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Cultural Understanding of Health and Adjustment to Cardiovascular Disease among the Greek Elderly

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Cultural Understanding of Health and Adjustment to Cardiovascular Disease among the Greek Elderly

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Abstract: The onset of chronic illness is a significant life event that poses a frightening challenge at a micro and macro level. One such chronic illness is cardiovascular disease (CVD), which is a major health problem in Australia. The way in which individuals adapt to chronic illness is closely related to the cultural and linguistic factors that are an integral part of personal identity. This study presents the health beliefs of elderly Greek Australians and the way they understand health and disease. The process through which elderly Greek Australians conceptualize CVD and seek medical care will be discussed in the context of their specific cultural views and attitudes towards illness.

Keywords: Health Beliefs, Conceptualization of Heart Disease, Cultural Views and Attitudes, Traditional Views and Beliefs, Elderly Greek Australians

Introduction

The onset of chronic illness is a significant life event that poses a frightening challenge at a micro and macro level. One such chronic illness is cardiovascular disease (CVD), which is a major health problem in Australia. The way in which individuals adapt to chronic illness is closely related to the cultural and linguistic factors that are an integral part of personal identity. These factors, in turn, can suggest approaches to treatment and management of disease that are tailored to the specific needs of the group in question.

CVD is one of the major chronic illnesses affecting the Australian population and is likely to increase in significance as the population ages (ABS, 2011b). In the interest of providing the most effective care for individuals with CVD, it is important to understand the factors that impact on the experience of specific groups who are affected by this disease, especially those who may be outside the cultural mainstream. The Australian Greek population is one population subgroup whose linguistic and cultural background is significantly different from the English-speaking majority and who display a high prevalence of CVD risk factors, including obesity, low physical activity, diabetes, and smoking (Kouris-Blazos, 2002), suggesting that members of this cultural group are likely to require care for CVD but may have health care needs that differ from those of the general public.

This study was conducted in Melbourne, Australia, in 2011. Melbourne is home to one of the largest Greek diasporas in the world, as large number of people from Greece migrated to Australia following World War II (ABS, 2011a). While second and third generation Greeks are highly integrated in to Australia society, Greek remains one of the top 10 languages in use in the nation today (ABS, 2010). Participants for the study were drawn from users of Fronditha Care, a community organization in Melbourne that provides a range of health and
social services to elderly people of Greek background. Thirteen individuals (five male and eight female) over the age of 60 who had been diagnosed with CVD or had a family member that they cared for with this condition and expressed an interest in participating in this study and were subsequently interviewed in depth about their experiences of illness and the way in which they understood this condition.

Once ethics approval was obtained from the management of Fronditha Care and also from the Human Ethics Committee of Latrobe University in Melbourne, a formal meeting was arranged with the planned activity co-coordinator. After meeting with the participants of the planned activity group, the personnel at Fronditha Care provided advice to the researcher but did not communicate with potential participants about this study. The researcher explained the study to potential participants verbally, in addition to providing them with written material. This information package, containing details of the study and the consent and withdrawal form, was written in plain English and Greek. Fronditha Care provided access to participants and an introduction for the researcher as well as advice about which individuals might be able to participate. Participants were chosen on the basis of these recommendations.

At the time of the interview, the participants were provided with further information on the project, were given the opportunity to ask questions, were assured that they could withdraw from the process if they wished to, and were also informed that they could take a break from the interview at any point if they required it. The participants of this study were encouraged to share their understanding of health, to reflect on their traditional views about what health is and how they might respond to medical advice.

Finally, they were asked to share their understanding of CVD and what their specific cultural views and attitudes are toward CVD. Data collection took place via in-depth, semi-structured interviews utilising a number of open ended questions which aimed to encourage the participants to share their personal experiences. Participants were interviewed over a one month period by a Greek speaking researcher and were encouraged to express their views in either English or Greek, depending on which language they felt comfortable with. The majority of the interviews took between 45 minutes to an hour each, with all interviews recorded using a digital voice recorded and transcribed immediately by the investigator. Transcription contributed to the analytical process as it was necessary to analyse and understand the terms/words used by the participants and the meanings they held for them.

**Cardiovascular Disease in Australia**

The growing prevalence of CVD in Australia has been noted in a number of publications. The Australian Bureau of Statistics (ABS) (2001) and the National Health Survey 2007–2008 (ABS, 2009) documented that cardiovascular disease remains one of the principle causes of death in Australia. More recently, the Australian Heart Foundation (2009) announced via a media release that, “CVD remains the number one killer in Australia responsible for 34% of all deaths”.

Statistics obtained from the Australian Bureau of Statistics (ABS) 2007–08 National Health Survey further confirm that the Australian population groups that showed highest prevalence of CVD were those born in northwest Europe (29%), followed by UK and those born in southeastern Europe (both at 28%). Dassanayake et al. (2009) studied the prevalence of CVD in immigrant groups in Australia. Their findings suggested that CVD is highest among communities originating in the Middle East and southern European. The Greek
population is part of this group, and CVD is a significant concern among them as well as in their nation of origin (Panagiotakos et al., 2008; Allender et al., 2008).

**Cardiovascular Disease in the Greek Population in Australia**

In the early 1990’s, a study was undertaken in the Marrickville area of inner Sydney that aimed to measure the prevalence of CVD risk factors among Greek Australians as well as this population’s knowledge and awareness of such factors. Data collected in this study showed that between the years 1966–1976 coronary heart disease in Australian born men decreased by 18%. However this was not the case for men born in Greece for whom there was an increase of 4% for the same period. Also this report found that increased length of residence in Australia increased this population’s risk of CVD. The findings also indicated a general lack of culturally and linguistically appropriate health programs for this, as well as other, ethnic groups (Wilson et al., 1993). This is consistent with a study undertaken in Greece by Kiritsi, et al. (2008) that showed risk factors for CVD among the Greek population are high and that CVD is one of the principle causes of death in Greece.

Kouris-Blazos (2002) conducted a study to examine what she calls the ‘morbidity mortality paradox of 1st generation Greek Australians. Her study presented some interesting facts about this group that suggest, despite its high prevalence of CVD risk factors, mortality rates are 35% lower compared to Australian born individuals. The existence of this ‘paradox’ indicates that there may be other factors specific to the experience of Greek Australians that provide protection from the negative effects of certain CVD risk factors. The present study seeks to identify some of these factors by elucidating the experience of elderly Greeks who are affected by CVD and describing the cultural influences that contribute to their resilience and ability to cope.

**Culture and Health**

Culture has a significant role in determining health and health behaviors and, as a result, is central to understanding how a particular group might conceptualize disease. Traditionally both health and illness have been described in biological terms, but it is also the case that beliefs about health can be influenced by culture (Burch, 2008). Cole, Stevenson and Rodgers (2009) note that culture may be a way that individuals can better understand and interpret a particular illness. People naturally ascribe meaning to their experiences (Geertz, 1973), and the meaning of illness is often found in the culture of the individual involved. These cultural norms relating to health are learned from the society in which a person lives and are also shaped by language.

Culturally acquired ways of thinking are often based on traditions and beliefs that have been handed down from one generation to the next and that have been embedded in a given culture over time. These cultural conceptualizations about health are not necessarily grounded in medical fact but are widely accepted as ‘trustworthy’ by most members of the community and shape their health beliefs and practices. Williams and Healy (2001) highlight the significance that culture may have in the area of mental health, more specifically how health beliefs may be a factor in making individuals reluctant to seek support outside their family. Dressler (2004) notes a discrepancy between the risk of disease in relation to culture, concluding that individuals from more developed industrialized societies have higher blood pressure in
comparison to those from less developed traditional societies, largely because of the discrepancy between ideal and actual experiences in terms of cultural expectations. This issue, termed cultural consonance, is helpful in understanding the impact of cultural change on the health of individuals (see also Dressler et al., 2005).

Winkelman, (2009) suggests that the effect that culture has on health is a macro issue as it affects society as a whole. An example of the effects of culture on health and behavior, as described by Winkelman (2009), is: “conceptualizing health maladies and their significance, affecting the distribution of causes of disease and illness, shaping utilization of the popular, folk, and professional sectors of health care” (pg 5), and there are many others. The cultural perspective is significant for this study as it will assist in understanding the participants’ conceptualization of health and how they respond to care. For example, traditional dietary choices may promote or prevent certain diseases. An understanding of culture-specific interactions of this type may assist at a macro level in addressing treatment plans and ensuring effective communication and appropriate services.

**Traditional Approaches to Serious Illness**

In many Greek families, chamomile tea is the cure for all illnesses. This and other traditional responses to most health concerns of this group represent folk remedies that might include a cup of tea or yiayia’s (granny’s) homemade chicken soup. For other illnesses, the most likely cause is often thought to be supernatural and may be attributed to “the evil eye,” an ancient form of ill wishing against a person by someone who wishes them harm (see Berger, 2011, for a complete discussion of this issue in Greek and other cultures). This belief is not just specific to the Greek population but is also found elsewhere in the world (Burch, 2008).

The Greek population, and particularly its older members, often prefer home remedies during times of illness. Traditionally, home remedies or folk healing activities were either known to the patient or their family or were recommended by a neighbor or a folk healer (wise women, sorcerers, priests, nuns). A study of health behaviors in ancient and modern Greek culture found that some of the most common remedies used to cure illness are: chamomile tea, holy water, olive oil, ouzo, wine, salt/pepper, soup and honey (Blum and Blum, 1965). For many older Greeks in Australia, traditional folk cures of this kind remain the first step in treating illness in themselves or in family members.

Caring for those who are ill is seen as a familial duty and not to do so is to dishonor one’s elders. The Greek people are very supportive when a member of their family is sick; instinctively they take on the care role as their responsibility and duty. An example of this is when a Greek patient is in hospital; their relatives visit and stay as long as possible, often disobeying policy and procedures put in place by the medical facility, such as limits on visiting hours or number of visitors. This is not a deliberate act to disrespect the rules but a misunderstanding due to their cultural interpretation of appropriate behavior (Pilowsky and Spence, 1977; Niakis et al., 2004). The importance of consultation and mutual support within the family cannot be overestimated and is one of the most important aspects of culturally-determined behavior transmitted by older family members to younger ones.

It is important to note, that many elders of the Greek Australian community came from poorly developed rural areas of Greece, and few completed basic schooling (Fakiolas, 2002). Some health services in the modern context, particularly allied health practices such as occupational therapy or advice from dieticians or other practitioners in rehabilitation fields,
may be unfamiliar to this population and, because of this, they may be skeptical about treatment plans and methods of prevention for a particular illness (Keleher and Hager, 2007; Papa et al., 2009). This is one significant reason why this group tends to prefer traditional approaches to illness as their cultural background influences how they perceive and respond to various health concerns.

**Adjustment to Life with Illness**

There are various schools of thought on the topic of adaptation and adjustment to chronic illness. The one thing, however, that is agreed upon by most health professionals is the process of adaptation which is, as described by Livneh (2001), is long term and continuous and does not occur in a linear fashion but can be unpredictable and complex. Livneh (2001) developed a model of psychosocial adaptation containing three dimensions. The first dimension considers the triggers associated with a particular condition, for example the onset, causes, and biological, psychosocial, and environmental variables associated with a particular chronic illness. The second dimension takes into account the experiences and reactions relating both to the social and psychological aspects of a particular condition for an individual. The third dimension evaluates the anticipated outcomes, for example an individual’s overall quality of life at a social level.

Adjustment to a chronic condition such as cardiovascular disease can be dependent on factors like the causes or onset of the illness as the model indicates, but, in practice, the second and third dimensions may be extremely significant to the individual in question in terms of his or her perceived experience. Kendal and Buys (1998) further explored this psychosocial adjustment in a study of acquired disability utilizing what they refer to as a recurring model “in which adjustment is viewed as an ongoing cycle” (p. 17). This model highlights the reconstructive process of adjustment following a serious condition, specifically the way people think about their overall experience. It is well documented in the literature that physical health is strongly associated with emotional wellbeing, and this is commonly found among middle age and older adults (Felton and Revenson, 1984). This underscores the connection between physical state and emotional state and suggests that adjustment to a chronic condition cannot be viewed along only one dimension or the other.

What is noted in the literature, however, is that people adjust differently to various health issues, and this is often associated with their coping strategies. Felton and Revenso (1984) confirm that “coping does influence the process of adaptation” (p. 352). This is supported by the findings of Kendal and Buys (1998) which indicate that adjustment will also vary from one individual to the next as it is dependent on coping sources available to them. Sollner et al. (1999), considering melanoma patients’ coping behaviors and social support, showed a link between positive social support and adjustment to illness. In relation to elderly individuals, coping in the context of ‘successful aging’ has often been linked to the avoidance of disease and disability (Rowe and Kahn, 1987), although cognitive factors and a high level of social engagement are often included (Young, Frick and Phelan, 2009). A strong sense of coherence and personal spirituality have, for older populations, been associated with better coping and enhanced quality of life in chronic illness (Delgado, 2007).

There is a large body of literature documenting the process of adjustment to illness that highlights the crucial nature of adaptation to a particular health issue and its relationship to an individual’s ability to cope. Coping is to some extent dependent on the emotional resources
of the individual that may derive from his or her social environment (Livneh and Antonak, 2007). One aspect of this environment that has relevance in the context of chronic health conditions is religious belief and faith, which is of particular importance to older Australians of Greek background.

**Religion as a Means of Resilience and Coping**

The importance of religious faith as a source of coping and a means of resilience to major life stressors is well documented in the literature and has been shown to have a significant role in supporting those affected by a life crisis as “religion has unique effects on resilience” (Pargament and Cummings, 2010, p. 193). Religiousness has been associated with resilience as faith seems to provide individuals with a means of survival, a level of understanding and the ability to endure the effects of various life crises such as illness. Through religious faith, individuals may give meaningful explanations to the life stressors they experience. Park and Folkman (1997) noted that people instinctively seek explanations and meanings for life events in general and particularly for highly stressful conditions. Having an explanation for a situation that causes high levels of stress can be of benefit to individuals’ psychological wellbeing (Pargament and Cummings, 2010).

Religiousness has also been associated with increased social support, a form of protection from further stressors, and hence is closely associated with a means of coping (Park and Folkman, 1997). This was noted by Ai et al. (2004) who showed that prayer undertaken by patients awaiting heart surgery has value as a means of coping. It was noted by Pargament et al. (2004) that methods of positive religious coping, such as the search for religious support among elderly patients, were linked to improvements in health. The significance of religious coping was also elucidated by Tix and Frazier (1998) who found that religious coping was associated with improved adjustment to the stress of kidney transplant surgery.

Numerous studies have confirmed the value of religious faith in individuals facing serious health challenges. A study by Prado et al. (2004) found that religious behaviors engaged in by HIV-seropositive African American woman were associated with greater coping abilities. Friedman et al. (2006) found support for this in their study of woman seeking medical consultations for symptoms of breast cancer. Similarly, a study by Koenig (2007) noted that patients who held strong religious beliefs had less hostile behavior prior to heart surgery. Studies such as these, and many others available in the literature, further indicate that religious people often show greater personal empowerment and demonstrate a clear connection between religion and resilience.

**Cultural Understanding and Adjustment to CVD among Elderly Greeks**

Without fail, the elderly Greek Australians who participated in this study associate their diagnosis of CVD very closely with God’s will and largely believe their state of health is an aspect of fate and/or luck that they do not have control over and must simply accept. It is important to note that the words ‘fate’ and ‘luck’ (τύχη = tyche; γραφτό = grahto) have a significantly different meaning in the Greek language as compared to the English. ‘Luck’ to this group is not random, which is the usual connotation of the word in English. Tyche (τύχη) was used in classical times to refer to a kind of minor deity that controlled the fortune of the Greek city states. This is of significance in understanding the meaning that these older
Greek individuals give to the word ‘luck’ in the modern world, which clearly shows that what seems to be random chance is really volitional on the part of a higher being. In the modern context, this is God, but certainly for this group, ‘luck’ does not mean something that occurs without any reason. γραφτό means ‘destiny; something that is written’ and contains the root ‘graph,’ that occurs in the English words photograph (‘written by light’), graphic (‘having to do with writing’), and so forth. In its usual usage in Greek, γραφτό refers to something that must happen to a person because it is predetermined and cannot not occur.

Acceptance of a predestined lot by members this population can be seen as a means of adjustment to illness, particularly in old age, as fate or luck to older Greeks is not random. The belief held by this group is that health at an advanced age is a matter of their individual lot. It is associated with an element of luck and their overall fate that has been predetermined by God in accordance with His judgment for them and hence is not random in the sense of having no purpose. It is important to understand that the etiology of disease for the Greek elderly of Melbourne, as resulting from divine will and not from individual risk factors, is of great significance as they perceive that there is no real need to change the way they conduct themselves or do anything special about their illness as illness is part of an individual’s fate. For example, there was recognition among this group that certain measures, such as diet and exercise, could be taken to improve health and wellbeing in the context of CVD, but their overall belief was that their health comes from God.

For this reason, there may be little inducement for members of this group to change their behavior in the context of ill health because of a perception that such measures do not really matter, either in the context of their health or in relation to the outcome of disease. There was an indication that the elderly participants in this study felt that following health advice might be viewed by God as them making an effort to take care of themselves and hence beneficial in terms of pleasing Him but not necessarily changing the outcome of their condition or improving their health in the way doctors or other health professionals intended.

This was evident in the way the participants perceived health promoting activities recommended to them by health professionals to deal with their condition. They largely identified as most important their capacity to socialize within their cultural group above formal health care. In fact, if medical/health advice is felt to conflict with activities of cultural or social importance, the latter are generally given precedence. This may be an indication of the importance of their native culture to this group in contrast to the culture of health promotion which they associate with doctors and other health care professionals but that is essentially foreign to them and lies outside their cultural expectations.

For many of these individuals, the ability to participate in the social life of their family and community is paramount, and illness is only significant if it prevents this. Fulfilling their social role, which includes a range of religious, family, and community activities, is a matter of enjoyment for these individuals but is also seen as a duty, in terms of using the opportunities allowed to them by God to the fullest extent. Having been permitted to reach an advanced age, they generally feel they have a responsibility to enjoy, accept, and use their time to the fullest. This tends to be understood as participating in the activities of their children and grandchildren, being a part of their church and religious community, and being personally happy. As a result, the elderly Greek participants in this study were mostly concerned that their illness be manageable in this context and did not feel particular distress at having a diagnosis of CVD. Instead, their distress centered on the possibility that worsening health might prevent them from fulfilling their social role and isolate them from their peers and...
family members. Absolute happiness was of great significance, something that the elders of this population described as a gift from God. It is well known among this group that stress and anxiety is a great risk to their emotional wellbeing. One of their means of coping with stress and anxiety is through religious expression and by seeking strength in their faith. This underscores the importance of religion to this group as a central feature of their cultural identity and the main means they use to understand and explain their condition.

Another interesting finding was the strong belief held by these participants of the various supernatural causes of ill health, such as the evil eye. Belief in supernatural causes of illness is not unique to this group, but it is significant, especially in light of their very strong religious faith and support for formal religious activities. Participants do not see these as conflicting despite the apparent incompatibility between a view that health and illness come from God and a parallel understanding that there are human beings who are capable of inflicting illness on others. They seem to reconcile these two perceptions by assuming that God, for some reason, might permit someone to cause harm to another but also that God might cure an illness inflicted by another person if the sufferer attempts to remedy the problem through religious actions.

Supernatural interventions in the form of religious rituals, for example, both Holy Communion and Holy Unction, are of great significance, particularly with reference to illness. The participants of this study perceived rituals such as these as a means of understanding, and in turn accepting their condition, especially following a diagnosis of a serious illness such as CVD. They recognized that religious blessings do not necessarily take an illness away; however, they do believe that religious rituals such as these are a key component of their treatment and management in providing emotional strength. A number of participants in this study described religion as a good luck charm (φυλακτό = phylacto), again emphasizing the significance of religious faith when it comes to how they approach, understand and accept ill health. Based on their use of the word φυλακτό (phylacto), which is the root of the English word ‘prophylactic’, it is apparent that what religion actually means for these participants is ‘prevention.’

The value of religious faith in the context of serious illness is well documented in the literature (see, for example, Prado et al., 2004; Friedman et al., 2006; among others) and has been associated with greater personal empowerment among those who feel they are working with God to recover or maintain their health (Pargament and Cummings, 2010). The findings of this study fit well with those reported in the literature and show the importance of traditional practices to emotional wellbeing as well as the value of continuity across generations. For this group of older Australians of Greek origin, their personal identity has remained aligned with that of their native culture of which they still feel a part, despite decades of residence in Australia.

The participants in this study all felt their actions and approaches to illness represent things that people like them (members of the Greek culture and community) have always done. Interestingly, for the participants in this study, long residence in Melbourne as part of an English-speaking community with different cultural roots, has done little to lessen the importance of their traditions or alter their understanding of the nature and expression of disease. In fact, the participants of this study display high levels of what has been referred to as “hidden resilience” (Luthar, 1999; Ungar, 2004; Ungar, 2010) which allows them to view their own situation subjectively as successful, stable, and desirable, despite the fact that they are also experiencing what, in an objective sense, is serious (and potentially fatal) illness.
Traditional religious beliefs seem to provide the resources for adaptation and resilience for this group and also provide their basic understanding of the meaning of the illness experience.

Religion is of great importance to the Greek elderly of Melbourne on a number of levels. Their strong religious faith is embedded within their culture, as they were raised to have faith in God and not question any aspect of their religion or God’s will. Their religion, for this group, serves as a lifelong source of resilience and also supplies context-specific behaviors that serve in times of illness or hardship. Their faith generally does not diminish with age and provides vital emotional support when they are faced with an unexpected or particularly challenging illness such as CVD. In fact, their strong religious beliefs can be seen as adaptive in giving them a framework for interpreting their illness and offering time-honored understandings of the meaning of ill health.

The elderly Greek Australians that took part in this study conceptualized CVD as a challenging, permanent, and unexpected condition that required frequent and at times long term admissions to hospital. In general, they described CVD as something that has significantly impacted their life and at times has caused both isolation and loneliness. What was particularly interesting, however, was the strong belief held by these elders that CVD is something unexpected, that they have no control over and that all people are at the same risk of becoming ill, as this depends on their fate. The level of acceptance of chronic illness is notable among this group, as they see both health and illness as closely linked to God and their strong religious faith, which they have been raised not to question. For this reason, they are generally not angry about their illness, nor do they feel it is unfair. While they may worry about their symptoms and prognosis, they see illness as part of their life and an aspect of God’s plan for them.

Religion, in a sense, can equate to a coping mechanism for this group with respect to adjustment to a chronic condition such as CVD. In this context, religion can serve as a key component in accepting and understanding their condition. The participants of this study were very much aware that their lifespan is finite and accept and understand that they will experience a ‘final illness.’ For many of them, their CVD may continue to progress and ultimately lead to greater disability and death; the participants of this study were very much aware of this possibility but did not fear it because of the comforting effect their religious beliefs are able to provide. They view illness in old age as an inevitable aspect of the life course, much like any other development that people experience at other times of life. The fact that religion provides appropriate rituals, explanations, and understandings to cope with such life events offers them comfort, even in the face of disease that can have distressing impacts, and also offers a time tested means for approaching such a situation.

There is a body of literature highlighting the association of various coping strategies with adjustment, and acceptance of one’s condition is an important basis for adapting to and coping with the condition (see, for example Felton and Revenson, 1984; Kendal and Buys, 1998; Delgado, 2007; Livneh and Antonak, 2007; among others). For participants in this study, the knowledge that generations of people, including their own ancestors, have faced similar disease in old age and that the rituals of their culture have proven valuable as a means for coping is a source of comfort and also a pattern for behavior in the context of serious illness. The importance of religion in the context of chronic conditions has been well documented (see, for example Pargament and Cummings, 2010; Park and Folkman, 1997, Koenig, 2007; among others), and for this group, the role of religion is of particular significance as it provides a source of resilience to chronic illness. For the Greek Australians who participated
in this study, their resilience is notable as their strong religious faith has the power to influence their emotions and how they recognize and conceptualize their particular health condition. For them, their religion serves as a source of strength and also a means by which they can make sense of their condition that is more powerful than alternate explanations offered by the medical profession and also more adaptive.
References


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Ms. Maria-Irini Avgoulas is currently employed at Latrobe University in Melbourne, Australia and holds the role of Associate Lecturer/Placements Co-ordinator Rehabilitation Counselling in the School of Public Health and Human Biosciences. Maria’s previous clinical experience includes several years of working in health (acute hospital settings and in-patient psychiatry). She was also employed for a number of years with Centrelink, an Australian Government statutory agency. In 2011 Ms. Avgoulas undertook a study examining the cultural understanding of health and adjustment to CVD among the Greek elderly of Melbourne, Australia. This study is part of a PhD research project that Ms. Avgoulas commenced in 2012 at Deakin University examining the Transmission of Culturally Determined Health Beliefs among Three Generations of Greek Families in Melbourne, Australia.

_Dr. Rebecca Fanany_

Dr. Rebecca Fanany is a Senior lecturer in the School of Humanities and Social Sciences at Deakin University. She is a very experienced teacher and researcher whose work focuses mainly on the relationship between language, culture, and health. Her most recent book is _Health as a Social Experience_ (Palgrave Macmillan, 2012).
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