Study in Sociology*, New York: The Free Press.

Fone D., Dustan F., Lloyd K., Gareth W., Watkins J. and Palmer S. (2007). "Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis", *International Journal of Epidemiology*, Vol. 36, pp. 338–345.

Fromm E. (1941). *Escape from Freedom*, New York: Holt, Rinehart and Winston Inc.

Harris J. (Ed) (2001). *Ferdinan Tonnies: Community and Civic Society*, Cambridge: Cambridge University Press.

Horney K. (1937). *The Neurotic Personality of Our Time*, New York: W.W. Norton & Co.,Inc.

Hughes C. C., Tremblay M. A., Rappaport R. N. and Leighton A. H. (1960). *People of Cove and Woodflot*: *Communities from the Viewpoint of Social Psychiatry*, New York: Basic Books.

Hyman H. H. and Singer E. (1968). *Readings in Reference Group Theory and Research*, New York: The Free Press.

Kleiner R. J. and Parker S. (1976). "Network participation and psychosocial impairment in urban environments", in: P. Meadows & Mizruchi (Eds.), *Urbanism, Urbanization, and Change: Comparative Perspective*, Reading: Addison and Wesley, pp. 322–337.

Kleiner R., Sørensen T., Dalgard O. S., Sandanger I., Okeke B. and Klepp O. M. (2006a). "Serendipitous research finding: New theorizing and psychological health status I", in: *Lewinian Psychology*: *Proceedings of the International Conference, "Kurt Lewin: Contribution to Contemporary Psychology"*, Poland, 85-090 Bydgoszcz Kamirerz Wielki University Press, pp. 222–230.

Kleiner R., Sørensen T., Dalgard O. S., Sandanger I., Okeke B. and Klepp O. M. (2006b). "Serendipitous research finding: New theorizing and psychological health status II", in: *Lewinian Psychology: Proceedings of the International Conference, "Kurt Lewin: Contribution to Contemporary Psychology"*, Poland, 85-090 Bydgoszcz Kamirerz Wielki University Press, pp. 231–248.

Kleiner R., Sørensen A., Sørensen T., Bøe N. and Ngo P. (2012). "Municipal politics and leadership structure as determinants of success and failure in community promotion projects — A multiple realities perspective", in: *SCCR Meeting in Las Vegas 2012*.

Leighton A. H. (1959). *My Name is Legion*, New York: Basic Books.

Leighton A. H. (1965). "Poverty and social change", *Scientific America*, Vol. 215, pp. 3–9.

Leighton A. H. and Murphy J. M. (1987). "Primary prevention of psychiatric disorder", *Acta Psychiatrica Scandinavica*, Vol. 76, Suppl. 337, pp. 7–13.

Lewin K. (1947). "Frontiers in group dynamics", *Human Relations*, Vol. 1, pp. 5–41.

Lewin K. (1951). *Field Theory in Social Science*, D. Cartwright (Ed.), New York: Harpers and Brothers Publishers.

Lippitt R., Watson J. and Wesley B. (1958). *The Dynamics of Planned Change*, New York: Hartcourt, Brace & Company.

Marrow A. J. (1969). *The Practical Theorist: The Life and Work of Kurt Lewin*, New York: Basic Books.

Medly B. C. and Acan O. H. (2008). "Creating positive change in community organizations: A case for rediscovering Lewin", *Nonprofit Management & Leadership*, Vol. 18, pp. 485–496.

Merton R. K. (1957). *Social Theory and Social Structure*, New York: The Free Press.

Mitchell J. C. (1969). *Social Networks in Urban Situations, Analysis of Personal Relationships in Central African Towns*, Manchester University: Bracton Books.

Parker S. and Kleiner R. J. (1966). *Mental Illness in the Urban Negro Community*, New York: The Free Press.

Putnam R. D. (1993). "The prosperous community — Social capital and public life", *American Prospects*, Vol. 13, pp. 35–42.

Schein E. H. (1992). *Organizational Culture and Leadership*, San Francisco: Jossey-Bass Publishers.

Sørensen T. (1979). "Pendling lokalmiljø og mental helse: En psykiatrisk befolkningsundersøkelse", Doktorgradsavhandling, Universitetet I Oslo.

Sørensen T. (1991). "Commuting, community disintegration and psychiatric disorder", in: T. Sørensen, P. Abrahamsen and S. Torgersen (Eds.), *Psychiatric Disorders in the Social Domain*, Oslo: Norwegian University Press.

Sørensen T., Bøe N., Ingebrigtsen G. and Sandanger I. (1996). "Individual — local community and mental health: Towards a comprehensive community psychiatric model for prevention of mental problems and promotion of mental health", *Nordic Journal of Psychiatry*, Vol. 50, Suppl. 37, pp. 11–19.

Sørensen T., Bøe N., Kleiner R., Sørensen A. and Ngo P. (2012). "Local historic, economic, and geographic determinants of success and failure in community promotion projects — A multiple realities perspective", in: *SCCR Meeting in Las Vegas 2012*.

Sørensen T., Kleiner R., Ngo P., Sørensen A. and Bøe N. (2013). "From socio-cultural disintegration to community connectedness: Dimensions of local community structure and their effects on psychological health of its residents", *Psychiatry Journal*, Vol. 2, Article ID 872146.

Sørensen T., Mastekaasa A., Kleiner R., Sandanger I., Bøe N. and Klepp O. M. (2004). "Local community mobilization and mental health promotion", *International Journal of Mental Health Promotion*, Vol. 6, pp. 5–16.

Sørensen T., Mastekaasa A., Sandanger I., Kleiner R., Moum T., Klepp O. M. and Bøe N. (2002). "Contribution of local community integration and personal social network support to mental health", *Norsk Epidemiologi*, Vol. 12, pp. 269–274.

Sørensen T. and Sandanger I. (1989). "The strategic network position: A feasible model for implementing a decentralized psychiatry", *Health Promotion International*, Vol. 4, pp. 297–304.