

Reciprocity in Education: A Model of Interactive Learning Between Migrant Communities and Mainstream Mental Health Services

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Abstract

This paper explains the way in which research was undertaken to develop and administer a model of interactive learning between mainstream mental health services and migrant communities. A model of interactive learning was developed through a practical exchange of ideas and beliefs between mental health workers and culturally and linguistically diverse community people. The major vehicle for these exchanges was the development of community composite stories and the subsequent mental health workers assessment and treatment strategies developed as a response to the composite stories. The stories contained collated elements from the personal histories of the community groups and illuminated experiences of emotional trauma, sadness, loss, isolation, family conflict and their encounters with mainstream services. The composite stories became a means for community members to interact directly with each other about mental health issues and for mental health workers to learn from them about their specific cultural perspectives on mental health. At the same time migrant communities, including consumers and carers, learned about the clinical role and service perspectives of mental health providers. While rigour and academic influences underpinned this study it became apparent that the model served to strengthen existing partnerships between communities of diverse cultural and linguistic backgrounds and mental health services.

Keywords

Culture, depression, mental health, migrant, refugee

Introduction

The Reciprocity in Education Project is a twelve-month pilot activity aimed at developing a model of interactive learning between three culturally and linguistically diverse background (CALDB) communities (Cambodian, Italian and Persian) and mainstream mental health services on the topic of sadness and depression (broadly defined). The ideas that underpin the project are based upon the belief that an absence of local services, or lack of culturally appropriate or sensitive services can and will prevent access of individuals or groups to effective assessment and appropriate treatment for mental health problems across the lifespan.

The educational interaction between community people and mental health providers focussed on the 'explanatory model' cultural awareness in mental health. Based on the work of Kleinman and Seeman (2000) this meant examination of the way symptoms of depression are understood, presented, the way help is sought and the way care is evaluated by those who receive it. This process linked the depression experiences of CALDB community people, their healers, and other concerned parties on depression (defined broadly and in a culturally congruent way), to mental health providers interpretation of these. Based on principles of 'reciprocity' — giving in return between mental health worker and client — the research task involved looking at the 'cognitive distance' (Weiss 2001) between people with mental health problems and what practitioners see as different perceived causes of illness, care and treatment. The Kleinman and Seeman (2000) explanatory model helped bring about more informed and compassionate awareness and respect for the alternate points of view. More specifically, to:

- have health providers learn directly from CALDB communities about their specific mental health issues, and their unique culturally based perspectives on mental health
- have CALDB communities, including consumers and carers, learn about mental health care by collaborating with mental health providers in planning, evaluation and delivery of mental health care services for their communities
- have members of CALDB communities, including consumers and carers, learn directly from each other about coping with mental health issues, early interventions to prevent problems of living and what practical help they can give themselves and members of their family
- educate and support CALDB community people as community educators
- add to existing forms of mental health education, networking and information exchange and capacity building between mental health service providers and ethnic communities
- establish national and international networks (via an international advisory group) — drawing on existing expertise and making the outcomes of the research widely available throughout Australia
- influence tertiary based mental health education curriculum and local staff development programs to become more open to creative teaching methodologies concerning mental health interventions for people from diverse cultural and linguistic backgrounds.

The decision to link CALDB community people and mental health providers was also a means to help bridge the theory-practice gap between mainstream mental health practices and culturally appropriate services. The *National Practice Standards for the Mental Health Workforce* identify a need for awareness of diversity by individual professionals to provide care in a culturally sensitive and appropriate manner. Specifically, Standard 3 states, "Mental health professionals [will] practise in an appropriate manner through actively responding to the social, cultural, linguistic, spiritual and gender diversity of consumers and carers, incorporating those differences in their practice".

Such actions are also consistent with *Australia's National Mental Health Plan 2003–2008* and *Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia*. Both documents contextualise Western psychiatric classifications as paying too little attention to narrative accounts of illness (Kangas 2001) and the overuse of psychiatric diagnosis among refugee and migrant populations (Commonwealth of Australia 2003).

The chief outcome of this project has been the design of an educational interaction that makes use of different perceptions, values and beliefs about sadness and depression held by migrant communities and mainstream mental health workers. The research team worked to ensure that information exchange between CALDB communities and mainstream mental health workers is a two way process. This is a key aspect of the design of the project model.

Why depression?

Depression is a common condition with some four per cent of adults in Australia having had a depressive disorder in the past month (Andrews 2000). It is the single biggest cause of disability in Australia (Henderson and Rickwood 2000) and recognised internationally as having widespread social, economic and personal costs (Sartorius 2001). The effects of depression can have a devastating impact on all aspects of life, causing intense suffering to the individual, family members and friends. Some researchers claim that moderate to severe depression is as disabling as congestive heart failure (Hays et al. 1995)

What is less known and understood by service providers is the way that sadness and depression is expressed within different cultural groups. Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and young people remain most at-risk of missing out on access to specialist services and best practice.

To maximise the benefits of productive two-way communications and learning between mental health workers and cultural groups, the research team and community participants began working with the broader terms of feeling down, unhappiness, emotional loss, feeling tearful or sad, rather than the more Western term of Depression.

Research methods

Throughout the project the research team needed to cross many cultural and linguistic boundaries and simultaneously negotiate reciprocal relationships; enter homes and community halls, professional mental health units, universities, government departments, non-governments centres and community health facilities and these endeavours are reflected in project outcomes (Procter 2003). As the research team encountered and crossed inter-subjective boundaries in order to explore dimensions of culture and mental health, the methodological accounts of their doing so was a means through which to yield findings. This

important methodological point is aligned with Anthony Giddens's (1996) 'double hermeneutic'. That is, a process where social scientists must inevitably be alert to the transformative effects that their research methods and methodology might have upon what it is they set out to analyse.

The methods employed for this research included individual and focus group interviews, document analysis and participant observation during group meetings and community outings. The modes of interconnection between data generation techniques and the development of individual understanding were largely informed through a three-way interaction between mainstream mental health workers, CALDB community participants and the research team.

Mainstream mental health workers learned from CALDB people about their cultural beliefs — the way that they guide and inform communication of health problems, the way symptoms are presented, the way stressors are perceived and when, how and why help is sought and evaluated.

This approach was informed by aspects of reflexivity in ethnography, described by Marcus (1994, p. 571) as:

“...[rather than their being] completely unknown worlds to be discovered... contemporary ethnography makes historically sensitive revisions of the ethnographic archive with eyes fully wide open to the complex ways that diverse representations have constituted its subject matter. Such representations become an integral part of one's fieldwork [and] define not only the discourse of the ethnographer, but his or her literal position in relation to [participants].”

Defining the discourse of the chief investigator as ethnographer became apparent during the giving and receiving of personal information between mainstream mental health workers and CALDB community participants. Personal stories of sadness, feeling down, loss, and grief, caring for a relative or friend with mental health difficulties or serious mental illness were, in this sense, presented in such a way that CALDB participants wanted to explore and explicate deeply personal situations.

A willingness to consider such issues surrounding interpretation, while developing clinical knowledge during fieldwork integrates selective aspects of Gadamer's (1975) philosophical hermeneutics and Marcus's (1994) ethnography as activity undertaken in the context of a researcher-participant relationship. The approach taken was for the research team to interpret what CALDB community participants and mainstream mental health workers said, thought, felt and did in the context of sadness and depression, without being separated from their own personal history as either a migrant or a mental health professional. The research team

sought not to withhold or suppress their own personal and professional history as self-knowledge in data generation. In practical terms this meant that the research team were not subject to detachment from the field of study. As Denzin (2000) and Ellis (2004) point out, reflection and introspection are brought to the research relationship and therefore implicated in every observation and interpretation. Instead of viewing personal background as a contaminating bias, the research team saw merit with the notion of being 'up front' and 'open with each other' about being present in the lives and experiences of CALDB community participants.

Community consultations

Groups from each of the three non-English speaking background communities have been meeting in various locations across Adelaide including a primary school, a community centre and a community health service. To facilitate a 'homely-feeling' and help create interaction between 'manager and client' the Italian group held its meetings in the home of the Chief Executive Officer of the South Australian Italian Village.

After extensive networking by the research team in the areas of developing trust, respect and effective working relations, the community groups, in partnership with three bilingual community educators developed five compilation stories (two Persian, two Cambodian and one Italian) about the experiences, views and specific cultural understandings surrounding sadness and the feelings and metaphors used to describe it. The compilation stories detail an experience participants have had or "could have had" during their migration and settlement experience (refer appendix 1 for a sample composite story).

The compilation stories developed in the four languages of the project (Cambodian, English, Farsi and Italian) were used as a basis to develop the educational interaction between the three communities and mainstream mental health services. The educational interaction was described by mainstream mental health service providers as being 'highly original' in the way it engaged both community people and mental health workers of various professional backgrounds as experts at a grass roots level.

Mainstream mental health services and the three South Australian universities

The project team incorporated learning materials from the development of the composite stories into graduate mental programs run by the each of three South Australian universities. Figure 1 illustrates the coming together of mainstream mental health service staff, CALDB community groups, research team and the three South Australian universities, through a series of weekend workshops and seminars.

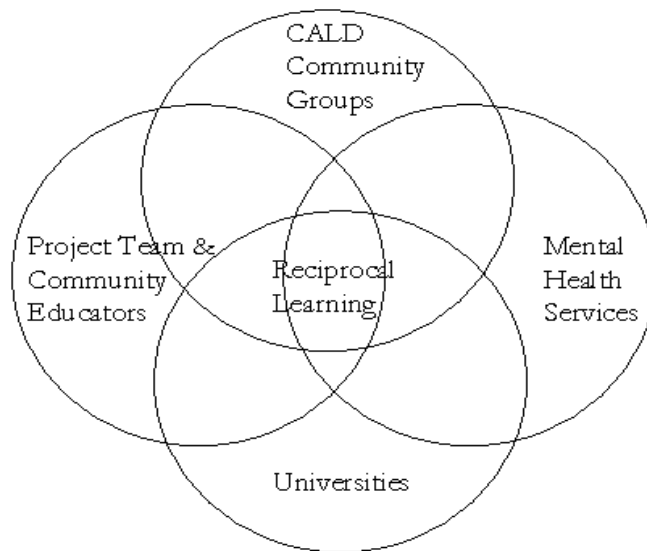


Figure 1. Reciprocal Learning Model

Stage one — first meetings

The research team met with the three community groups for the first time. The purpose of this initial meeting was to introduce the project, the reasons behind its establishment and anticipated benefits for both CALDB communities and mainstream mental health communities. During this initial phase, it was important to:

- introduce group members to each other, to introduce the research team, explain individual roles, and disclose aspects of their personal and professional background to help put community members at ease
- present an overview of the project, answer any questions and queries and remind participants that, should they like to become involved in the project, their participation will be voluntary and they may withdraw from it at any time
- seek to develop rapport and trust between the research team and participants by explaining what was required of them and frequently ask for feedback and clarification on the information presented by the research team so far
- initiate general group discussion, using pre-prepared starting questions including: What does it mean for you to feel healthy? How do you/people in your community stay healthy during the experience stress and/or major life changes?

At the end of the session team members drew the discussion to a close and obtained feedback from participants on their initial reaction to the project. They then thanked participants for their contributions and ascertained if future group meetings were desirable and possible. The research team then checked if everyone was okay to conclude the first

meeting, checked on the suitability of the venue and confirmed arrangements for next meeting (involving meals and refreshments).

The research team then offered debriefing to the community educator on her/his experience of the group; impressions and reflections on material discussed and how they saw their role developing. This, and subsequent debriefing discussions, were structured throughout development of the model.

Stage 2 — meeting again

The research team met and talked with each of CALDB speaking groups for a second time. The research team also introduced new members to the group and re-visited the project aims and objectives.

This was followed by general discussion about life experiences, coping with feeling unhappy, emotional stresses and tension. For those who were willing to participate and share experiences, a more focused discussion on their understanding of sadness began:

- Does the experience of sadness, worry or unhappiness (broadly defined) exist in your community?
- If so, what is like to feel sad and/or unhappy? What do community people say and do when they feel this way? Is it something people in your community find easy to talk about? How do people get help?
- What words and phrases are used in your community to describe the experience of sadness?
- What do people in your community do to cope with sadness?
- Where do community people say their feelings come from?
- Is it a topic that people in your community find easy to talk about? If not, why not?
- What practical help is needed and by whom is it needed to help manage these feelings?
- What do community people understand to be the role of mainstream health professionals?

The underlying assumption here was for the research team to engage the community group as a cultural guide and trusted adviser on the nature and scope of their own experience and/or the experience of caring for someone experiencing sadness.

As trust developed it was possible record the discussion — in both languages — so that it could be relayed later to an audience of mainstream mental health workers. The responses from participants were documented using community educators as interpreters and assistants.

Stage 3 — analysis and generation of composite stories

The information provided by participants on their experience of sadness and depression was analysed. Composite stories were generated from the material that adequately captured the issues and concerns raised by participants. The composite stories were written in English and the appropriate community language. Two Persian stories, two Cambodian stories and one Italian story were written.

Community participants were directly involved in the creation of the stories and the research team continued consulting with them over the nature and scope of each story. The purpose of these consultations was twofold: to ensure ongoing development of trust and acceptance of community people and the stories they told, and to enable better understanding of community people's views of their realities and background issues that inform ways of seeing, organising and understanding experience.

Stage 4 — seeking clarification

Clarification was sought from Community Groups.

- Do the compilation stories accurately represent an experience of sadness/loss within their community?
- Does the compilation story accurately reflect what they personally think, feel and experience or have seen in other community people?
- Does it reflect what they have told the research team? Is this story believable? What changes (if any) are required?

Stage 5 — service provider workshops

Weekend workshops with fifty-eight mental health workers were held. The mental health workers were divided into eight workshop groups; two held in the university sector and six held in professional settings. With the support of the community educators, the mainstream mental health workers undertook small group-work to resolve the issues in each of the community composite stories.

The following activity and questions were used to help generate dialogue as a two-way process of capacity building and information sharing between individuals within groups.

- What is the problem here?
- What help is needed here and by whom?
- Does your service have the necessary resources (for example, time, skills, equipment) or is it able to arrange the necessary resources, personnel or expert help to provide interventions? (Expert help may include other members of the team or another service all together)
- Does your service and the individuals who operate within it have the agreement or cooperation of other people and/or service networks that might be involved in the plan?

- What individual or service should take overall responsibility for care?

In addressing the above issues participants were given the following guidelines to consider.

- Only consider one problem or issue in each scenario at a time
- Avoid getting sidetracked into attempting to solve the overall problems of the service or service delivery team
- Where possible, apply the principles of goal setting and planning that reflect your service culture.

The mainstream mental health workers designed an intervention for the client and family from the workers' perspective and presented them in written form. Wherever possible, the actions nominated by workers included rationales and explanations for the care given.

The mental health workers were asked to put forward views and opinions that resembled as closely as possible what they would hope to undertake in the 'real world' of clinical practice. During this process the group of mental health workers were encouraged by the research manager to engage the bilingual community educator as a cultural guide and trusted adviser.

Stage 6 — analysis of service provider responses

The research project team and community educators analysed mainstream mental health worker responses to each of the three compilation stories. Clarification and comment was sought from the mental health workers via e-mail and/or world-wide-web page. The finalised solutions were then translated into appropriate community languages.

Stage 7 — feedback from community groups

The research team returned to the Persian/Afghan, Cambodian and Italian groups with the responses developed by the mental health workers in each of the community languages. Where precise translations were not possible, the research team with support from the community educator initiated discussion and sought clarification with community participants. At that point community participants were asked for their constructive feedback and response to what was developed by the mental health workers, in such a way as to help explore and explicate the understandings and views held by them.

The community groups learned of the understandings and views held by the mental health workers that underpinned their response to the mental health issues they thought existed within the composite story and informed their planning and delivery of services.

Stage 8 — further clarification

The three community groups were presented with a summary of their feedback for checking and clarification. Participants were asked to clarify and discuss any ambiguous words or

phrases to help with accuracy of translation. This information exchange was a means of helping to generate further discussion and exploration of issues, themes and aspects of two-way learning between community participants and mainstream mental health providers via the research team.

Stage 9 — service provider feedback workshop

The research team returned to the mainstream mental health workers for a weekend workshop with feedback from the three CALDB communities. The feedback took the form of discussion points for people to respond to. The mental health workers worked on the material in small and large groups with a view to learning from community people about their specific enhancing and strengthening skills, knowledge and expertise built around the topic.

As the workshop drew to a close the mental health workers were asked for anecdotal feedback on their experience and thanked for their participation

During the workshops local networks were being established between mental health professionals across teams and jurisdictions, drawing upon existing expertise from government and non-government organisations to help make the benefits of the research widely available throughout mental health service delivery units. During these workshops emphasis was placed upon having mental health workers learn in a very immediate and clinically relevant way about the mental health issues that arose from the information exchange. Emphasis was placed upon the life experiences and unique culturally based perspectives of people from the different groups.

Stage 10 — project evaluation

This involved independent evaluation of the project from the perspective of all stakeholders.

Cultural sensitivity and capacity building

Occurring at the same time as the development of the educational interaction outlined above, the project team undertook to identify areas of strength and areas for further development of their own capacity building, cultural sensitivity and self-awareness. This reflective process was guided by the following questions:

1. What are the areas of strength for the groups we are working with?
2. What must we do to develop our working style with the community groups?
3. How do we approach the next group meeting?
4. What strategy and/supports are needed to help us at the next group meeting? Who else should be involved?
5. What information is needed for the next group meeting in community languages?
6. What is needed for us to ensure ongoing capacity building — actual and potential — for community participants and members of the research team?

The above questions were helpful in a number of ways. They enabled reflection on ways to be innovative and creative in an environment that was dynamic in the way it provided workforce development for all concerned (Giugni 2001). The questions also helped the research team and community groups better understand and relate to each other, as well as identify what practical steps are needed to ensure continued inter-cultural respect and growth and development of social capital.

Education and training for community educators

The role of bilingual community educators (BCE) has been crucial to the success of the research. Their role incorporates ability to:

- bridge gaps between mainstream mental health system and community people
- work between and within both “worlds”
- believe and respect the cultural values and beliefs of community people
- be a trusted guide and adviser and critical friend to the project team
- seek out effective ways to work with the language of emotional health and wellbeing used by participants
- seek out and respond to opportunities for capacity building and community development for both self and others.

A comprehensive education and training package for the bilingual community educators attached to each of the three groups was developed as the project unfolded. The package centred upon learning directly from mental health workers about the way they interpret, analyse, and intervene upon mental health issues in clinical practice.

Recruiting BCE's occurred through a community consultation process. CALDB community people identified publicly perceived honesty, integrity and willingness to engage in a process of two-way learning and community development as the key attributes of BCEs. These attributes are consistent with ethnic community health worker effectiveness in supporting and promoting research involving migrant communities (Andrews et al. 2004).

Conclusion

This educational interaction was highly original in the way that it engaged both community people and mental health workers as experts at a grass roots level. At the same time, it is expected that the educational interaction between groups via the community educators will add to existing forms of mental health literacy, networking and information exchange between mental health service providers and ethnic communities — that is, a model of educational interaction that leads to increased awareness and understanding by mental health service workers of Persian, Cambodian and Italian cultural formulations, beliefs and ways of knowing and responding to mental health issues and problems. For Persian, Cambodian and Italian

group members there is an opportunity to learn about the understandings and views held by mainstream mental health workers that underpin their response to mental health issues for people from culturally and linguistically diverse backgrounds.

Appendix 1. Sample Composite Story: Mohammad (Persian)

Mohammad is a 52-year old Iranian married man with a wife and 3 children who arrived in Australia nine months ago. He has a son Reza, 20, and two daughters Mahnaz, 16, and Mitra, 14. He worked as an accountant before the Revolution in Iran. He had thought he would be able to secure a good job and future for his family, but after the revolution this all crumbled because of his political beliefs. He was sacked from the government body he worked for. He started his own business but faced constant discrimination and harassment and his son Reza was denied entry into university.

With the assistance of an interpreter he said that for the last two weeks he has been having constant headaches. Mohammad went on to explain:

“I am not sure if it is because of the constant arguments that we are having at home or if it is because of all the hassles I am having here in Australia, but I am in pain. My pain is like a pulsating pain, a vibrating pain. It is as if my neck cannot support my head anymore. I went and saw a doctor about this and he told me that my problems were emotional problems. The doctor told me that my headaches were caused by the emotional problems I am having at the moment.

I have nothing to do. During the day I just walk around the streets, with nothing to do. I don't pay attention to the way I dress or if I am shaven or not. Sometimes, when I am walking, I feel that I will collapse in the street. If you see me during the day and take a look at me, you will see that I am always tired. My wife has told me that during sleep my body moves rapidly around the bed. I shout and twist when I am asleep. ... I don't know what else to say (pause) ... it is as if I have been buried under all of these things that are happening to me. Now I have a stiffness of my neck, the pain in my shoulders and back.

Do you think that medication will help me? I now know that I need help. It is not easy for me to say this but now I feel that I need some help. I know this as the time has come for me to no longer handle this situation myself. Both my parents had a stroke and died at young age, 47 and 48 years old.”

Mohammad then began to talk about his life in Iran before coming to this country. “I did not have any financial problems — just problems with the authorities”. This he said was “the harassment he experienced in Iran”. He talked of being frequently arrested by the police and

taken in for questions about his life, which he was and what he was doing. On occasions he was beaten with metal rods and cables during these interrogations. On one occasion this involved the police coming to his house:

“One afternoon, when I was out, the police came to my house looking for me. I was not at home and they told my family that I was to report to them in the morning. When I came back later that day to hear the news, I was left lying awake all night thinking about what it was that they wanted. I just waited for night to turn into day. I was thinking about what they might do to me the next day. I was thinking about the sorts of questions they might ask me, or what they might do to me. Now I hate nights. It is like I am in a hole and as I try to get out of this hole, someone is trying to pull me back into it. Now I feel that I need to have a healthy body. I need a healthy body to help me come with the situation I am in.”

It was at this point that he and his family decided to leave Iran. They stayed in Turkey for two years before being able to migrate to Australia. He says that he feels guilty. He says that he feels that he has lost a lot of his confidence in himself and his family. He said that his family was divided about whether or not to come to Australia. Some wanted to come and others did not. For example, his younger child did not want to leave Iran. She wanted to stay at home (Iran) and study medicine at university:

“I told my younger daughter that life would be better here (Australia) and that if she worked hard she would be able to study medicine here. But this ended up not being what happened. My daughter was accepted to study for a medical science degree at Melbourne University but did not accept the offer. I tried to encourage her to take the offer, but she would not listen to me.”

His family receives some money from the government and it is this money that they spend among themselves. The family payments, for example, go directly to his wife and children:

“They control this money by spending it on whatever it is they think they need. At the same time they come to me expecting me to provide money for other things they need. How do I work, get a job and have money. Sometimes I think that if I had some money — a lot of money, then everything would be OK. On some things that happen between us in our family they want to be ‘modern’. On other things that happen in our family they want to be ‘traditional’. I notice that if my children are successful in life then they will take the credit for their success. If they are not successful at school or with their friends, then it is me that they blame.”

The family was very happy when they first arrived in Australia. He thought Australia to be a safe place. That is, a place for him to be respected for his accountancy knowledge and qualifications. He also believed that he would be able to re-build his family using traditional family values.

On arrival in Arrival he immediately enrolled in English classes. After staying in new arrival accommodation for one month they rented a house in the southern suburbs of Adelaide. He tells of the way they are being treated by people here in Australia, as also being is also a problem for him:

“For example, my house needs to have things done to it and the landlord is not willing to spend any money to fix them. He has told me that if I am not happy with the place then I should leave. What choice do I have?”

As he is a university educated man he was hopeful about a job but English language proficiency was a barrier from the very beginning. He soon found that learning English for day-to-day things is one thing, but to work as an accountant is something quite different all together. At the Centrelink office he was told that after finishing his English course he is required to actively look for work. He was also told that family payment and rent assistance would be paid to his wife. The family had wanted to buy some furniture but Mohammad had spent all his savings in Turkey. All in all, money was short and he was no longer financially in charge and in control of present and future incoming finances. While the family talked about budgeting and the need for contribution from everybody in the household, it still seemed that the family expected him to do what he always did: find a well paid job and provide whatever the family needed and wanted. But things were very different in Australia as he was no longer the sole provider and manager of household finances. He was deeply troubled by this.

He was interviewed at Centrelink about his job prospects and was told that considering his outdated skills and limited English; the likelihood of him getting a job as an accountant was minimal. He needed to go back to university and study accountancy again from scratch. Something that at his age, he found very difficult and humiliating. He did give it a go, however, and early on was very distracted and started missing his classes. Some weeks after he started he withdrew from others and did not want to leave home or see anybody and remained in bed for up to 16 hours per day. He felt by going out everybody knew that he had no job. As he put it:

“I feel alone and very, very, lonely. I feel that I don't have anyone to talk to about my feelings. I feel that I don't have anyone to express my feelings to. If I did not trust you then I would not come to see you. If I did not trust you then I would not want to tell you about how I am feeling.”

He also felt that people were talking about him behind his back.

Back in his home country, despite all its political problems, he had friends who understood him. But in Australia he was feeling incredibly lonely, sad and isolated. In his homeland he was a very proud man — one that had been able to provide for his family reasonably well. A man respected for this by his family and friends. He now feels that at the same time he is losing his self-respect, he is losing that respect from others which is so important to him and his children. He is also feeling that he is losing his mind. His wife and children are challenging his authority. They say that he is “old fashioned and not able to cope with the changing times”. His children are saying they don't want to live the way they did back home. He says that communications between the children and him are strained.

As the interview progressed he spoke of the work problems he was having in Australia. He had been working for a market gardener in the outer Adelaide suburbs. He was not being paid regularly or on time. Rather than be paid on time for his work, he was being told by the market gardener “I have not enough money to pay you ... please come back and see me tomorrow”. This situation became a worsening one and eventually he decided to leave the market garden. Leaving his job was difficult for him to do as this meant that he was walking away from money, albeit sporadic in payment. All monies owing to him were paid upon leaving.

He went to see a local doctor and with the help of an interpreter talked about feeling sad, alone, misunderstood and moody. He talked of feeling bouts of extreme rage and anger, and bouts of extreme emotional exhaustion. He says that some days he feels that nothing interests him any more and on other days he “just wants to explode”. He tries to hide this from his family, none of this he wants his family to see, as it will, in his eyes, make the situation

worse. He says he is worried about his future and wants the Australian Government to intervene. He asks you to give him some medicine to lift his spirits and take away his problems. He says that he needs to get help before something “bad happens to him and his family”. He told the doctor he feels alone and misunderstood by the world around.

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