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From GPs to Psychologists: The patients' perspective on help-seeking and referral

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From GPs to Psychologists: The Patients' Perspective on Help-Seeking
and Referral

Zdenka Bartova

A Report Submitted in Partial Fulfillment of the Requirements for the Award
of Bachelor of Arts (Psychology) Honours,
Faculty of Computing, Health and Science,
Edith Cowan University.

October, 2007

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Abstract

The experience of living with psychological problems has a profound effect on an individual's life. For those actively seeking help, General Practitioners usually present the first point of contact. General Practitioners thus serve as gatekeepers who either decide to manage the individuals themselves and/or refer them to a mental health professional. The referral decision is part of a complex help-seeking process in which patients have to mediate their own understanding of their problems with that of the practitioner, all within the structural constraints of the current health care system. This literature review discusses constructs of mental illness and the impact of these constructs on symptom management. It is argued that a person's perception of symptoms, problem recognition and help-seeking decisions are strongly influenced by social, political and cultural contexts, in combination with the individuals' interpretation of their experience. Using the concepts of Gadamer's (1975) hermeneutic phenomenology, it is suggested that in order to understand the way individuals choose to manage their psychological problems, both research and practice need to focus more on patients as important sources of meaning. Involving both scientific expertise and patients' interpretation of their lived experience could result in better mental health care.

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Submitted: August 2007

From GPs to Psychologists: The Patients' Perspective on Help-Seeking and Referral

Introduction

Mental illness has been identified as the leading health problem contributing to years lost to disability in Australia (The Senate, 2006). Mental illness is a collective term for different types of mental disorders, where the term mental disorder refers to a clinically diagnosable disorder that significantly impacts on an individual's cognitive, emotional or social abilities (APS, 2007). According to Australian Bureau of Statistics' data collected in 1997, approximately 18% of Australian adults had dealt with a mental disorder at some time during the previous 12 months (ABS, 1998). However, only about one third of those adults sought assistance from a health service, with the majority (77%) consulting their General Practitioner (Department of Health and Ageing, 2005).

During the last decade, the Australian government has introduced a number of new measures aimed at improving the quality and accessibility of mental health services. For instance, between 1993 and 2003, the total Australian government spending on mental health increased by 73% (the data were adjusted to eliminate the effect of inflation). In the same period, the number of practicing psychologists increased from 696 to 1417 (Department of Health and Ageing, 2005). In addition, since November 2006, patients with mental disorders have been eligible for Medicare-rebatable services from psychologists and other allied mental health professionals on referral from a General Practitioner (Department of Health and Ageing, 2006).

While the newly introduced government changes represent a positive step, they may be insufficient to combat the many deficits in mental health care services. In spite of the increased national funding, Australia spends about 8% of its total Health Budget on mental health, with nearly two thirds of the increased funding accounted for by

greater expenditure on psychiatric drugs (The Senate, 2006). It has been reported that the available funds may not be always well utilized and that some mental disorders receive more attention than others (Mental Health Council of Australia, 2005).

In this literature review, the concept of mental illness as experienced and understood by individuals will be explored, and some general issues related to coping and help-seeking will be highlighted. The review will start with a short overview of the Australian health system, followed by a discussion of barriers to referral as identified by General Practitioners (GPs). Next, models of mental illness from both medical and philosophical points of view will be described and critiqued. Because the review draws on phenomenological work of Hans-Georg Gadamer, his philosophy will then guide discussion of factors that impact on help-seeking efforts of individuals experiencing psychological distress.

Gadamer (1975) proposed that each person makes sense of his/her experience through a process that incorporates the person's interpretation of the experience as well as general presuppositions that are formed within the person's social, political and cultural contexts. Thus patients coming into consultations do not just present with symptoms but they also bring in their own understanding of those symptoms. Issues such as what constitutes mental illness, when it is appropriate to seek help or what happens in consultations are all subject to personal interpretation and may have an impact on the person's help-seeking decisions. Similarly, practitioners do not act only as providers of treatment or gatekeepers to referral but also as sources of knowledge and understanding. Just as patients learn from the expert knowledge, practitioners could be more opened to patients' understanding of their lived experience and the language they use when they express this understanding.

Because language is a tool of understanding, some of the terms used throughout this review should be explained. There have been debates in the literature on the use of the terms mental illness vs. mental health. Western society has largely adopted medical terminology in referring to psychosocial problems and emotional distress as mental illness (Ishibashi, 2005). Recently, there has been a tendency to move away from this terminology and towards more empowering language, suggesting use of terms such as ‘mental health difficulties’, although even this step has its opponents who claim that such terms are no more than politically correct alternatives (Barker & Buchanan-Barker, 2006). Similar debates centre around the medical term ‘patient’ which is sometimes rejected in favour of terms such as client or user (Faulkner & Thomas, 2002; Rose, Thornicroft, & Slade, 2006), mental health consumer (Hensley, 2006) or psychiatric survivor (Crossley & Crossley, 2001).

Throughout this review, individuals experiencing mental illness will be referred to as patients or research participants. A large number of the discussed studies dealt with individuals in primary care settings (i.e., in consultations with medically trained professionals), hence the use of the medical term patient. Regarding the illness vs. health debate, the author is aware of the irony of mental *health* professionals dealing with mental *illnesses*, and although she does not believe that the terms ‘mental illness’ and ‘mental health problem’ necessarily refer to the same concept, throughout this review both terms will be used interchangeably. It is the author’s belief that the difference between the two terms may not so much reflect the difference in severity of the problems or their ‘diagnosis’ but rather the patient’s or the practitioner’s interpretation, and thus presents more of a philosophical dilemma. Some people may understand their experience as a personal deficiency or something that happens to their

body and thus should be cured, while others may treat it as something that has a meaning and that may not necessarily prevent their successful functioning.

The reason for the present choice of language is not to confuse the reader but because the scope of this review will not allow for a lengthy discussion of current psychiatric terminology as a linguistic system. For those interested in a more detailed exploration of these issues, readers are referred for instance to Crossley and Crossley's (2001) narrative-style analysis comparing patients' accounts of mental illness in the 1950s and the 1990s, or to Speed's (2006) analysis of service user discourses.

Australian Health Care System

Almost one in five Australian adults experience mental illness but only one in 15 (i.e. 6% of the adult population) seeks professional help (ABS, 1998). The most common interactions between patients and the health system take place in the primary care settings (Duckett, 2004). Similarly, most people who experience mental illness and who decide to seek help from a health service, do so through their GPs (Department of Health and Ageing, 2005). Those individuals, who consult a professional other than their GP, seek assistance not only from psychiatrists, psychologists and other allied health professionals but also from naturopaths, acupuncturists or spiritual healers (Issakidis & Andrews, 2006).

While some individuals may prefer to manage themselves (Andrews, Issakidis, & Carter, 2001), others may have only limited choice. It has been reported that individuals living in rural areas do not have the access to the same type of services as people living in metropolitan areas (e.g., Lockhart, 2006; Mental Health Council of Australia, 2005; Samy et al., 2007). That the proportion of people receiving help may be

even lower in rural areas than in the general population is alarming, given the already low usage of existing services. Although many GPs have basic training in mental health, they may be the only health professionals available to people living outside capital cities (The Senate, 2006).

In addition, Medicare, Australia's universal health insurance scheme is set up to encourage shorter, individual patient-practitioner consultations (Duckett, 2004). The Medicare Benefits Schedule also provides government rebates for some medical services but not others, and although it now rebates psychology services, patients are generally eligible to no more than 12 consultations per calendar year (Department of Health and Ageing, 2006). While this initiative makes specialist services much more accessible and thus presents a significant improvement, a number of individuals experiencing mental health problems may need more consultations. This area is important for further inquiry and could help guide mental health policy in the future, as for those individuals who cannot afford private cover the services made available to them may be limited in choice.

Referral from Primary Care Settings

In Australia, General Practitioners serve as gatekeepers who decide whether to refer their patients to mental health professionals (Mori, LoCastro, Grace, & Costello, 1999; Verhaak, de Lisdonk, Bor, & Hutschemaekers, 2000). Although research has indicated shortages in the mental health care workforce (e.g., Lockhart, 2006; Mental Health Council of Australia, 2005; Samy, Hall, Rounsevell, & Carr, 2007), referral rates remain low even when specialized help is available (Simpson, Emmerson, Frost, & Powell, 2005) and when practitioners themselves feel inadequately prepared or too

time-deprived to provide competent psychosocial care (Sotile, 2005).

General Practitioners have themselves identified a number of issues that influence their decision to refer, including the costs incurred by the patient (Kainz, 2002; Pryor & Knowles, 2001), beliefs about patients' coping skills (Sigel & Leiper, 2004), relationship styles with mental health professionals (Hull, Jones, Tissier, Eldridge, & Maclaren, 2002) and practitioners' confidence in their own ability to treat the patient without referral (Lockhart, 2006). Another commonly reported issue relates to long waiting times to get an appointment with the mental health professional (Simpson et al., 2005; Walders, Childs, Comer, Kollher, & Drotar, 2003), and there are some indications that part of the problem may be a shortage of psychiatrists, especially in rural areas (Same et al., 2007).

Physicians also take into account the severity of the psychosocial problem, with more severe illnesses or acute cases, such as when a patient becomes suicidal, receiving more focus. This also means that clients with high-prevalence but potentially less severe problems receive less direct assistance with making an appointment (Kravitz et al., 2006), experience longer waiting times to get an appointment (Simpson et al., 2005) or receive no treatment (The Senate, 2006; Sigel & Leiper, 2004). However, in view of the recent changes to the Medicare rebate system, some of these perceptions and structural barriers may be less prominent. Future research should examine whether and how the factors impacting on the GPs' decision to refer have changed since the November 2006 initiative.

Mental Illness

Mental illness has been receiving considerable attention in scientific research,

government initiatives and media reports. However, although various definitions of mental illness have been proposed, there seems to be little agreement about its broader concept. Probably most attention has been directed to two models: medical and social. According to the medical or biological model, the term mental illness refers to behavioural patterns that can lead to distress, disability and a potential loss of freedom (Corrigan & Kleinlein, 2005). Mental illness is viewed as a set of symptoms that are organic in character and that are clearly distinguishable from another set of symptoms and from normalcy (Maddux, 2004). Because the behavioural patterns are believed to have a neural basis, the most effective treatments are biological in nature (Kandel, 1998).

The biological model has been challenged by proponents of a social model. The social model posits that mental illness is a social construct that is subject to cultural influences and personal expectations (e.g., Bracken & Thomas, 2001; Rosenhan, 2004). The concept of mental illness is rejected as a myth and symptoms are viewed as deviations from social norms. Interventions are thus more likely to focus on social inclusion in the form of housing and employment opportunities, and user advocacy (Bracken & Thomas, 2001; Rose et al., 2006).

Perhaps to accommodate both sides of the argument, another model was proposed that involves both biological factors and psychosocial factors; the biopsychosocial model is currently the primary paradigm of psychopathology (Kinderman, 2005). According to this model, there are three classes of predictor variables that can lead to individuals experiencing a mental disorder: biological factors (e.g., biochemical abnormalities), social factors (e.g., poverty, unemployment) and psychological factors (e.g., childhood abuse). However, this model has also been

subject to criticism. Apart from being described as too broad, it was pointed out that even in the biopsychosocial model the focus remains on the biological factors, with the social and psychological factors given only the role of moderators (Kinderman, 2005). This dominance of biological factors is believed by some to be hampering improvement in the Australian mental health system, due to its emphasis on pharmacological approaches while overlooking other effective alternatives (The Senate, 2006).

Just as the model of mental illness is guided by its biological components, the diagnosis and treatment of it is conceptualized similarly to physical ailments. Current classification systems, such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) categorize and label groups of symptoms as classes of criteria that lead to a person being diagnosed with one (or more) disorders. Although it has been pointed out that there are no natural boundaries between particular mental disorders and indeed between mental disorders and normality (Jablensky, 2005), the DSM is now commonly used as a guide to phenomenology of mental illness (Andreasen, 2007).

Mental illness and phenomenology

Phenomenology is well known in psychology, especially as a research method used to study the lived experience of participants within particular contexts (Willig, 2001). As seen from a previous section, however, the term phenomenology is also used in some current writings as synonymous with the study of psychopathology, including signs and symptoms (Andreasen, 2007). This understanding is partially influenced by the philosophy of Edmund Husserl who approached phenomenology as a rigorous science examining human consciousness (Thomas & Bracken, 2004).

Husserl's phenomenology focused on description of a lived experience, rather than its understanding (Dowling, 2007). According to Husserl, this unbiased, assumption-free description could be achieved through a process called eidetic reduction (Wertz, 2005). The process starts with a concrete experience of a phenomenon that is then imaginatively varied so as to distinguish those features of the experience that are invariant and essential from those features that are accidental. Through this process, one would derive the essential aspects that form the experience and thus could describe the typical presentation of a phenomenon (Hein & Austin, 2001).

Elements of Husserl's philosophy can be seen in the current conceptualization of mental illness, as seen in the ICD and DSM classifications. The experience of living with depression, for instance, is "reduced" to a number of symptoms (e.g., loss of interest, feelings of worthlessness) as its essential features. However, not all individuals described as suffering from depression experience the phenomenon in the same way. Similarly, all assessments are largely based on the individual's description of his or her experience but different people may understand their experience differently.

Thomas and Bracken (2004) suggested that it is the meaning people give to their "symptoms" that enables better understanding of their experience. They propose the use of other branches of phenomenology, such as that of Martin Heidegger, to help people understand human experience and the way it is embedded in contexts. Heidegger, like Husserl, was concerned with experience as it is lived (Dowling, 2007). Unlike Husserl however, Heidegger believed that just as people do not exist in isolation and separated from the world, their experience cannot be separated from the background of their knowledge.

Heidegger's phenomenology was the study of the meaning of Being, or a person's presence in the world (Polkinghorne, 2000). Heidegger believed that history and language are important aspects of human existence and that these aspects are transmitted through culture. He thus claimed that history and language of one's culture are fundamental to understanding of the lived experience (Hein & Austin, 2001). When applied to mental illness, this proposition moves the lived experience from a simple check-list of typical symptoms to broader issues. For example, one's background knowledge provides some understanding of what a mental disorder is, how it should be treated, where and when help should be sought or what the lay attitudes to it are.

While Heidegger's understanding of experience as having a meaning only within a particular context moves the conceptualization of mental illness beyond a narrow biological definition, his view of the individual's ability to move outside the culturally given understanding was rather pessimistic. He believed that just as people have no choice in what background they are born into, they cannot exit this background and therefore their understandings of the self and the world will always be bound by this culturally transmitted background knowledge (Polkinghorne, 2000). This position was later disputed by Heidegger's student, Hans-Georg Gadamer.

Gadamer believed that people draw on their background knowledge which is formed from their culturally given understanding as well as their personal experience but that this background knowledge has a loose texture that allows for a number of solutions and thus advances their understanding (Hein & Austin, 2001). So while an individual's understanding is dependent on the historical, cultural and social context in which he or she lives, through a process of self-reflection he or she can remove himself/herself from this context and broaden one's knowledge (Lebeck, 2006).

Gadamer introduced the concept of horizon which he defined as “the range of vision that includes everything that can be seen from a particular vantage point” (1975, p. 269). And it is through a fusion of horizons, of the so-called universality (i.e., historically transmitted pre-understanding) and a person’s present range of vision, that a person reaches understanding (Polkinghorne, 2000). Gadamer (1975) also pointed out that experience should not be judged in terms of its results because experience is a process. When individuals experience a phenomenon, they already have certain generalizations and assumptions about it that are confronted through the experience. It is through a process of questioning these generalizations and assumptions that people gain knowledge (Gonzales, 2006).

Application of Gadamer’s assumptions to the phenomenon of mental illness means that social, historical and cultural contexts forming a person’s pre-understanding need to be considered. Thus empirical examinations of how people experience mental illness, what guides their help-seeking efforts and what influences their decision to accept referral to a psychologist should occur within these contexts. The following sections will explore several such contexts that have been grouped under following headings: Perceptions of mental illness and problem recognition, Mental illness and stigma, Models of help-seeking, and Patient-practitioner interactions. It should be noted that majority of the discussed studies have been conducted in Australia, the United Kingdom or the United States and thus present a Western perspective to mental illness and help-seeking.

Perceptions of mental illness and problem recognition

Before people decide to seek help for psychological problems, they first need to

be able to recognize and describe their symptoms. Based on Gadamer's (1975) position that it is our contexts that provide us with generalizations and assumptions that we bring into an experience, it is these contexts that would inform a person that what they might be experiencing is a mental illness. St. Claire (2003) proposed that people form common sense models of symptom appraisal and that they tend to classify their symptoms according to their degree of fit with prototypes of disorders they have stored in their memory. The degree to which these prototypes reflect existing scientific knowledge of mental disorders will affect that person's mental health literacy.

Mental health literacy has been defined as knowledge and beliefs about mental disorders that facilitate recognition and appropriate help-seeking (Jorm, 2000). It has been suggested that mental health literacy influences a person's self-management of psychological symptoms and guide his or her help-seeking strategies (Jorm et al., 2006). Jorm, Christensen and Griffiths (2006) indicate that mental health literacy in the Australian public is low and although there have been some improvements during the last decade, mental disorders are still not well recognized. However, recent research suggests that the level of literacy may depend on the particular disorder under investigation and that people may have a better knowledge of those disorders that they have some experience with.

For example, Bartlett, Travers, Cartwright and Smith (2006) surveyed 666 adults from eight towns in rural Queensland, presenting them with a vignette that described a person suffering from major depression. Eighty one percent of the respondents were able to correctly identify the described symptoms as depression. Those individuals who knew someone with a mental health problem were more likely to make the correct identification. Although the response rate ranged between 31% and 85% across the

eight towns, the researchers found no consistent relationship between the response rates and the literacy levels. Overall, the high rate of correct identification suggests high mental health literacy, at least with respect to depression. In another study, 1207 young Australians aged 12 to 25 years completed a telephone survey (Cotton, Wright, Harris, Jorm, & McGorry, 2006). Results showed high rates of recognition for symptoms for depression but low accuracy of recognition for a vignette describing psychosis. In addition, there were gender differences, with females showing better depression literacy than males.

As mentioned earlier, mental health literacy plays an important role in symptom management activities. Jorm (2000) pointed out that the person affected by psychological symptoms is usually the primary agent in these activities and that professional help is only one of many possible symptom management strategies. Pill, Prior and Wood (2001) conducted a series of focus groups (127 participants in total) where participants were asked to respond to vignettes describing individuals dealing with various symptoms. One of the main reasons suggested by the participants for failure to consult general practitioners for emotional problems was uncertainty about the legitimacy of the symptoms as 'real illness'. Most participants tended to normalize the symptoms as an inevitable human experience, something they should be able to deal with without professional help. The lay public thus tended to differentiate between what they believed was a real, clinical illness (i.e., characterized by physical symptoms), and emotional complaints. In other words, as far as real illness was understood, only physical symptoms, not emotional ones, were considered appropriate to take to a consultation. The fact that a number of the participants contrasted the emotional problems to physical problems suggests how influential the biological model is in

forming people's understanding of health and help-seeking.

Similar themes emerged in McNair, Hight, Hickie and Davenport's (2002) study examining the experiences of more than 1500 people who have been affected by depression. Thematic analysis of data gathered from community meetings, focus groups and written feedback suggested that people affected by depression experienced a perceived lack of appreciation from family members as well as the wider community. The lay belief seemed to be that depression was not a real illness due to the absence of physical symptoms but was rather perceived as personal inadequacy or normal sadness.

Both studies have direct implications for help-seeking. It is possible that rather than poor knowledge of particular mental disorders and their symptoms, an individual's decision to seek help is influenced by the way the person constructs health and illness as broad concepts. If physical symptoms are considered worth consulting for, but emotional/psychological symptoms are not, then individuals may not consider seeking help until their psychological distress starts interfering with their lives in a more profound way. Thus, although many people use self-management strategies such as social support, self-help or exercise with positive results, for others delays in seeking professional help may lead to exacerbation of their symptoms.

Thompson, Hunt and Issakidis (2004) presented 233 patients of an anxiety treatment clinic with a self-report questionnaire assessing their help-seeking activities. Results showed that the main reason for delays in help-seeking was lack of knowledge about mental health problems and available treatments. Two thirds of the respondents reported that what prompted them to seek help (after the delay) was the severity of their symptoms and the degree to which they interfered with their daily activities.

Based on the concept of mental health literacy, several initiatives such as

beyondblue have been carried out to improve public awareness of mental health problems (McNair et al., 2002). Despite these commendable efforts that have contributed to increased depression literacy, as discussed earlier, the number of public campaigns is insufficient. In addition, studies and initiatives tend to focus on depression, with other high-prevalence disorders receiving considerably less attention. In view of this, the most common source of information about mental health is personal experience of someone with a mental disorder or the media.

Coverdale, Nairn and Claasen (2002) identified the media as the primary source of information about mental health for the general public. They collected 600 print items with a mental health/illness aspect, mostly news articles and editorials, published throughout New Zealand during a one-month period in 1997. They analyzed their content and concluded that media's depictions of mental health were predominantly negative, presenting mentally ill individuals as dangerous to self or others, or as incompetent and unable to control their lives.

These findings are somewhat in contradiction to more recent findings from an Australian study. Francis et al. (2004) collected a total of 13 389 newspaper, television and radio items relating to mental health/illness that were published during the year 2000. In terms of their content, over half of the items reported either on policy initiatives and programs or on causes, symptoms and treatment of mental disorders. Ten percent of the items were randomly selected to assess their quality of reporting. The researchers concluded that the items presented an extensive coverage of mental health and that most of those items were of good quality. Apart from possible cultural differences, the discrepancy between the two studies can be due to the fact that the larger sample in the Australian study was more representative. In addition, the New

Zealand data might have been skewed because the sample included an event (a murder by a psychiatric patient) that received considerable media attention.

Despite the overall positive outcomes of the Francis et al.'s (2004) study, several of their findings should be further discussed. Almost one third of the items featured an unnecessarily dramatic or sensationalized headline or content, such as 'tragic affliction' or 'dangerous and debilitating'. Approximately one in five items used outdated or inappropriate language (e.g., 'cracked up') and 14% reinforced negative stereotypes. A preliminary analysis of the data also showed that although a relatively small number (6%) of the items was mentioned in the context of crime, the number climbed to 16% of items on schizophrenia and 11% of items on substance use disorders (Francis, Pirkis, Blood, Burgess, & Dunt, 2003).

Another study of media items was conducted by Gattuso, Fullagar and Young (2005) who examined magazine discourses of depression in two publications with high circulation rates for women: *Cosmopolitan* and *Australian Women's Weekly*.

Magazines, being a major source of health information for Australian women, present an important building block in the formation of depression literacy. Analysis of items collected during a three-year period showed that depression was mostly explained as personal inadequacy, as being caused by insufficient coping with the competing demands in women's lives. In terms of management of depression, the most commonly mentioned strategy was self-management and seeking social support. Just as the causes of depression were individualized, the magazine items stressed that it was the individual's responsibility to 'get over it'.

This emphasis on self-management is somewhat surprising, given that previous studies have indicated that women are more proactive in help-seeking (Issakidis &

Andrews, 2006; Verhaak, Brink-Muinen, Bensing, & Gask, 2004), and that women are referred to psychologists at a greater rate than men (Pryor & Knowles, 2001). However, as Cotton et al. (2006) indicated, there may be gender differences in mental health literacy, with more women making a correct identification of depression vignettes than men (60% vs 34%). Thus it is possible that even though discourses of mental illness in women's magazines are incongruent with current expert literature, the simple fact that mental illness is discussed may increase women's awareness of it. A future study comparing magazine discourse in women's vs. men's publications could provide some answers to the question of gender differences in literacy and help-seeking.

The aforementioned discourse analysis provides further support for the way a person's pre-understanding is being shaped by our culture. The concept of mental health literacy has received a considerable attention in the past decade and may play an important role not only in early symptom management but also prevention. However, the concept has its limitations; as Jorm (2000) pointed out, the concept is built around the assumption that professional expertise is superior to lay beliefs. Even if individuals achieved full mental health literacy, it does not necessarily mean that they would more readily seek professional help, especially if their understanding of mental illness, based on psychiatric knowledge of symptoms and classification categories, was challenged by their personal interpretation of their condition.

In recent years, there has been a push to examine personal narratives to gain better understanding of the meaning people give to their symptoms and of their coping strategies (e.g., Herxheimer, 2001; Thomas & Bracken, 2004; Ziebland & McPherson, 2006). Harper (2004) argues that users of mental health services have a right to understand their experience in a way that is meaningful to them and that is put into their

historical and biographical context. Treating a person's symptoms as deviations from normality adds to the person's sense of isolation and indicates that the person may not achieve full inclusion until his/her abnormal symptoms are cured.

This line of reasoning suggests that there is only one understanding, one horizon of meaning. However, each individual has a certain way of experiencing a phenomenon into which he/she brings meaning (Bracken & Thomas, 2002). Harper (2004) thus believes that rather than trying to change the person's theories of meaning, practitioners should work with them. As Gadamer (1975) proposed, experience is a process through which individuals question their theories. One cannot question, and gain better understanding of, something which he/she is expected to disregard. Helping individuals live *with* their own understanding of the experience, not *in spite of* it, may thus be beneficial. This assumption should be explored in future research.

Mental illness and stigma

Stigma is a complex concept that involves "elements of labeling, stereotyping, separating, status loss, and discrimination" all within the context of unequal power dynamics (Link & Phelan, 2001). It is a mark of discredit that separates a person from other individuals (Byrne, 2001) and that has a number of negative consequences for the person's identity and social interactions (Prior, Wood, Lewis, & Pill, 2003). Since Goffman's (1963) conceptualization of stigma as a perceived attribute that leads to exclusion, researchers have produced a number of studies that examined stigma and the process of stigmatization from personal, historical, psychiatric, sociological and other perspectives. The concept of stigma has been applied to a wide range of contexts, from exotic dancing to leprosy, cancer and mental illness (Link & Phelan, 2001).

Byrne (2001) pointed out that stigma has a negative impact on every stage of the mental health experience, including presentation, diagnosis, treatment and outcome. A number of General Practitioners also identified stigma associated with utilizing mental health services as a barrier to referral (Lockhart, 2006; Pryor & Knowles, 2001). Although their concerns should not interfere with the referral process, research shows that people with mental illness do experience stigmatization. As a consequence of stigmatization, individuals may have difficulty with establishing supportive environments and finding work (McNair et al., 2002), may experience verbal or physical abuse and social isolation (Kai & Crosland, 2001) and may have limited housing options (Mental Health Council of Australia, 2005).

There are some indications that the perception of being stigmatized can be minimized by the location of care setting. For example, research found that some patients have a preference for community or general practice settings because those places give them a sense of anonymity (Kai & Crossland, 2001; Todahl, Linville, Smith, Barnes, & Miller, 2006). Being seen in a psychiatric setting was believed to highlight the issue and give the patients a mental illness label. As one patient stated, going to the doctor was acceptable while the idea of being seen going to counseling made him feel uncomfortable (Todahl et al., 2006).

Although both General Practitioner and psychiatrist can make a diagnosis and thus potentially have the power to label a person, the findings are congruent with the lay beliefs that psychological symptoms are not a 'real illness' for which one would seek a consultation (Pill et al., 2001). Thus going to a GP is acceptable because observers would have no way of knowing whether the individual consulted for a 'real illness' or for psychological problems. The issue is even more prominent in small towns and rural

areas where the question of confidentiality is more complex (Lockhart, 2006). There are some indications that rural areas have lower rates of referral (Sorgaard, Sandanger, Sorensen, Ingebrigtsen, & Dalgard, 1999); however, it is not clear whether these rates are influenced by the problems of confidentiality and perceived stigma or whether they are due to the shortage of psychiatrists in rural areas (Samy et al., 2007).

While stigmatization from the general public can be, sadly, explained by lack of awareness, the problem is not limited to lay views. There are some indications that professionals themselves do not always conduct themselves in a way that portrays support and empathy. Some may be operating under what Maddux (2004) described as the myth of the superiority of clinical judgment. Although people expect least stigma from GPs (Barney, Griffiths, Jorm, & Christensen, 2006), first-person accounts suggested that sometimes patients were not taken seriously by their GPs (McNair et al., 2002), that some GPs did not seem to be interested in their patients' psychological difficulties (Outram, Murphy, & Cockburn, 2004) and that some mental health professionals acted in a patronizing manner or viewed patients in terms of the label (e.g., as 'anorexics' or 'schizophrenics') which had a dehumanizing effect on the patients (Angell, Cooke, & Kovac, 2005). Moreover, the issue of labeling is systematized, as under the current Medicare scheme patients cannot be referred unless they have been diagnosed with a mental disorder.

While research has clearly indicated the effects of stigma on people who have already entered and used the mental health services, there are some indications that both self-stigma and perceived stigma reduce the likelihood to seek help in the first place (Barney et al., 2006). Vogel, Wester, Larson and Wade (2006) reported that people's evaluation of the costs and benefits of their decision to seek help involved several

factors, such as fear of self-disclosure or expectations about therapy; however, stigma topped the list as the most cited cost linked to help-seeking. Thus it is possible that within certain contexts, people have socialized and built their shared understanding of mental illness, as opposed to physical illness, around the idea that mental illness is something abnormal. When the individuals then experience mental illness, this understanding together with fear of stigma may result in their decision to manage the symptoms by themselves. It may be only when the symptoms worsen and obviously resist the self-management attempts, that the person is faced with a dilemma of whether to continue in their efforts or whether to seek professional help. Using Gadamerian approach might be helpful in examining this area of research.

Models of help-seeking

It has been proposed that people form common sense models of illness that in turn determine their response to symptoms, help-seeking strategies and adherence to treatment (Dunning, Heath, & Suls, 2004). Symptom perception and problem recognition represent the first step in help-seeking efforts which occur within the context of mental health literacy and stigma expectations. Vogel et al. (2006) proposed an information-processing model of help-seeking. The model begins with encoding and interpreting of symptoms and other relevant information which occurs within the context of the person's knowledge. The second step consists of behavioural options the individual generates based on the symptom perception and the person's current goals. The third step involves evaluating the costs and the benefits of the behavioural options and consequent decision making. In the last step, the individual evaluates the outcomes of the chosen behavioural option.

Although constructed as four steps, the authors pointed out that not all individuals will go through all four steps and not all of them will follow the steps in the proposed order. For instance, some people may believe that the symptoms they commonly experience are normal or harmless and thus do not require treatment (Dunning et al., 2004), while others do not see treatment as a viable behavioural option because of limited knowledge of available treatments and general negative beliefs about medication (Jorm, 2000). Some people are influenced by internalized beliefs that they acquired as children (St. Claire, 2003). For instance, if the early caregivers' response to their child's symptoms is an immediate trip to a family physician, the child may later use the same automatic behavioural response. The likelihood of the decision to seek professional help can be also increased or decreased by interpersonal consultation a person may have with friends and relatives (Angermeyer, Matschinger, & Reidel-Heller, 2001; Vogel, Wade, Wester, Larson, & Hackler, 2007), as well as other sources of information, such as homeopaths or hairdressers. St. Claire (2003) reported that these lay, 'over-the-fence' consultations may even involve sharing of prescription drugs between friends and relatives.

Vogel et al.'s (2006) model works well on a descriptive level but seems to have a lesser explanatory power. For example, some individuals may go through the decision-making process but even though they may believe that the benefits of help-seeking far outweigh the costs, they still may not proceed with this decision. Although they may suffer significant distress and may believe that their practitioner could help them relieve the symptoms, they may not seek help because their cultural belief suggests self-management of psychological distress. In other words, the person cannot reconcile the personal meaning with general presuppositions.

Another factor influencing coping with symptoms and help-seeking is the sort of attributions people make about responsibility for the problem and for the solution.

Based on these attributions, Brickman et al. (1982) identified four models that determine people's behaviour. In the moral model, individuals hold themselves responsible for both the problem (illness) and the solution (treatment). Examples of this attributional style can be found in current discourses of mental illness found in women's magazines where depression is presented as a problem of self-management (Gattuso et al., 2005). In the enlightenment model, people are responsible for the problem but not the solution. This places the patient in a position of discipline where they must submit to an authority that will determine the course of treatment.

In the medical model, people are responsible for neither the problem, nor the solution. As Brickman et al. (1982) pointed out modern medicine is based on this concept where the correct solutions are generated by experts and patients are required to comply with the experts' recommendations. The medical model is most likely to be favoured by individuals with high interpersonal dependency. These individuals initiate treatment relatively quickly after the symptom onset and tend to be highly compliant with treatment regimens (Bornstein, 1993). On the downside, dependent individuals may be reluctant to terminate their treatment and thus cease their role as patients (Gardner & Helmes, 2007). In the compensatory model, people are responsible for solutions but not the problem. According to this model, mental illness 'happens' to people but with a degree of empowerment, they should be able to deal with it.

Brickman et al.'s (1982) models can be applied on several levels. Firstly, the models can reflect a general outlook of a given social context. For instance, as pointed out earlier, many Western societies follow the medical model of mental illness which

has been systematized (e.g., the need for diagnosis in order to receive Medicare rebate). Secondly, attributions about responsibility can also influence perceptions of specific mental disorders. For instance, some people may believe that responsibility for the problem in substance abuse lies with the individuals while responsibility for the problem in schizophrenia lies elsewhere. And thirdly, attributions about problems and solutions determine an individual style of help-seeking and coping that a person has developed through the process of experience. In other words, the models can help explain the formation of horizons of meaning on the general, culturally-transmitted level of pre-understanding as well as on the more personal level.

One issue that has been discussed on both levels and that has received considerable attention in recent years, partially as a response to the dominance of the medical model, is the issue of patients' empowerment (e.g., Ghaemi, 2006; Herxheimer, 2001; Kai & Crossland, 2001). For instance, Haidet, Kroll and Sharf (2006) used a narrative framework to examine transcripts of qualitative, semi-structured interviews with 16 primary care patients. Based on the analysis, they created a conceptual model of patient participation, based on four common themes: the centrality of the illness in the patient's life, perceived change of the illness for the better, the degree of illness-related activity and the role of partnership with the physician. Haidet et al. (2006) found that illness-management strategies that involved negotiated empowerment were most productive as they led to active patient participation (e.g., illness monitoring or preventive actions) while strategies that were marked by passivity and fatalism were least productive. Ironically, however, assertive, empowered users of mental health services are at risk of being labeled as manipulative or noncompliant (Bernstein, 2006).

Because empowered individuals take responsibility for the management of their

illness, they are also more likely to instigate their referral. For instance, in a randomized controlled trial study Kravitz et al. (2006) trained 18 actors to portray symptoms consistent with major depression. The actors made a total of 298 unannounced visits to 152 general practitioners. Results showed that those participants who prompted the GPs by requesting antidepressant medication were more commonly referred than those patients who simply presented with symptoms (50% vs. 19%). Although the results suggest that patient's initiative may play a role in referral, only first visits were examined. Referral does not always occur upon the patient's first presentation, sometimes requiring several consultations.

In another study, a total of 2015 individuals from rural and urban Norway were surveyed in structured face-to-face interviews (Sorgaard et al., 1999). They were presented with questionnaires assessing their experience of negative life events, social support, well-being, personality-related variables and their previous help-seeking efforts. It was found that participants who had been referred had an attitude of not accepting sub-optimal conditions and of speaking out when dissatisfied; these personality-related characteristics had a more important role in the referral than most demographic variables.

While empowerment and increased patient participation have been identified as influential factors in help-seeking efforts, trying to apply the same strategy to all individuals could be counterproductive. One issue is the question of which empowerment strategies are most effective and how to apply them. Haywood, Marshall and Fitzpatrick (2006) have conducted a review of literature spanning more than 20 years. They found that while there was a wide range of strategies targeted at both patients and providers, there was insufficient evidence for a single intervention strategy

to be identified as most effective in increasing the patient's participation. However, patient-practitioner interactions are so complex that even if effective in statistical terms, a single strategy would not be sufficient to suit different personalities, communication styles and illness-management strategies of individuals.

Much of the research on empowerment does not consider the importance of underlying social and historical contexts. Anderson (1996) believes that empowerment is built around concepts of individualism that assumes that individuals are equally able to take responsibility for their health. This concept of empowerment does not take into consideration issues such as cultural, racial or gender differences that may prevent the person from active participation in the consultation process. As an example, Anderson (1996) draws on his work with immigrant women in Canada; many of these women were not fluent in English, did not know where to go for help or feared that they could lose their jobs should their employers find out about their illness. Thus attempts to empower a patient who struggles with basic communication or has difficulties coping with multiple roles (e.g., as a mother, a worker, a migrant, a patient) may not only fail but in fact can create additional pressures that can consequently lead to delays in help-seeking or treatment non-compliance.

Patient-practitioner interactions

Once an individual identifies his or her symptoms and considers the costs and benefits of various management strategies, he/she may decide that professional help is needed. Provided that professional help is accessible and financially viable, the individual then enters the consultation where he/she needs to describe the problem to the physician. Research indicates that because of the lay perceptions of what constitutes

'real illness', patients are more likely to communicate their physical symptoms before the psychological and emotional ones (Gabbay et al., 2003). Although communication is central to building a good therapeutic relationship (Kai & Crosland, 2001), research has shown that many consultation environments are not conducive to effective information exchange (Bugge, Entwistle, & Watt, 2006).

One important factor that impacts on patient-practitioner interactions are the structural barriers imposed by the current health system. As mentioned earlier, the Medicare Benefits Schedule is set up to encourage shorter, individual consultations (Duckett, 2004) and there are some indications that many GPs do prefer problem management adapted to a 10- to 15-minute time frame (Lockhart, 2006; Outram et al., 2004). As a result of these time constraints, some information does not get exchanged between the patients and the practitioners.

For example, Barry, Bradley, Britten, Stevenson and Barber (2000) interviewed 35 patients before their appointments and compared the data with transcripts of the actual consultations with their GPs. The comparison showed that only four patients voiced all their concerns. The unvoiced agendas included mostly psychosocial problems but also the patients' views of what the problem was or their reluctance to accept prescription. The researchers did not ask their participants why they did not disclose all their concerns or what sort of questions the physician could have asked to make them feel more comfortable in voicing their concerns. However, given previous research three possible explanations can be applied.

First, it is possible that within the constraints of short consultations, patients may feel that there is insufficient time to voice all of their agenda, especially if it is complex. And because patients tend to communicate their physical symptoms before the

psychological ones (Gabbay et al., 2003), the psychological concerns remain unvoiced. The second explanation regards the way people understand what constitutes illness. As mentioned earlier, the lay public tends to view 'real illness' in terms of physical symptoms rather than psychological ones (Pill et al., 2001). They may not discuss psychological symptoms because they are unsure of whether those symptoms constitute a legitimate illness. Thirdly, patients may not disclose psychological concerns for fear of being labeled with mental illness and thus becoming stigmatized.

Different explanations for not exchanging information in consultations were identified in Bugge et al.'s (2006) study. Although participants were recruited from five different clinical areas (family planning, primary care for diabetes, homeopathy, cancer genetics and oncology) and thus the study does not directly relate to mental health, some of its findings may be relevant to patients consulting for psychological issues. Twenty patients were interviewed before and after consultations, with additional information obtained from transcriptions of the videotaped consultations. Bugge et al. (2006) identified a number of important issues that were not discussed in consultations, such as the patients' beliefs about the cause of the symptoms, preferences for specific treatment options and details about the problem history. The patients reported that sometimes the consultation environment prevented effective communication because of other people present, and that many health professionals appeared hurried (and indeed the professionals themselves identified time constraints as one of the reasons for poor information exchange). Another reason for non-disclosure was a belief about appropriateness of the information; patients seemed to hold general ideas about the type of information that they believed was required from them by different types of professionals.

However, structural barriers, such as other people present in consultations and limited time per consultation are not the only factors that may put constraints on how much agenda is voiced. Patient characteristics may play a role as well. Gask, Rogers, Oliver, May and Roland (2003) conducted semi-structured interviews with 27 patients undergoing treatment for depression. They found that for many of the patients depression negatively impacted on the communication process. The patients found it difficult to disclose their feelings or felt ambivalent about actively participating in the consultation process. Gask et al. (2003) suggested that it may be the symptoms of depression such as feelings of low self-worth that may make the patients feel unworthy of the doctor's attention or make them hold low expectations of the treatment.

Other studies suggest that sometimes it is not the patients' inability to express themselves but rather the practitioner's lack of engagement and expression of interest that prevent full exchange of information. Salmon, Dowrick, Ring and Humphris (2004) analyzed transcripts of audiotaped consultations and found that although most of the 36 patients disclosed psychosocial problems, typically asking for explanation for their symptoms, the practitioners rarely responded to these cues. Common responses included reasserting a somatic agenda, disregarding the cues or normalizing them.

The findings of Salmon et al. (2004) have important implications. As suggested earlier, the lay public tends to view illness primarily in terms of physical symptoms. The responses of the practitioners from Salmon et al.'s (2004) study suggest that some practitioners may hold beliefs similar to the lay public. It is possible that their views are somewhat biased by their medical training that focuses mainly on the physical illness and its biological causes. It has been reported that many general practitioners receive only basic training in mental health (The Senate, 2006) and that they are not usually

trained in the use of psychotherapies (Kravitz et al., 2006). Therefore the lack of engagement that some practitioners display can be due to a lack of skills related to mental illness. For those practitioners who do not have the necessary training or who have limited referral options, investigation of psychosocial difficulties may place them in a difficult position.

Another important determinant is patients' perceptions of the relationship between themselves and their physicians. Verhaak et al. (2004) found that patients who were well known to their GP made more frequent requests for psychological help. Similarly, Todahl et al. (2006) reported that patients who had established relationships with a trusted physician were more likely to accept the referral and experienced more confidence in the therapist. On the other hand, Outram et al. (2004) suggested that a long-term GP-patient relationship was not necessary for rapport; rather their participants stressed the importance of GPs' interpersonal skills, their interest in patients' psychological problems and their ability to recognize hidden emotional agendas.

Thus successful skill acquisition that is based on comprehensive medical training is likely to increase the practitioner's confidence in his/her ability to recognize and deal with mental health issues. This confidence would then be reflected in increased engagement in the consultation and better rapport with the patient. Patients, as carriers of meaning, have some pre-understanding of what occurs in consultations, and so do medical practitioners. As seen from the studies discussed in this section, expectations of both parties may differ. It is important that some of the common patients' expectations be translated into practical skills taught at medical schools.

Conclusion

Research suggests that quality of patient-practitioner relationship and communication, and the extent to which patients recognize and disclose their psychological problems and take initiative in help-seeking are interlinked. Practitioners play a very important part not only as gatekeepers deciding whether a person gets referred to a mental health professional but also as providers of new horizons of meaning. Prior et al. (2003) emphasized that health practitioners should bear in mind that meanings of concepts such as mental illness are always situated. Just as patients bring their own understanding into consultations, based on cultural pre-understanding as well as their own interpretation of the phenomenon (e.g., the experience of mental illness), practitioners conduct themselves in a way that is influenced by their own horizons.

The currently favoured medical model of mental illness posits that the practitioner is the expert whose knowledge is based on science and therefore is superior to lay understanding. Many concepts, such as mental health literacy, work around the same assumptions. An individual is considered literate if he or she possesses knowledge of mental disorders that is congruent with the scientific expertise. On the other hand, patients' lived experience and exploration of meaning they give to their experience has received less attention in both research and practice. Surveys that measure levels of mental health literacy usually involve descriptions of symptoms taken out of manuals such as the DSM. These classifications, however, present prototypical patients who are rarely seen in consultation rooms. Many clinicians would probably agree that the proportion of patients who neatly fit all diagnostic criteria for a given disorder, with no co-morbidity, is relatively low.

Just as different individuals present with different symptoms, they also interpret these symptoms in a unique way. This interpretation is in part influenced by general presuppositions which have been shaped and transmitted through culture, and in part by the individual's personal experience and analysis of it. Understanding comes from a fusion of horizons and thus where patients learn from the expert knowledge, practitioners should be opened to the patients' own understanding. It is when the fusion is not achieved that patients might feel misunderstood, unheard or frustrated and might decide to not comply with the suggested treatment.

In this literature review, several factors impacting on a person's help-seeking activities have been discussed. However, there are still many unknowns that should be addressed in future research. One such study should address the impact of the changes to the Medicare rebate system that were put into practice in November 2006. These changes make psychotherapy more accessible to people who might have otherwise be left without professional help. It remains to be seen whether this has led to improved care, such as increased referral rates, smaller delays in help-seeking and increased patient satisfaction. In addition, the process of referral as experienced and interpreted by the patients should be examined.

Future studies should also further examine the issue of mental health literacy. Current studies tend to focus on depression and, to a lesser extent, psychosis and schizophrenia, while other disorders have received less attention. Thus lay knowledge of a variety of high-prevalence disorders could be examined. However, given the current number of diagnosable disorders and given the overlap between them, such narrowly-focused studies may not be viable. To further our knowledge of help-seeking, researchers should turn their attention to the constructions of illness. As seen in the

literature review, the lay public tends to categorize symptoms based on whether they are physical or psychological. Physical symptoms are believed to characterize a 'real' illness and thus precipitate help-seeking while psychological symptoms are dealt with through self-management. It seems that this view is part of people's pre-understanding that is transmitted through culture and learned through socialization. Future research should examine how this pre-understanding is formed, for example, how do children define illness or at what stage of their development do they start to differentiate between physical and psychological symptoms.

In summary, perception of symptoms, problem recognition and help-seeking decisions are strongly influenced by social, political and cultural contexts, combined with the individual's interpretation of their experience. Individuals experiencing psychological difficulties are not, however, the lone players. Once they decide to seek professional help, they have to navigate themselves through the current rules and structural barriers of the medical system. Through an opened, two-way communication with their general practitioner they need to be able to communicate their symptoms and come to a new understanding, based on the fusion of two horizons of meaning: their own and their practitioner's. The lived experience of individuals is a rich source of information that should be utilized beyond the diagnostic process.

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From GPs to Psychologists: The Patients' Perspective on Help-Seeking and Referral

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Abstract

General practitioners usually present the first point of contact for individuals seeking help for psychological problems. General practitioners (GPs) thus serve as gatekeepers who either manage the individuals themselves and/or refer them to a mental health professional. This study investigated the subjective experience of individuals who had been referred by their GPs to psychologists for treatment of psychological problems. The second aim was to demonstrate the use of Gadamerian hermeneutics in qualitative psychological research. Audiotaped transcripts of interviews with five Australian adults were analysed. While all participants agreed that the referral process was well-managed, the referral itself played a minor role in the lived experience. Rather, the participants emphasized the broad context within which the referral took place, and their understanding of the concept of mental illness. Issues related to self-management and coping, self-disclosure and personal identity were examined as well. The themes were linked by the patients' self-realization which was a process through which they acknowledged that their problems were psychological in nature. Implications related to the impact of self-realization on help-seeking and on the therapeutic relationship are discussed.

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From GPs to Psychologists: The Patients' Perspective on Help-Seeking and Referral

Introduction

Mental illness has been identified as the leading health problem contributing to years lost to disability in Australia (The Senate, 2006). Mental illness is a collective term for different types of mental disorders, where the term mental disorder refers to a clinically diagnosable disorder that significantly impacts on an individual's cognitive, emotional or social abilities (APS, 2007). It has been reported that only about one third of Australian adults who experience mental illness seek assistance from health services (Andrews & Issakidis, 2001). Of the third who seek assistance, around 80% consult their general practitioners (Department of Health and Ageing, 2005). For those individuals, general practitioners (GPs) serve as gatekeepers who decide whether or not to refer their patients to mental health professionals (Pryor & Knowles, 2001).

Previous research indicated several issues that influence the person's decision of whether or not actively seek help and that may also impact on his/her perceptions of the referral process. These issues include not only illness-related factors, such as severity of the symptoms and the degree to which they interfere with one's life (Thompson, Hunt, & Issakidis, 2004), but also the person's knowledge and beliefs about mental disorders (e.g., Bartlett, Travers, Cartwright, & Smith, 2006; Jorm, 2000), perceived stigma (Barney, Griffiths, Jorm, & Christensen, 2006; Link & Phelan, 2001), and opportunity for lay consultations with the person's social network (St. Claire, 2003; Vogel, Wade, Wester, Larson, & Hackler, 2007).

Pill, Prior and Wood (2001) conducted a series of focus groups in which participants responded to vignettes describing various symptoms. The study indicated that one of the main reasons for failure to consult general practitioners for emotional

problems was uncertainty about the legitimacy of the symptoms as 'real illness'. The symptoms were viewed as inevitable human experience and something that individuals should be able to deal with without professional help. In other words, people differentiate between what they consider are real, clinical illnesses (i.e., characterized by physical symptoms), and emotional complaints. Similar themes emerged in McNair, Highet, Hickie and Davenport's (2002) study examining the experiences of people affected by depression. Participants reported perceived lack of appreciation from family members as well as the wider community who did not view depression as a real illness due to the absence of physical symptoms, but rather as personal inadequacy or normal sadness.

The persons' personal characteristics may also impact on their illness management strategies, including their experience of referral. For example, Sorgaard, Sandanger, Sorensen, Ingebrigtsen and Dalgard (1999) found people who had been referred from their GPs had personality characteristics of not accepting sub-optimal conditions and of speaking out when dissatisfied. The person's initiative (Kravitz et al., 2006), level of participation in the consultation process (Haywood, Marshall, & Fitzpatrick, 2006), beliefs about responsibility for the cause and treatment of the illness (Brickman et al., 1982), and readiness to change (Prochaska & DiClemente, 1983; Prochaska & Norcross, 2001) may also play a role.

Previous studies of referral practices have utilized various methodologies, including focus groups, surveys and semi-structured interviewing. However, they have generally focused on the perspectives of GPs and therapists (e.g., Kainz, 2002; Lockhart, 2006; Pryor & Knowles, 2001; Sigel & Leiper, 2004) while far less is known about how the process is experienced by the patients themselves. A United States

ethnographic study explored the experiences of collaborative health care from the perspective of physicians, therapists, staff and five patients (Todahl, Linville, Smith, Barnes, & Miller, 2006). Domain analysis of interviews with the patients, in which the data were analysed for semantic relationships, identified four reasons for accepting referral: timing, physician influence, convenience and confidentiality. Thus timing of the referral, perceived relationship with the physician and the manner in which the referral was presented, together with convenience and confidentiality provided by the site played an important role.

In spite of the impact mental illness has on affected individuals, little is known about the subjective decisions involved in their help seeking efforts. It is likely that the actual decision to seek help is part of a process that is influenced by a complex set of factors. These factors may be understood as a person's pre-understanding, or horizon of meaning. Gadamer (1975) defined the horizon of meaning as "the range of vision that includes everything that can be seen from a particular vantage point" (1975, p. 269). He proposed that each person makes sense of his/her experience through a process that incorporates the person's interpretation of the experience as well as general presuppositions that are formed within the person's social, political and cultural contexts.

The aim of this study was to show the application of Gadamer's (1975) hermeneutic phenomenology not only as a philosophical approach to the construct of mental illness but also as a paradigm guiding the research process. The Gadamerian hermeneutic approach does not appear to have been applied to psychological research before. However, it is widely used within nursing research, where it addressed topics such as the lived experience of patients with coronary artery disease (Bergman &

Bertero, 2001), chronic fatigue syndrome (Whitehead, 2004) or the experience of older adults in acute care sector (Koch, 1994). It is believed that apart from providing some insight into the experience of being referred, this study could help introduce the Gadamerian approach to psychology and thus provide researchers with another qualitative paradigm.

The present qualitative study examined the experience of being referred from GPs to psychologists. A qualitative method based on principles of hermeneutic phenomenology was selected because it is more sensitive to user-led agenda, gives individuals more freedom to express what they really think and thus provides the depth of insight (Edwards & Staniszewska, 2000). Hermeneutic phenomenology allowed exploration of the referral experience within its context, and it took into account the subjectivity of the participants' as well as the researcher's viewpoints. In addition, openness of the interviews enabled participants to tell their story the way they wanted, which allowed for a detailed description of the experience as well as the meaning the participants gave to that experience. Thus, the aim of the present study was to examine the subjective experience of Australian adults who had been referred from their GPs to psychologists for treatment of mental health problems.

Method

Design

Gadamerian hermeneutic phenomenology was used in this study. Gadamer (1975) believed that people draw on their background knowledge which is dependent on the historical, cultural and social contexts in which they live, as well as their personal experience (Hein & Austin, 2001). It is through a fusion of this historically transmitted pre-understanding and a person's present range of vision, that a person reaches

understanding of his/her experience (Polkinghorne, 2000); it is this understanding that is subject of phenomenological research. Phenomenology as a research method thus enables the study of the lived world as it is perceived and experienced by individuals in a way that is personally meaningful (Willig, 2001). The method produces concrete descriptions that reflect rich and complex details of lived situations (Wertz, 2005).

The Gadamerian hermeneutics further involve three key philosophical constructs: the fusion of horizons of meaning, the hermeneutic cycle and dialogue (Koch, 1996). The first construct refers to the assumption that understanding comes from the fusion of two perspectives or horizons of meaning (Dowling, 2007): that of the people who express themselves (i.e. participants) and that of the people who understand (i.e. researcher). Therefore, the experience of a phenomenon is studied through the researcher's personal involvement in the dialogue with their participants. Hermeneutic interviewing is akin to conversations that are characterized by openness and non-directiveness. The interviews follow the logic of question and answer, and it is what is said that directs their course (Gonzales, 2006).

The hermeneutic circle refers to the analytic movement between the whole and the part (Whitehead, 2004). It means that in the interpretative phase of the research, the analysis functions on two levels: the descriptive one concerning the content (parts of the phenomenon), and the interpretative one that relates to placing the parts within the whole of the experience.

Another key aspect of the hermeneutic phenomenology as a research method is the representation of the researcher. Mantzoukas (2004) argues that because the researcher actively participates in the data collection and analysis, his or her presence cannot be excluded from the study. The issue of representation requires self-awareness

on the part of the researcher. Throughout the research, the researcher kept a journal in which she recorded her expectations prior to the interviews, the events and her responses to them as well as reflections on her role in the research process. The journal data allowed the researcher to reflect on the way her preconceptions impacted on the interviews and the data analysis.

Sample

The recruitment was carried out with the assistance of Delta Psychology, a professional agency that supplies psychological services to GPs. Clinical psychologists who had agreed to assist with the recruitment were sent an information letter (see Appendix A) and were asked to give the letter to all eligible patients. Exclusion criteria included self-referral, length of treatment less than four sessions and severe psychopathology, as determined by the participating psychologists. While they came to the Delta Psychology clinic for their appointment, each eligible patient who expressed an interest in participation was approached on an individual basis. The potential participants were informed of the purpose of the study and invited to take part. The researcher's presence at the clinic was important as it enabled the participants to ask questions about the research and as it helped build a connection.

With the exception of one participant, the sample was selected from within one geographic area because of the location of Delta Psychology. The strategy was not designed to provide representative views of patients currently attending psychotherapy but rather to gain rich descriptions of their lived experience. A total of five participants were interviewed, three male and two female. Four were recruited via Delta Psychology and one was recruited through snowballing. The participants were not asked about their diagnosis or the reasons why they attended therapy.

Procedure

In-depth interviews were conducted at mutually agreed locations. Two interviews were conducted in a library meeting room at Edith Cowan University, the Joondalup campus, and one interview each were conducted at Delta Psychology, the Heathridge clinic, in a cafe and in the Perth RSL building. The researcher conducted all interviews. In accordance with the Gadamerian construct of a dialogue, each interview was considered an opened conversation rather than a structured interview. The researcher started the interviews by asking an opening question: "Can you tell me about your experience of the referral?" The interviews lasted 15 to 35 minutes each. All interviews were tape-recorded and transcribed verbatim. The data collection took place between August 14, 2007 and September 12, 2007.

Establishing trustworthiness

In qualitative research, rigour (or trustworthiness) refers to four main constructs: credibility, transferability, dependability and confirmability (Nagy & Viney, 1994). Consistent with Gadamerian hermeneutics, the role of the researcher as an active participant in data collection and analysis needs to be acknowledged. Thus Whitehead (2004) suggested that credibility can be established if a researcher describes and interprets his/her own experience. This was done in the present study by keeping a journal that served as base for self-reflection. Another method for increasing credibility is providing the participants with the outcome of the analysis, asking them to discuss and comment on them. However, due to time constraints of the present study, further interviews with the participants were not possible.

Transferability can be assumed if readers consider that the study findings can be applied to other settings (Whitehead, 2004). Koch (1994) suggested that because

transferability depends on the similarity between the contexts, readers should be provided with sufficient contextual data. In the present study, this included data from the journal, data from pre-interview conversations, content of the interviews as well as related literature. The contextual data also formed an audit trail which allows readers to follow the data collection and analysis (dependability) as well as the way in which interpretations have been formed (confirmability).

Ethics

The project was approved by ECU Human Research Ethics Committee prior to commencing. All potential participants were first contacted by their clinicians, informing them about the research. The participants were informed that they could withdraw from the study at any time. Signed consent forms (see Appendix B) were obtained from all participants. Any potentially identifying information was removed from the transcripts; participants' names used in this paper are fictional.

Analysis

One of the principles of hermeneutic analysis is that the transcribed interviews are treated as texts (Koch, 1996). Another principle is that of the temporality of the data. Gadamer proposed that the meaning of the text is not given once and for all but rather that each person understands the text in the light of his/her present pre-understanding (Lebech, 2006). Readers themselves act as interpreters as they bring their own presuppositions and thus the themes arrived at through the analysis may not be the same for the researcher and readers. However, readers should be able to follow the way of the researcher's process of interpretation (Koch, 1994). Thus the researcher's task is to demonstrate that his/her interpretation is plausible in comparison with other possible constructs (Bergman & Bertero, 2001).

The analysis consisted of four phases. In the first phase, the transcribed interviews were read several times to gain an overall picture of the data. In the second phase, each text was analysed for key words or concepts that emerged from the data (see Appendix D). The third phase involved the researcher's reflection on the themes in terms of their relation with other perspectives. This included the relation of the themes with each other, their relation with the overall experience of the phenomenon and their relation with the researcher's own reflections, gathered from the journal data (see Appendix E). The themes were also considered as part of the related literature. In accordance with the concept of the hermeneutic circle, the analysis moved between the whole and the part (Whitehead, 2004). This means that the analysis had to function on the descriptive level proceeding from the horizon of meaning of the text, as well as on the interpretative level proceeding from the researcher's own horizon of meaning. The last phase involved the fusion of the two horizons of meaning. Thus the themes were integrated into a coherent picture of the experience, including quotations that illustrated each theme.

Findings and Interpretations

The findings involve three main sections. One provides a reflection on the contexts surrounding the referral process as told in individual stories. The second section relates to the content of the interviews and thus presents common themes found in the text. The third section relates to the research process and is based on contextual data from the journal, from pre-interview conversations with the clients as well as the interviews themselves.

I. Reflection on individual contexts surrounding the referral

There were individual differences and great diversity of issues in the stories told.

This section of the paper presents a reflection on how individual participants made sense of their experience and what meaning they applied to it.

Adam:

Adam had been experiencing his problems for a long time. He made an appointment with his GP for physical problems but while there, he disclosed his psychological concerns as well:

I just mentioned it to her... I thought maybe she, what I was looking for was... maybe there's some kind of, natural sort of... some tablet that you take... so I thought that's what she was basically gonna prescribe or something like that. I had no idea that she was going to send me to a psychologist...

The referral was not anticipated but at the same time, Adam was going through a process of transformation in how he perceived his problems. This readiness to change was crucial in his acceptance of the referral:

I think I was ready for, I'm ready for a change, you know, in how I handle situations so I think it's a good thing... I suppose you just can't keep on shoving it under the pillow all the time...

Adam's readiness to accept professional help did not include readiness to accept the diagnostic label. The label itself was less important than his need to understand why the problems occurred. His view of his problems as a personal inadequacy illustrates previous findings on lay views of mental illness (e.g., McNair et al., 2002; Pill et al., 2001). Redefining causes of illness in terms of its biological underpinnings made it easier for him to accept it.

I couldn't handle my stress and anger a little bit... I think it's been happening for many, many years... Most people don't know how the brain works, I

certainly haven't but I'm starting to get an idea of... acts that you perform...

You know when you're under stress, how you react... I think if you could control your emotions, you could control your thoughts.

He was aware of the contextual factors that might have contributed to the problem, including personality traits, major life change (immigration) and a personally significant event that acted as a trigger for his disclosure to the GP (argument with wife). His construction of mental illness was incongruent with his self-identity which was strongly defined by management and controllability.

I guess, there are a lot of, I suppose, traits in my character that are awful for myself, you know... like stress, anxiety, and you need to cope with it. You know, one basically allows this to happen to oneself... I never believed in psychology, I always thought that I was my own psychologist...

Barbara:

Barbara had a long history of depression and over the course of years had seen various specialists. The treatment she was receiving was not effective which is why she decided to look for help elsewhere. The referral was initiated by her:

... it was my request really... I said to my GP, I think it's time I went somewhere else... I think my GP was quite aware of the fact that I really needed, you know, longer sessions as much as anything...

Barbara's perceptions of psychotherapy were thus strongly influenced by her previous experiences, which included primary care as well as psychiatric care.

I've had two very good GPs... The big problem with that is, they don't have the time because their appointment times are so, you know... they're only just like 10 or 15, 20 minutes at the most and they just don't have the time, which is a

nuisance... I could talk to both of them and I have done, you know, shared all sorts and bits of my life with them, but you have to keep going back all the time and even though they wanna help and they come up with some strategy and things like that, it's just too drawn out, because they seriously don't have time to deal with patients like this...

For Barbara, one of the main issues was the time constraints presented by the current health system, as suggested by Outram et al. (2004). She needed enough time to tell her story and she wanted to be heard but she also looked for some specific strategy, a more concrete assistance. Support and encouragement were also important:

I think it's [psychological treatment] not so clinical ... that's a funny word, but it's not so... by the book sort of, yeah, not so by the book as I remember psychiatrists usually went by the book... and he's [the psychologist] so much more encouraging than anyone else that I've dealt with... I feel like somebody cares, I'm not a number.

Although Barbara voiced satisfaction with her current treatment, she expressed little anticipation of recovery. She accepted her diagnosis to a point of resignation. This might have been due to years of little improvement when she had to rely on her own coping strategies:

I just feel I have to keep busy. I can't see any other way of coping with life... And sometimes it's hard but sometimes that's the only way I can exist, is to keep busy.

Another contextual factor were the perceptions of others in her life. She felt unheard and misunderstood, alone with her illness. Research on first-person accounts reported lack of appreciation by others (McNair et al., 2002), as well as the isolating

consequences of mental illness (Kai & Crossland, 2001). It might have been this social exclusion that gave her little hope of recovering:

... and because I keep busy all the time, it seems so out of character to be depressed... And consequently they just look at you and say 'You can't be depressed, what do you mean you're depressed'... If you haven't had it, it's too hard to explain and if you haven't had it, they don't know what it's all about...

Charles

Charles had also seen various health specialists in the past and it was through a realization that his symptoms were not improving that he decided to take the initiative and ask for referral:

I sort of did my homework and actually my brother [psychology student] had already known about such things because I already spoke to a person and I was thinking I should try CBT, I had heard of it before... and a psychiatrist, not psychologist has recommended me, has talked about it with me once... so it was mainly, really, I chose to actually go and have CBT treatment...

Charles' evaluation of effective help was similar to Barbara's, in that he valued being heard and getting concrete help, tailored to his needs with active input from the therapist.

I've been to a psychologist before but... I could just talk their ear off, basically. They didn't put any input in. They just were there to talk to... He [current psychologist] seems determined to actually help me, he's not cold or anything, he's got a certain part of... he's got determination to help me and he also does want to talk, unlike the first person, he actually wants to talk to help, not just talk about anything...

Charles' change in self-realization was triggered by his transition from high school to university and by the new challenges this transition brought. Increased severity of symptoms and their interference with a person's functioning were previously cited as common reasons for the decision to seek help (Thompson et al., 2004).

Officially I was diagnosed with GAD, generalized anxiety disorder and it's just been getting more obvious that it was much larger in my life, that it was really... prevalent and it became really... That's when I came to the university first semester and doing that and I was thinking, you know, I can't get through this, I need some sort of help.

Charles spoke about his problems in terms of diagnostic labels and seemed quite comfortable using clinical terms. However, he himself pointed out the importance of self-realization and suggested that it is a process that may take time:

I mean, as a person to realize this sort of thing, you've got to realize that this is all, this is not normal, you just need to tell the person, basically... You need to make them realize somehow that what they're feeling isn't actually normal... it's, there's something wrong... Not actually be thinking I have some problems and it's because I'm a loser or something, it's because this is real and it's wrong and I can't exactly go on like this... It's only, it takes a while but it can actually sink in.

Charles was very positive about his improvement and suggested possible recovery. Although he accepted his illness as part of life, he was ready to create a new identity which would not be determined by the illness:

They [on YouTube] mainly just talked about their stories... they were just people like me, and also it put things into perspective because some of them are, I

mean, some people are really, like, housebound or, you know, some have had it for 30 years. Well my disorder is, like, half dead now and theirs is still going. So it was also hopeful for me and also even they themselves have hope... I actually myself thought about, if this CBT treatment gets even better that I might actually publicly speak about it myself...

Deborah:

Deborah's referral decision was made while consulting her GP for physical problems. She had been treated by psychologists before and her positive experience with them helped her accept the referral.

... at that time I saw her [the GP] because I have to see my doctor regularly. I can't get the medication for the pain. I have to have it prescribed... That day I did not need any prescription I just... I started to cry, dear! I was in a deep hole and I was hanging on by my feet.

Deborah had suffered previously from depression and she accepted her diagnosis. She was aware of common misconceptions and as a result did not disclose her problems to many people.

I think that a lot of people think that if you go and see a psychologist, you must be a nutcase. People still think that. You don't tell everybody that, no, no, no, no... A great deal of people still think, ah, snap out of it. You can snap out of it. They think that depression is an indulgence or something. Because they never experienced it before, they don't know. You don't want to be in that place, you don't want to feel that way.

Although aware of the misconceptions, the issue of disclosure did not seem to play a large role, possibly because the illness was not central to her identity. Her self-

identity seemed to be defined by relationships with others. It was these relationships as contextual factors that Deborah mostly focused on. She clearly viewed loss of long-time friends (due to immigration) and difficulties in her marriage as causes of depression and it was these causes she needed assistance with.

It was very hard when I came to Perth because I left many long-time friends behind. I mean, when I first came here I thought, What have I done?... It was so painful leaving my friends.

Edward:

Edward was reluctant to accept the referral because he did not believe he needed psychological help:

I was sent there by Veteran Affairs... I said, if I have to go, then I'll go and do it. I didn't believe in psychology... I was told I was going to have to do it. So I did. But I didn't listen. Because I didn't believe that I was needing one [psychologist] to start with.

Edward described his journey as an attempt to come to terms with his illness. He frequently referred to his response as denial. He did not identify with his diagnosis and still struggled to accept that he had psychological problems. The transition in his attitudes was prompted by a life-threatening event.

I came home to my wife and I said: "My doctor's telling me that I'm suffering from depression and post-traumatic distress, my psychologist is telling me that I'm suffering from post-traumatic distress, the doctor in [town] is telling me that I'm suffering from post-traumatic distress and Leslie there, the matron in [town] is telling me that I'm suffering from it, and I'm the only one that's saying that I'm not... So I said, the odds are that all of those people can't be wrong.

Someone must be wrong and it looks like it's me. And then I changed my thinking.

It was not just the diagnosis itself that Edward struggled to accept; it was the concept of illness as such that challenged his self-identity. He was aware of factors that contributed to his sense of identity, primarily his upbringing and his professional background. His sense of strength, self-reliance and control were incongruent with his view of mental illness:

I just thought, well, this could never happen to me because I'm too strong-willed... My background is the army and the police force. You know, we're very rigid, not rigid, we're, what do you call it, regimented, discipline-orientated... Weakness is something you don't accept.... People my age, like, we were brought up to be tough... I was always told to stand on my two feet... I was saying: "This could not happen to me. It's impossible. I can't have it". You know but it did happen. It has happened to me...

It was Edward's self-identity rather than lay misconceptions that prevented him from disclosing his problems to others. Although he was offered support from other people suffering from PTSD, he refused to accept it.

No, you don't tell police officers that... I was the team leader and I expected that it would undermine my position. They do know now but they didn't when I left. I never told anyone, I never told my wife for a long time...

Edward's self-realization was still in its early stages. However, his reluctance to accept the illness did not involve reluctance to accept help. While he relied on self-management for a period of time, his view of psychology changed following his experience of the therapy and he was willing to participate in his treatment:

I did have some problems in the 80s but I just took myself away and changed my thinking... So that's what I did. I tried the same thing with this but it didn't work... I was in total denial. When people are in total denial, it's almost impossible to help them. No matter what you do... And when I came back, it was actually helping me... It has certainly helped me a lot in the last... since I've become aware that it was doing me good.

II. Themes

Three main themes were identified in the texts: the referral process, the context of the phenomenon and the discourse of mental illness. The three themes are not distinct and there is an overlapping construct that links them together: the process of self-realization (see Appendix C). Self-realization as experienced by the participants was a process through which they started to acknowledge that the problem they experienced was psychological in nature. The different stages of the self-realization process ranged from complete denial, to awareness, acceptance and resignation.

Theme 1: The referral process

The participants generally agreed that the referral process itself was fast and well managed. However, there were individual differences in reasons for accepting the referral, which consequently influenced the person's perceptions of the process. Some participants had asked for the referral, based on their assessment of the effectiveness of their coping strategies. Other participants were guided by their previous experience with psychotherapy, by their own readiness for change, as suggested by Prochaska and DiClemente (1983), or because of outside pressure. Readiness for change was demonstrated by Adam in his interview:

... everything was just getting on top of me and I thought it's time to do

something about my life, myself, my thoughts and that I'm not such a happy person...

Although all participants dealt with problems that were either ongoing or that had occurred in the past, their management of those problems varied greatly. Some had sought professional help before while others relied on self-management.

The referral decision marked a transition in their journey to recovery. Those participants who were at the later stages of self-realization (acceptance or resignation) accepted the referral or even initiated it. Those participants who were at the early stages of self-realization (denial or awareness) struggled with acceptance and responded with surprise or even refusal, as seen in Edward's response to being diagnosed with PTSD:

They were telling me it was post-traumatic distress, I was telling them it wasn't... I went there and I told them I didn't believe in psychology and as far as I was concerned, it was all a lot of [rubbish]. I was there only because I had to be there.

Theme 2: Context of the phenomenon

Although the referral was a transition point, the process itself played only a minor role in the overall coping and help-seeking efforts. Rather, all participants emphasized the broad context within which the referral occurred. This is in accordance with Gadamer's (1975) position that the process of experiencing is based on the person's horizon of meaning which is in turn based on the person's historical, cultural and social context. The contextual issues the participants focused on tended to represent the stage of self-realization they were currently at. For example, Charles stated:

I'm definitely making some progress... I've actually only been there for the last six weeks so it started to help challenge the things for my anxiety disorder which

is mostly what this is about.

Thus those participants who were at the early stages of self-realization focused more on possible causes of their problems, while those participants who have accepted that they were suffering from mental illness focused more on getting better.

The contextual issues can be broadly categorised as issues of self-management and coping, issues of self-disclosure and issues of personal identity. All participants engaged in self-management and coping activities, usually involving busyness and social support. However, for each participant those activities served a different function, such as minimizing the impact of symptoms on one's functioning, dealing with contributing factors or gaining a sense of hope for recovery. Although the participants accepted professional help, they incorporated it into their ongoing coping strategy rather than replacing it. Learning from the successes and failures of self-management is important (Herzheimer, 2001), and the participants clearly indicated this learning experience in their responses.

In addition, the participants spoke about self-disclosure with respect to their relationship with others:

I don't tell many people [about depression], I can't be bothered with all the drama that goes on with it, I just go along and, yeah, there's a handful of people that know but that's it, yeah... And most people, including my own daughter, will tell you to put up your socks and get on with life.

There was a consensus that self-disclosure was selective, often because of misconceptions held by the general public about mental illnesses. This supports previous research on lay attitudes which suggested that mental illness is often not considered 'real illness' due to lack of physical symptoms (Pill et al., 2001).

Participants also reported lack of appreciation from others who tended to normalize or dismiss their experience (McNair et al., 2002).

In terms of self-identity, mental illness presented a factor that may have challenged it. Acceptance of illness did not necessarily mean that self-identity centered around it. The way in which the illness was incorporated into one's self-identity varied greatly across the participants.

Theme 3: Discourse of mental illness.

Although the participants were not asked about their diagnosis, they all disclosed it. However, there were differences in the way the participants identified with the diagnostic label, which could represent their stage of self-realization which in turn was instructed by their constructions of (mental) health and illness. Those participants who accepted the existence of a psychological problem tended to accept the diagnosis. Those participants who were in denial or had some awareness rejected the diagnosis and tended to describe their problems in terms of the symptoms and possible causes, as stated by Adam:

I just didn't say to her [GP] that I was depressed because I don't think that I'm depressed as such. I think it just has to do with stress and whatever... probably just stress and situations.

III. Reflection on the research process

Interview as a functional conversation

Hermeneutic interview style is characterized by openness and non-directiveness (Koch, 1996). Participants engaged in a great deal of self-disclosure that often included descriptions of hurtful and distressing events. However, they also indicated that the process of self-disclosure had a function. For example, Charles remarked:

I'm becoming more... even just talking to you about it, it's pretty good... Last week I decided, it just came up in a conversation, I told a lecturer that I had it [anxiety disorder]... .. then I said it to you as well that I have anxiety disorder... so it's less severe, it's much more comfortable now.

For Charles, being able to disclose to others was a mark of improvement in his problems. However, the problem of self-disclosure was common. Because of lay misconceptions, the participants felt they had to weigh carefully to whom they could self-disclose. At the same time, there were indications that talking about their problems helped them, as indicated in Edward's comment:

... talking about it makes it easier. Where I wouldn't talk before. I would answer questions but I wouldn't talk.

Although his comment was made in the context of his experience with the therapy, it seemed to be applicable to the interview as well. He described his experience in great detail and needed very little prompting to carry on in his story. Deborah suggested:

I've had counseling before and it always helped because if you really talk to a psychologist, you unburden yourself better... And having no friends here, too, because I like to have a chat... Having a good friend does help.

Thus the interview may have served as a source of social support, as a place where the participants could "unburden" themselves or where they could vocalize their doubts about the diagnostic process. The participants were aware that the researcher was a psychology student and may have felt comfortable talking about their problems because the risks of doing so were perceived as low. They might have felt that the researcher would have some understanding of what they were going through. For

example, Deborah remarked:

One of them [previous counselor] was actually like you, he was not qualified.

You say you're not qualified if you had four years but you know a heck of a lot.

But they said they were in the early stages of their studies and I said, that's fine.

This fusion of roles presented a potential ethical dilemma. As an aspiring psychologist, the researcher was aware that some of the personal issues would be subject to exploration within therapeutic settings. As a researcher, she looked for rich information that would allow for better understanding of the phenomenon under investigation. Koch (1994) and Whitehead (2004) who both conducted research following the Gadamerian hermeneutics wrote about the risk of multiple roles: being a researcher while maintaining a non-therapeutic relationship.

The researcher managed this risk by allowing the participants tell their stories the way they wanted. While some of the prompts served to gain more details about an issue, the researcher did not ask therapeutic questions. Her pre-interview conversations with the participants allowed her to learn a bit about them as individuals. In spite of the issues discussed during the interviews, none of their behaviour raised concerns for their well-being. Had there been any concerns, the researcher was prepared to discuss them with the relevant psychologist.

The researcher's own emotional responses were noted when analysing the data. For example, in response to Barbara's description of having lived with depression the researcher noted:

I felt sad and a bit upset. Sad because having no support is difficult, especially when you are a teenager. Upset because of the realization that this woman has suffered from depression for more than 50 years and over that period of time,

little seemed to have been accomplished in terms of her getting better.

Noting her own affective and cognitive responses made the researcher more aware of her own pre-understanding which in turn helped her better understand both the interview content and the interview process.

Discussion

The present study explored the subjective experience of patients who had been referred from their GPs to psychologists for treatment of mental health problems. In addition, the study demonstrated the use Gadamerian hermeneutics in psychological research. The Gadamerian paradigm not only acknowledges the role of researcher in the data collection and analysis but it makes his/her role explicit. The researcher's pre-understanding is taken into consideration when working with the collected data, thus demonstrating the way interpretation was carried out. Conducting interpretation as fusion of two horizons of meaning, the participant's and the researcher's, is innovative and opens new possibilities for qualitative inquiry in psychology.

In terms of the experience of the referral process, the participants generally agreed that the referral process was fast and well-managed. However, their experiences differed in terms of their reasons for accepting the referral, which included readiness to change, previous experience, outside pressure or the participant's own initiative, as suggested by Kravitz et al. (2006). Although important as a marker of transition, the referral itself played only a minor role in the overall help-seeking strategies. The participants emphasized the context within which the referral took place.

While different participants focused on different contextual factors, three subthemes were common: self-management and coping, self-disclosure and personal identity. All participants engaged in self-management activities that were beyond the

strategies outlined by their therapy, with the most common strategies being busyness and social support. This supports Jorm's (2000) position that individuals affected by mental health problems act as primary agents in symptom management. The participants also described their experience of self-disclosure. They indicated that disclosing their problems to other people was always carefully thought out. The problem of lay misconceptions about mental illness (Pill et al., 2001), lack of appreciation from other people (McNair et al., 2002) and social exclusion (Kai & Crosland, 2001) are well documented in the literature. However, the present study also illustrated how these issues relate to the concept of personal identity.

The issue of personal identity is closely linked to the third main theme: discourse of mental illness. All participants mentioned their official diagnosis but they differed in the degree to which they identified with it. Kralik, Brown and Koch (2001) suggested that the experience of being diagnosed can be rather negative because of the challenges it presents to the person's identity. They believed that the adjustment process through which the individual learns to integrate the meaning of the diagnosis with their self-identity is important.

The present study supports these findings but also adds another dimension. Kralik et al.'s (2001) research was based on studies of individuals adjusting to diagnosis of physical illness. However, mental illness carries negative connotations for some people; it has been linked to stigmatization (e.g., Barney et al., 2006; Link & Phelan, 2001) and discrimination (McNair et al., 2002). Thus people have to adjust not only to the notion of having *an illness* but they have to incorporate the diagnostic label of a *mental illness*. It has been suggested that the meaning of the term mental illness is always situated (Prior et al., 2003), and that illness journey cannot be separated from the

person's context (Telford, Kralik & Koch, 2006). Therefore, the differences in the way the participants identified with the diagnostic label represented how well they managed to mediate their constructs of health and illness with their own self-identity, all within the broad contexts of their lives.

The three themes did not represent three distinct categories but rather overlapping issues linked together by a concept of self-realization. Self-realization can be defined as a process through which the participants started to acknowledge that the problem they experienced was psychological in nature. The different stages of the self-realization process ranged from complete denial, to awareness, acceptance and resignation. The stages seemed to impact on the persons' perception of the referral process, the contextual factors they tended to focus on and the way they spoke about their problems.

Stages of adaptation have been explored in the health literature (Noar & Zimmerman, 2005), and parallels can be found between the self-realization process described in the present study and health behaviour models, such as the transtheoretical model of change (Prochaska & DiClemente, 1983). This model presents behavioural change as a process involving five stages: precontemplation, contemplation, action, maintenance and relapse. For example, Prochaska and DiClemente's description of contemplation has similarities with awareness as a stage of self-realization. However, the process of self-realization presented here is not meant to serve as a theoretical model, and although it has an impact on a person's behaviour, it usually reflects affective and cognitive responses. It describes an inner journey that each participant had to navigate in order to acknowledge the existence of the problem and to accept professional help.

Limitations

The issue of sampling can be identified as a limitation of the study. The sample was small and largely selected from within one geographic area which raises issues of generalization of the findings. It is also not clear whether those patients who decided to participate differed consistently along some common dimension from the nonparticipating patients. However, the patient characteristics varied across several demographic variables, such as sex, age (range from 20 to late adulthood) or country of origin. In addition, the study was not designed to provide representative views of patients currently attending psychotherapy but rather to gain rich descriptions of their experience of referral.

Implications and future directions

The participants demonstrated a great deal of insight. When talking about their experiences of referral, they integrated their views of possible causes, contributing factors, contextual issues and expectations with the description of symptoms. In fact, the symptomatology seemed to take a second place to the context of the experience. Rather than being assessed on a checklist of symptoms, patients should be able to tell their stories with all the non-clinical details. Storytelling in itself can be a therapeutic experience, and its use, for instance in narrative psychotherapy, is well documented (e.g., Carr, 1998; Goncalves & Machado, 1999). However, it requires time, something which primary care setting does not usually allow. All five participants were satisfied with the psychotherapy, which is consistent with earlier findings (Outram, Murphy, & Cockburn, 2004). This demonstrates the importance of the recent changes to the Medicare rebate scheme which now provides government rebates for psychology services. Further research could examine the impact of these changes on referral rates

and patients' satisfaction.

The present research described the process of self-realization as an inner journey that impacts on the person's understanding of the phenomenon. This concept is in need of further investigation. Participants in this study had all accepted the referral. While psychotherapy can be beneficial, it is the individual's prerogative to accept or refuse it. It remains to be seen how the self-realization process operates in people who refused the referral or did not seek professional help. It should also be examined what tools individuals employ in order to move between the stages.

The participants indicated different needs when it came to therapy. Common expectations were support and encouragement, provision of information and concrete strategies with an active input from the therapist. Prochaska and Norcross (2001) suggested that just as each patient moves through stages of readiness to change, so should the therapeutic relationship. They also posited that while for different individuals the time spent in each stage varies, the tasks for each stage remain the same. The present study seems to support the former position but not the latter. The therapeutic relationship should be adjusted depending on the stage of self-realization. However, given the complexity of each individual's context, it seems more likely that the tasks required for movement to the next stage should be adjusted as well.

Conclusion

The present study demonstrated the use of Gadamerian hermeneutics as a paradigm underlying qualitative research design. Putting participants in the role of co-researchers and acknowledging researchers as active participants in data collection and analysis is an effective method for examination of the lived experience. This paper introduced it as an innovative method with great potential for future psychological

inquiries.

The study investigated the subjective experience of Australian adults who had been referred from their general practitioners to psychologists for treatment of psychological problems. While the referral process was generally described as fast and well managed, the reasons for accepting it varied across individuals. The experience of the referral seemed to be influenced by the timing of the referral, by the participants' understanding of (mental) illness and their stage of self-realization. Rather than the referral process itself, the participants seemed to focus on the personal context within which the referral took place. In accordance with Gadamer's (1975) philosophy, a person presenting with symptoms of psychosocial distress should not be viewed as separate from his/her background.

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Appendix A

Information Letter***From GPs to Psychologists: The Clients' Perspective on the Referral Process***

Dear Participant,

My name is Zdenka Bartova. I am conducting research on the experiences of people who have been referred from their General Practitioner to a psychologist. I am interested in what people felt, thought and experienced during the time of the referral. I would like to invite you to participate in my study; its findings would provide some insight into the referral practices.

You will be asked to participate in a one-on-one discussion that should last approximately 30 to 45 minutes. Participation in this study is voluntary and you will be able to withdraw at any time. The discussion will be audio taped and the tapes consequently transcribed. Following my initial analysis of the transcribed interview data, you will be invited to a second meeting where you will be able to provide comments on my analysis. Your contact details, used to arrange the second meeting, will be held confidential.

After transcription, all tapes will be erased and transcripts locked in a storage area at the Edith Cowan University. No personal details will be identified outside the context of the interview discussion. No other person besides my project supervisor and I will have access to the research data.

It is possible that throughout the interview we will discuss personal issues that might cause you discomfort. Should that occur, please let me know immediately. Similarly, should I feel that there are any concerns for your well-being, I will raise the issue with you. If necessary, the interview will be terminated and your psychologist will be informed so that she/her can provide you with assistance.

This research project is being undertaken as part of the requirements of an Honours program at Edith Cowan University. The project has been approved by ECU Human Research Ethics Committee.

In case you are interested in participating in my research or have some questions regarding the study, please contact me by phone (0405 663 342 or 9472 6581) or via email (zbartova@student.ecu.edu.au), or speak to the project supervisor, Dr Ken Robinson (phone: 6304 5526, email: k.robinson@ecu.edu.au).
Thank you.

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact: Research Ethics Officer, Edith Cowan University, 100 Joondalup Drive, JOONDALUP WA 6027 (phone: 6304 2170, email: research.ethics@ecu.edu.au).

Kind regards,
Zdenka Bartova

Appendix B

Consent Form

Project Title: **From GPs to Psychologists: The Clients’ Perspective on the Referral Process**

I _____ have read the information provided with this consent form and have understood the purpose of this study. I have been provided with satisfactory answers to my questions regarding this research.

I agree to participate in the interviews that are involved in this research and understand that I can withdraw from the study at any time.

I agree to provide the researcher with my contact details, provided that these details will be used only to arrange our second meeting and that they will be held confidential at all times.

I agree that the information gathered during the interview can be used to complete a research report, provided that I am not identified in any way.

I agree to being audio taped and to having the tapes erased after the transcription.

I agree for the researcher to contact my psychologist should there be any concerns for my well-being.

_____	_____
Participant	Date
_____	_____
Researcher	Date

Appendix C

Thematic content analysis: General findings

Themes		
The referral process	<div>The context of the phenomenon:<ul style="list-style-type: none">• <i>Self-management and coping</i>• <i>Self-disclosure</i>• <i>Personal identity</i></div>	Discourse of mental illness
←	Self-realization	→

Appendix D

Thematic content analysis: Findings at the individual's level**Participant 1: Adam**

On being referred	<ul style="list-style-type: none"> • Then one day I was at the doctor, I had my blood taken for uric acid and sugar and all the rest of it, and I was feeling really down that day and I just said to my doctor I can't see the wood for the trees, I don't find anything exciting in life... • I was pretty upset that day. I had a huge argument with my wife on Saturday and ... it was a really bad argument... • She asked me quite a few questions and obviously she wouldn't go into all the detail, but I did tell her what I'm telling you now. I just didn't say to her that I was depressed because I don't think that I'm depressed as such... • ... yes, I did speak to her about that and she referred me to [the psychologist] and I wasn't sure... • She did it [the appointment with the psychologist] all herself • Look, I just mentioned it to her... I thought maybe she, what I was looking for was... maybe there's some kind of, natural sort of... some tablet that you take... • ... so I thought that's what she was basically gonna prescribe or something like that. I had no idea that she was going to send me to a psychologist at the end of the day • If she gave me a tablet, I would have walked out with that tablet or whatever, something to relax, and I would be happy with that... • I just went to the doctor, as I said, on the day specifically for my blood test, OK, otherwise I wouldn't have gone. • I would never have gone to a psychologist, I don't think. Had I not spoken to her that day and I just kept it all bottled up. • The [referral] process was very quick and I would highly recommend it.
Self-management and coping	<ul style="list-style-type: none"> • I have never ever seen a psychologist or a psychiatrist or anybody prior... • I don't know if I can cope with that [stress] ... so I need to manage it. • ... you're tired at the end of the day, you come home and everything needs to be right... You're tired, you want things to be right but you don't want to hear any more problems, you don't want to hear it... you wanna hide under the table... • And my wife said to me that I really think you should get some anger management... and she's given me books to read in the past but I've never really done so... And I read a couple of pages and I thought, this is not me... • You know, one basically allows this to happen to oneself. • I react calmly on the outside, but on the inside I'm burning up... • I never believed in psychology, I always thought that I was my own psychologist. • I have taken natural products in the past in South Africa, I can't remember their names but it's more like a vitamin and it did help, it helped so that you wouldn't get yourself so worked up and, so I thought that's what she was basically gonna prescribe or something like that. • I suppose you just can't keep on shoving it under the pillow all the time... • I think if you could control your emotions, you could control your thoughts. • So my wife suggested that I should, you know, perhaps see somebody or that maybe we should go to a marriage counselor.
Discourse of mental illness	<ul style="list-style-type: none"> • What I really felt was a lot of ... I couldn't handle my stress and anger a little bit... I think it's been happening for many, many years • I can't see the wood for the trees, I don't find anything exciting in life. • I would blow up at anything... you know the kids have got chores to do in the house and if they're not done, small things... because I've got all this...build-up, build-up, build-up... and I've got nothing left. • You're tired, you want things to be right but you don't want to hear any more problems, you don't want to hear it.

	<ul style="list-style-type: none">• You know, one basically allows this to happen to oneself.• I just didn't say to her [GP] that I was depressed because I don't think that I'm depressed as such... I think it just had to do with stress and whatever... probably just stress and situations...• ... the brain is fascinating... Most people don't know how the brain works, I certainly haven't but I'm starting to get an idea of ... acts that you perform... You know when you're under stress, how you react...• ... especially when it comes to the brain, you can't sit with a piece of paper and sort that out for yourself and it all makes sense when he tells you how and why and what's happening...• I did know I had, you know, problems with dealing with stress and I had a bit of anxiety• I think if you could control your emotions, you could control your thoughts.• I was feeling really really down after the argument that I had with my wife, and everything was just getting on top of me• I do believe that there's things in my life that I need to be able to learn how to control in a good way, stress, anger.
Reflecting on the role of psychology	<ul style="list-style-type: none">• I have never ever seen a psychologist or a psychiatrist or anybody prior to coming to [the psychologist].• ... as I said this was the first time that I ever come to psychologist... I never believed in psychology, I always thought that I was my own psychologist...• I never thought psychologists are a waste of time and I had friends who had depression and they used psychiatrists and it's worked pretty well for them.• .. if she [GP] gave me a tablet, I would have walked out with that tablet or whatever, something to relax, and I would be happy with that... but I don't think it would sort out the deep feelings...• I think for so many years I've always thought that I could use psychologists or somebody else who would listen to my story, my side of things• It's different talking to your friends because your friends can't give you advice, they're not trained in that.• I think at the end of the day, I don't know how many sessions I'll go through, I definitely think, it's making me see things in a different way... as the sessions go on, I can see it more and more...• I do definitely see it as a positive experience... as I said as the sessions go on, I can see more and more positive.• ... at the beginning I didn't quite understand, you know, it was just getting to know each other, it's just, it's just... the brain is fascinating... Most people don't know how the brain works, I certainly haven't but I'm starting to get an idea of ... acts that you perform... You know when you're under stress, how you react...• ... especially when it comes to the brain, you can't sit with a piece of paper and sort that out for yourself and it all makes sense when he tells you how and why and what's happening• ... you train your mind, I suppose, to react differently to these situations which is a good thing• We're all running around, thinking that we can solve our problems... and there are people that are trained to explain to you why this is happening to you
On transformation: insight into the process of self-realization	<ul style="list-style-type: none">• I think it's been happening for many, many years and I have never ever seen a psychologist or a psychiatrist• Basically I've got a lovely family, a lovely wife and we had an argument, and all of this, this mismanagement of stress and everything else... I think over the years, it's...I don't know if I can cope with that ...• Well, I was pretty upset that day. I had a huge argument with my wife on Saturday and ... it was a really bad argument...• I never believed in psychology, I always thought that I was my own psychologist...• I think for so many years I've always thought that I could use psychologists or somebody else who would listen to my story, my side of things...• So, I think I was ready for, I'm ready for a change, you know, in how I handle

	<p>situations so I think it's a good thing.</p> <ul style="list-style-type: none">• I definitely think, it's making me see things in a different way... as the sessions go on, I can see it more and more...• Most people don't know how the brain works, I certainly haven't but I'm starting to get an idea of ... acts that you perform... You know when you're under stress, how you react...• I suppose you just can't keep on shoving it under the pillow all the time...• We immigrated... I'm at home a lot. I used to be at the office every day and you come home after five... so the immigration has been quite a big thing for us to change in our lives...• I was feeling really really down after the argument that I had with my wife, and everything was just getting on top of me and I thought it's time to do something about my life, myself, my thoughts and that I'm not such a happy person.• I think a lot of people should go on that journey, especially anger management. We're all running around, thinking that we can solve our problems... and there are people that are trained to explain to you why this is happening to you but I would never have gone to a psychologist, I don't think. Had I not spoken to her that day and I just kept it all bottled up...
Construction of personal identity	<ul style="list-style-type: none">• Basically I've got a lovely family, a lovely wife and we had an argument, and all of this, this mismanagement of stress and everything else...• ... and I've got nothing left and that's what I used to find, coming back from work, after a day of understanding everybody else's problems and listening to everybody else's side of the story... and motivating people to do what they're supposed to do.• You're tired, you want things to be right but you don't want to hear any more problems, you don't want to hear it... you wanna hide under the table...• I like things to be done right, and when I do something and I don't do it properly, I get upset with myself• So, you know, I was thinking my liking things the right way, would you call yourself a perfectionist, and certainly a perfectionist is somebody who likes to control...• I guess, there are a lot of, I suppose, traits in my character that are awful for myself, you know... like stress, anxiety, and you need to cope with it. You know, one basically allows this to happen to oneself...• I react calmly on the outside, but on the inside I'm burning up...• I don't think that I'm depressed as such... I think it just had to do with stress and whatever... probably just stress and situations...• I never believed in psychology, I always thought that I was my own psychologist...• I did know I had, you know, problems with dealing with stress and I had a bit of anxiety and... I suppose you just can't keep on shoving it under the pillow all the time...• We spend so much time together because I'm stuck in my office at home all day and I just think you're with your family a lot more... I pick up the kids at school which I never did, and I interact with my kids at night and on weekends...

Participant 2: Barbara

On being referred	<ul style="list-style-type: none">• I was gonna go through a new program in Joondalup but they didn't have a psychologist at the time. I was interviewed and put on the list but they were still trying to get a psychologist...• And so it was my request really... I said to my GP, I think it's time I went somewhere else and that's when he met [the psychologist], so that was when it was decided that I'd go there.• I think my GP was quite aware of the fact that I really needed, you know, longer sessions as much as anything...• He [the psychologist] rang me up and said, you know, who he was and that he had a referral and... I had to get the referral otherwise I wouldn't have claimed it on Medicare. So then when the six weeks ran out I had to get another referral in order to
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	<p>claim for the next six weeks and that's up now ...</p>
<p>Traveling through the health system</p>	<ul style="list-style-type: none">• I don't know where to start because I've suffered from depression since I was a kid so I've seen lots of people over the years• I've had two very good GPs. One of them I still see and the other one's in the suburb where I used to live. So I started going to them and they would refer me to somebody.• This was the first time that I've seen a psychologist actually, because I've been referred to psychiatrists before and then I don't go, I just talk to the GPs. I've been to about four psychiatrists.• I've just gone to my two GPs that I had that had seen me through the worst of my times... .. well, they're the ones who have given me medication and so forth...• The big problem with that is, they don't have the time because their appointment times are so, you know... they're only just like 10 or 15, 20 minutes at the most and they just don't have the time, which is a nuisance...• I could talk to them but, you know, it means going back so often. I could talk to both of them and I have done, you know, shared all sorts and bits of my life with them, but you have to keep going back all the time and even though they wanna help and they come up with some strategy and things like that, it's just too drawn out, because they seriously don't have time to deal with patients like this...• They just suggested medication and we started off on medication and that was it, and I just trusted them enough to think that at least they would put me on the right stuff... and a few times over the years we've changed it or we've gone to higher doses or whatever. I've just gone to higher doses at the moment, but that's how I've seen it happen...• But I've never had any other sort of treatment, I've never been to hospital or anything like that... I wouldn't go... I don't think I would go to hospital. I've heard too many stories about what happens when you go to hospital, so... but yet at the same time I go and visit people at the hospital. Over the years I've done that too, but I wouldn't go myself, I wouldn't go myself, no.
<p>Evaluating treatment experiences</p>	<ul style="list-style-type: none">• I don't like psychiatrists at all.• I've been to about four psychiatrists and ... is this gonna be eradicated? Don't write this junk [laugh]...I think they're a waste of money, put it that way, they are. They're too... clinical, if that's the right word...• I've had two very good GPs... I could talk to both of them and I have done, you know, shared all sorts and bits of my life with them, but you have to keep going back all the time...• I think it's not so clinical [psychological treatment]... that's a funny word, but it's not so... by the book sort of, yeah, not so by the book as I remember psychiatrists usually went by the book and now I just don't, you know...• And he's [psychologist] so much more encouraging than anyone else that I've dealt with...• I feel like somebody cares, I'm not a number... I think that's the difference, I do feel that somebody cares... and certainly my GP cares I know that but, and even [the psychologist], I think he cares, he has that attitude, you know, that makes you feel like at least somebody cares...• But I've never had any other sort of treatment, I've never been to hospital or anything like that... I wouldn't go... I don't think I would go to hospital. I've heard too many stories about what happens when you go to hospital...
<p>Reflection on common misconceptions (sense of isolation)</p>	<ul style="list-style-type: none">• I don't tell many people, I can't be bothered with all the drama that goes on with it, I just go along and, yeah, there's a handful of people that know but that's it...• No, no, most of the time they don't, no, they don't understand what depression is. If you haven't had it, it's too hard to explain and if you haven't had it, they don't know what it's all about... and most people, including my own daughter, will tell you to put up your socks and get on with life...• And because I keep busy all the time, it seems so out of character to be depressed because I'm busy doing things, and I'm busy out there helping people. And consequently they just look at you and say 'You can't be depressed, what do you mean you're depressed, you're doing this, you're doing that, you're doing something else' but

	<p>I have to do that...</p> <ul style="list-style-type: none">• I mean if you get gallstones people go ‘oh my goodness what can I do, can I come around and vacuum for you’ or whatever, break your leg, any of those things... and if you got something wrong with your head, nobody wants to do anything, you know, so...• ... and they’ll make, some people will make some rude remarks about, you know, ‘I missed you last Sunday or last Tuesday night or why weren’t you at work’, that sort of thing, you know... but whereas if you had internal problems or a heart attack, they’d say ‘I’m sorry you were sick the other day’, that type of things...• Geoff Gallop said, ‘well, I’m better now’, well good luck to him if he says that because he was supposedly cooked for only a little while and then he got better but I know I’ve been sick ever since I was a teenager, or younger than teens, when I was eleven or twelve, I can remember... and with no support from family at all... just get on with your life, you’ll be alright, you know...
Self-management and coping	<ul style="list-style-type: none">• And because I keep busy all the time, it seems so out of character to be depressed because I’m busy doing things, and I’m busy out there helping people. And consequently they just look at you and say ‘You can’t be depressed, what do you mean you’re depressed, you’re doing this, you’re doing that, you’re doing something else’ but I have to do that otherwise I’d finish up in Graylands if I didn’t.• I just feel I have to keep busy. I can’t see any other way of coping with life... And sometimes it’s hard but sometimes that’s the only way I can exist, is to keep busy.• Not really, no, [talking to other depression sufferers is not helping] because their response to their depression is different to mine. Theirs is more like sleeping in till midday, not getting up until even one or two o’clock in the morning, complaining about it all the time, how tough life is...• Now, the only people who are allowed to listen to me complaining are the ones, you know, my GPs or people like [the psychologist] or somebody like that because, you know, I just don’t think it’s worthwhile...• I mean there are some times that I wish I wasn’t going out but generally speaking, I just keep doing things, you know...• And when I’m in a good place, I like doing nice things. But when I’m going through a bad patch of depression, then I hate doing them... but I’ll still do it.• I don’t think I would go to hospital. I’ve heard too many stories about what happens when you go to hospital, so... but yet at the same time I go and visit people at the hospital. Over the years I’ve done that too, but I wouldn’t go myself, I wouldn’t go myself, no...
Discourse of mental illness	<ul style="list-style-type: none">• I don’t know where to start because I’ve suffered from depression since I was a kid• ... They [GPs] seriously don’t have time to deal with patients like this... They’re OK if you’ve broken your leg but they can’t...• If you haven’t had it, it’s too hard to explain and if you haven’t had it, they don’t know what it’s all about...• And because I keep busy all the time, it seems so out of character to be depressed because I’m busy doing things, and I’m busy out there helping people.• And when I’m in a good place, I like doing nice things. But when I’m going through a bad patch of depression, then I hate doing them... but I’ll still do it.• I think that it needs to be put in the same sort of... like into the category that other parts of the body get sick, so they get sick as well, you know... whereas at the moment it’s treated quite out of character to the rest of the body.• I mean if you get gallstones people go ‘oh my goodness what can I do, can I come around and vacuum for you’ or whatever, break your leg, any of those things... and if you got something wrong with your head, nobody wants to do anything, you know• ... some people will make some rude remarks about, you know, ‘I missed you last Sunday or last Tuesday night or why weren’t you at work’, that sort of thing, you know... but whereas if you had internal problems or a heart attack, they’d say ‘I’m sorry you were sick the other day’, that type of things...• Geoff Gallop said, ‘well, I’m better now’, well good luck to him if he says that because he was supposedly cooked for only a little while and then he got better but I know I’ve

	<p>been sick ever since I was a teenager...</p> <ul style="list-style-type: none">• Well, for a start, I was eleven or twelve, it just didn't happen to somebody at that young age, you know, and yet you read about so many young people that have been depressed and they're, you know, in their early teens and so forth.• And when you don't know what it is and what causes it, how can you change it? You know, I don't know what started it off, who knows what started it off, it's just one of those things. There's no history of it in my family, but then I've got diabetes and there's no history of that in the family either, not that I'm aware of anyway, yeah...
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Participant 3: Charles

<p>On being referred</p>	<ul style="list-style-type: none">• We got set up on a mental health plan, which is a... I believe it's a new initiative by the Australian government and he suggested that I book in a psychologist, cognitive behavioural therapy• ... we asked specifically, probably it would be better if I had a male therapist, and he talked to his colleague and said that this guy was pretty good...• It was quite fast, like within two weeks or so, I went to my first appointment with him... And it was through a recommendation that we actually got to that step.• We've seen him [GP] for a couple of years now but my mum speaks to him all the time and he is clearly like a really nice guy... Yeah, he's a really nice guy and he's very understanding of what's happening...• He wanted to know what I wanted out of it and... was it cognitive behavioural therapy what I wanted, etcetera.• Yeah, he [GP] did help me by referring me to this guy and said that he was really good unlike some of the other places that I've been to.• I sort of did my homework and actually my brother [psychology student] had already known about such things 'cause I already spoke to a person and I was thinking I should try CBT, I had heard of it before... and a psychiatrist, not psychologist has recommended me, has talked about it with me once, so it was mainly, really, I chose to actually go and have CBT treatment and such...• Actually, I've got to mention I went to the [university] place here and, the psychologist here, and she recommended getting a mental health plan that's how it first began, while I talked to her about some problems and she said... She actually pointed me in the right direction. She pointed me to GP and he pointed me to the psychologist I now see.
<p>Traveling through the health system</p>	<ul style="list-style-type: none">• I've been to a psychologist before... but not in any... mainly like at the school that I attended, and they weren't very good...• I already spoke to a person and I was thinking I should try CBT, I had heard of it before, and a psychiatrist, not psychologist has recommended me, has talked about it with me once...• I went to the [university] place here and, the psychologist here, and she recommended getting a mental health plan that's how it first began, while I talked to her about some problems and she said... She actually pointed me in the right direction. She pointed me to GP and he pointed me to the psychologist I now see.• Yeah, [I've seen a psychiatrist] for a diagnosis and things... well, he dispensed stuff, pills and such, medication. And he was quite... didn't really seem to care about what was happening, actually, and he just dispensed things.• Only recently, I don't know if it's something that's been just put forward or it's always been there, we didn't realize, but we actually don't have to see him [psychiatrist] anymore, we can actually get the medication, when I used to take medication, I used to go to him all the time. So now we don't have to see him which is actually good.• I used to take medications, like Lexapro and stuff like that and they actually made me sick, and Ritalin and all that, it made me very sick. I discovered that it actually had something to do with acid reflux in my throat so it could be that... so I needed another method. I couldn't take any medication so I had to see someone else in the psychiatry segment.• I think I've been through a couple of people, I only had one psychiatrist. I've been

	<p>through a couple of psychologists but they were like... there was no ranking, they weren't qualified enough to actually do these particular surveys themselves... They did just counseling, basically, like a LJBC counselor</p> <ul style="list-style-type: none">• ... once I had to be referred, cause I did come IQ tests years ago and she didn't seem very good either...• ... even though the psychologist I saw at school seemed pretty useless, she actually did do one thing which was put me on to another person to another person to another person that got me my first diagnosis even if that seems not very important any more, the ADHD.
Evaluating treatment experiences	<p>(Good):</p> <ul style="list-style-type: none">• Yeah, he's [the GP] a really nice guy and he's very understanding of what's happening.• The first time we met him [the psychologist], he went through a bunch of standard procedures, stuff like, you know, whatever you tell me is private and if there's anything like suicide or something then I may have to take it to authorities. So half of the first session was actually about that... and my mum was present in the room and it was quite casual.• With the psychologist, he actually asks me about my problems specifically, and reminds me, this is right, this is wrong, this is how you should be trying to fix stuff, with CBT.• Eventually I got to the psychologist who is very good, who I'm now with so I'm very happy...• Yeah, I'm definitely making some progress... I've actually only been there for the last six weeks so it started to help challenge the things for my anxiety disorder which is mostly what this is about.• He seems determined to actually help me, he's not cold or anything, he's got a certain part of... he's got determination to help me and he also does want to talk, unlike the first person, he actually wants to talk to help, not just talk about anything... <p>(Bad):</p> <ul style="list-style-type: none">• I've been to a psychologist before... and they weren't very good. They were just, I could just talk their ear off, basically. They didn't put any input in. They just were there to talk to.• And he [the psychiatrist] was quite... didn't really seem to care about what was happening, actually, and he just dispensed things.• With the psychiatrist, it was very passive, he just, like, gave me a survey and he'd say dah, dah, dah, you've got this.• I could certainly tell them everything but they didn't seem to put any input in. The counselor was very passive... It felt like I was just talking to someone else, it was just like I talked to someone up the street... like I was talking to you, just like yep, yep, yep, yep, just talking...• While the psychiatrist, he didn't do anything, he was very cold, and my mum was with me in the room and my brother, I think, he... he knows about psychology and stuff and he doesn't like how he operates at all.• The psychiatrist just seemed almost like he didn't care anymore, like if he was burned out, like 30 years or something.
Discourse of mental illness	<ul style="list-style-type: none">• I mean, what I have, basically, is social anxiety disorder and, like, ADHD and OCD. Officially I was diagnosed with GAD, generalized anxiety disorder and it's just been getting more obvious that it was much larger in my life, that is was really... prevalent...• That's when I came to the university first semester and doing that and I was thinking, you know, I can't get through this, I need some sort of help.• It doesn't matter, you know, it's all anxiety, it's not actually someone's looking down at me• Now I know... like these thought things they're not like... it's not like there's something wrong with me. I've got this thing inside of me and it stops me from functioning, you know, normally, I know how controversially it must sound "normal" but yeah...• Maybe they [school counselors] thought it could be just general stuff, like, oh, they're shy, well they don't know that my shyness is actually diagnosed as an anxiety disorder.

	<ul style="list-style-type: none">• I mean I stewed over for a couple of years, you know, at school where by far I had the worst symptoms. I had the worst symptoms of my anxiety disorder at school yet they didn't seem to help.• I mean, of course it was also self-realization of, hey, you know, you're not supposed to be terribly scared just walking to get a cup of water or something like that.• It went on the record that I had ADHD... and later I found out that I actually had OCD and, like, GAD...I say GAD but that's officially what I was told that I have, but really I read about the anxiety disorders and they all seem very similar, except for a couple, and they all seem quite applicable to me anyway and I talked to my psychologist and he agrees.• I mean, some people are really, like, housebound or, you know, some have had it for 30 years. Well my disorder is, like, half dead now and theirs is still going. So it was also hopeful for me and also even they themselves have hope.• And also, we really need to beat the idea into them that it's not their fault exactly. I mean, I'm not trying to compare myself but I know it's like, you can't tell someone with an eating disorder that they look fine or something, it's not rational for them. The rationality seems to work for people like me. It's only, it takes a while but it can actually sink in.
Self-management and coping	<ul style="list-style-type: none">• I sort of did my homework and actually my brother [psychology student] had already known about such things [CBT]• In my unique position, I guess I shy away from making many friends because of my social anxiety disorder but my brother and I are extremely close and I can talk to him...• Last week I decided, it just came up in a conversation, I told a lecturer that I had it... I was thinking... I told the lecturer I wasn't going to do my presentation in front of the class at all, then I thought about it and I thought, you know what, maybe I should just do it, you know.• If you've been on places like YouTube, that's where it seems to be really coming out now. I look on that and there is actually always other people now with anxiety disorders unlike years ago... I may actually see some sort of connection. I mean, I've always sort of explored what's wrong with me, is there something different, but they're actually talking about their problems, you know, they're very similar to mine. Of course, there's actually someone more severe, it seems, than mine... They mainly just talked about their stories, they didn't say, like, about coping strategies or anything, they were just people like me, and also it put things into perspective because some of them are, I mean, some people are really, like, housebound or, you know, some have had it for 30 years. Well my disorder is, like, half dead now and theirs is still going. So it was also hopeful for me and also even they themselves have hope.• It used to be, you know, I used to tell them [teachers] to close the door because I didn't want anyone to know about it.• It's actually quite good in a way because, I mean, my parents always said, you know, they'll pay for my... They'll take us until I finish my education but if I hadn't, if they hadn't done that I probably would have actually become... I can certainly imagine myself actually becoming a housebound person because I couldn't handle the responsibilities. I've never had a job or anything like that before. Prospects like that truly terrify me.• The rationality seems to work for people like me. It's only, it takes a while but it can actually sink in...
Effects of therapy (on the road to recovery)	<ul style="list-style-type: none">• Yeah, I'm definitely making some progress... I've actually only been there for the last six weeks so it started to help challenge the things for my anxiety disorder...• But I'm becoming more... even just talking to you about it, it's pretty good.• Last week I decided, it just came up in a conversation, I told a lecturer that I had it... I was thinking... I told the lecturer I wasn't going to do my presentation in front of the class at all, then I thought about it and I thought, you know what, maybe I should just do it, you know. It doesn't matter, you know, it's all anxiety, it's not actually someone's looking down at me• ... then I said it to you as well that I have anxiety disorder... so it's less severe, it's much

	<p>more comfortable now.</p> <ul style="list-style-type: none">• I used to tell them [teachers] to close the door because I didn't want anyone to know about it. But now it's not so bad, I can actually talk to, I can just say it now.• I actually myself thought about, if this CBT treatment gets even better that I might actually publicly speak about it myself which is kind of, you know, difficult for someone in my position.• Well my disorder is, like, half dead now.
Suggestions for change	<ul style="list-style-type: none">• Well, of course I'd like more awareness and things like this, especially in my areas but I think there needs to be better counselors at school. I mean... I think that's like... haven for people who... with problems.• So I think there needs to be, like... counselors and there also needs to be some people of higher psychological training.• You also wanna get... people that actually really want to get into it [psychology].• I wandered if there's any sort of thing at, like, [university], I mean, I don't think there is, like, you know, any persons talking openly about this sort of thing, but I can imagine people with the disorders that I have but not really publicly talking about it.• But there was certainly no thing like that in school, I mean at high school, of course, and at [university] I don't know of any kind of programs, like, run by students or maybe... It would be nice to have the psychology people here put up posters and things, I haven't seen any around, I mean, it shouldn't be that difficult.• I think even [university] students under the guidelines of their teachers could put posters around. And even though, like, you know, a poster probably won't change someone's life to go suddenly, you know, 'I've got this', it will all add up at the end, it will just be like 'Hey, I have depression' like that person says, you know, actually, I can't actually get out of my seat and grab some water without being afraid.• I think it's actually very important to actually be diagnosed quite quickly, that you actually have a disorder if you do have one.

Participant 4: Deborah

On being referred	<ul style="list-style-type: none">• I originally went to see him [the psychologist] because I had a bout of depression... He is very good, he knows his stuff..• No, [the GP did not provide treatment] she just sent me straight, it's a woman, she just sent me straight to [the psychologist].• I made the appointment. She just gave me the referral.• ... at that time I saw her because I have to see my doctor regularly. I can't get the medication for the pain. I have to have it prescribed.• [while with the GP] I started to cry, dear! I was in a deep hole and I was hanging on by my feet.• I've got a doctor who doesn't communicate at all... Absolutely. It [the communication] IS a problem, it wasn't a problem, no, it is a problem.• I'm very lucky that she got me on to [the psychologist]. I was very lucky.• Yes [the referral process was quick]. And I found, just after having talked to him I felt, like I said, you unburden yourself if you talk about it .
Traveling through the health system	<ul style="list-style-type: none">• I was on antidepressants for a while but I can see I won't need them for long because I feel a lot better after a few weeks.• Well, I've had about... probably four bouts of it [depression]... When my [first] marriage broke down, it was very bad... I've had the odd one but...• I've had, not a psychologist but I've had counseling before and it always helped because if you really talk to a psychologist, you unburden yourself better.• One of them was actually like you, he was not qualified. You say you're not qualified if you had four years but you know a heck of a lot. But they said they were in the early stages of their studies and I said, that's fine, I mean, OK... Actually one was very good, I think she... She was only in her early part of her studies and she was very good.

Discourse of mental illness	<ul style="list-style-type: none">• I originally went to see him because I had a bout of depression.• Well, I've had about... probably four bouts of it... When my [first] marriage broke down, it was very bad... I've had the odd one but... I do get a bit down• I was in a deep hole and I was hanging on by my feet.• I have [had depression]. At different times. Especially... like I said, when my marriage broke up. It was a very bad one. I've had about two episodes since, I'm talking about thirty, forty years ago, so not too bad.• It seems to be up when my husband and I have a big session, I just feel, you know, it's hard to get away from it.• Generally I'm quite a happy person, I don't know why it knocks me like that.• I was very very much down, like I said.
Reflection on common misconceptions	<ul style="list-style-type: none">• One of my daughters knows. The other one is not so... I wouldn't say that she's not supportive but she probably wouldn't go see a psychologist ...• I think that a lot of people think that if you go and see a psychologist, you must be a nutcase. People still think that. You don't tell everybody that, no, no, no, no. My youngest daughter knows.• A great deal of people still think, ah, snap out of it. You can snap out of it. They think that depression is an indulgence or something. Because they never experienced it before, they don't know. You don't want to be in that place, you don't want to feel that way. But I think that it's in your nature, some people do and some people never really do.• Yes, I certainly would, I certainly would [recommend seeing a psychologist]. If they were the kind of friends that would not laugh at me.
Construction of personal identity (the relational self)	<ul style="list-style-type: none">• It was very hard when I came to Perth because I left many long-time friends behind. I mean when I first came here I thought, What have I done?• I came here to be with my family. I've got two daughters, four grandchildren and five great-grandchildren, no, six great-grandchildren.• Anyway, that just hit me and I didn't know what to do. I felt like getting on the next plane and leaving it all behind here. You don't realize how important your friends are. I mean we're talking about twenty, thirty, forty years, even more... and they are your family because there's no family.• It was so painful leaving my friends.• I've got problems with my relationship with my husband... It's just all the anger this man has inside. I said to [the psychologist], he's like a dragon. He's got fire coming out of his mouth... I can't stand it.• I mean, we're old, we should support each other.• And then we have a nice day or so and the next thing you get the screaming again, and, yeah... I said to [the psychologist] I can't really put up with this... I would have left if I had somewhere else to go.• And having no friends here, too, because I like to have a chat. I was very very much down, like I said. I have a good time with friends too, you see. My daughters are actually wonderful and they're very special. But they have long days at work and they can't really come and see me so I stop every second day or something and I visit my friend, so I feel so much better. Having a good friend does help.• I feel hurt, I feel hurt because... I know what he went through when he was young, I'm a mother, and I don't know why he treats me like that. I mean if I give him a bad time, yes, OK, but... all of a sudden, as I said, he just takes offense so quickly.
Self-management and coping	<ul style="list-style-type: none">• I like the [retirement village], it's a lovely place, a nice lady, I never see other people but this one, I met her at the pool, and she's very pleasant and then we have a cappuccino afterwards, after the session. It's really nice. And I see my daughters, and a bit of my great-grandchild and I get to see my granddaughter.• I visit my friend, so I feel so much better. Having a good friend does help.• I have to see what makes me happy without him. Forget about him, making him happy, do what makes you happy.• I'm a bit limited here because I used to I do all kinds of things. I love things that I can see with but now I can't do these kind of things. But it's not always on the negative, I

- can still garden. I do a bit of gardening, I grow my own vegetables.
- And I go to balancing class. It's a wonderful class and... she knows her stuff. I've been going out for the best part I lived here. Every time she's got something new on. She's very skillful. I very much admire what she does because of her skills.
- You have to sometimes say, I need help. It's nothing to be ashamed of.

Participant 5: Edward

On being referred	<ul style="list-style-type: none">• I was sent there by Veteran Affairs. I went there and I told them I didn't believe in psychology and as far as I was concerned, it was all a lot of bullshit. I was there only because I had to be there. The reason I went there was, I was losing energy. And... all the medical tests I had come out that I was medically fit.• My energy rates were falling all the time... and finally they said, you should do something, you're suffering from post-traumatic stress. And I said, that's impossible because the Vietnam, it didn't bother me at all. So I went there and it took some time, and that's why I was going there.• But early at the beginning, I just wouldn't listen. I just went there and looked at him and said: 'I don't... this is bullshit'.• I didn't think much of it at all. I said, if I have to go, then I'll go and do it. I didn't believe in psychology.• Well, I was told I was going to have to do it. So I did. But I didn't listen. Because I didn't believe that I was needing one to start with.
Self-management and coping	<ul style="list-style-type: none">• I did have some problems in the 80s but I just took myself away and changed my thinking... I thought alright, what I'll do here is, my thinking is wrong, I'll change my thinking.• So that's what I did. I tried the same thing with this but it didn't work.• I wasn't listening before. I just thought, well, this could never happen to me because I'm too strong-willed and I still find it difficult that it did happen.• I've always worked long hours. Most of my life. My kids called me a stranger because I would be getting home from work after they'd gone to bed and I would be gone before they got up. And that went on for years, years, years and years...• I had flashbacks, it was like a DVD, just rolled. But it never really concerned me. It happened, it's there, it's over.• I was in total denial. When people are in total denial, it's almost impossible to help them. No matter what you do.• And talking about it makes it easier. Where I wouldn't talk before. I would answer questions but I wouldn't talk.• Younger people are different, I think. They think differently than older people. People my age, like, we were brought up to be tough. When now, people are brought up to be more sensible, I think. You know, if you wanna cry, you cry, if you want your emotions out, you let your emotions out... In the modern world, I think, it might be different.
Discourse of mental illness	<ul style="list-style-type: none">• I've got an injury on my back from Vietnam, jumping out of trouble which was about thirty years ago and I hit the deck out here, just collapsed. And after that I got worse. My energy rates were falling all the time.• I was very aggressive in the early period of time. I'm not an aggressive person. I wasn't.• So I come along fifteen years later with the same stuff that they [other Vietnam veterans] had ten, fifteen years ago. Because they rung me and said, yes, this is what we went through and this is what we did. But I didn't listen to them then and I should have...• They were telling me it was post-traumatic distress, I was telling them it wasn't.• I was changing. I was staying in bed longer before I left for work and I couldn't move. I was on the floor and couldn't move lots of times.• It was very hard early, when I had total denial. I was saying: 'That is totally wrong. I am not depressed'. I don't think I was depressed either. But I said, I don't have post-

	<p>traumatic distress either. I refused to... I was in total denial.</p> <ul style="list-style-type: none">• I did have troubles in the 80s and I worked it out myself. I had flashbacks, it was like a video. I used to have them regularly... I haven't had any for a long time now. Lots of terrible things that happened there...• My need has got stronger. And now that I believe in it... Now that I've recognized the problem, I have to put full [inaudible] ahead to beat this thing... Which I'm never ever going to beat. It's always going to be there but at least it will make it easier.
Reflecting on the role of psychology	<ul style="list-style-type: none">• It has lately, yeah [the treatment has been working]. But early at the beginning, I just wouldn't listen.• I didn't believe in psychology. I've always thought that ... When I was in the police force I used to see them regularly. They would do tests to see whether you were in the state of mind to be a police officer. We went for those regularly.• I never had faith in mumbo jumbo before.• But I didn't listen. Because I didn't believe that I was needing one to start with. And I always thought that they [psychologists] were a bit weak in the head...• I enjoyed his company after a while because I liked him. And I said to him: 'I'm very sorry about my early days.' And he said: 'Don't worry about it, just about everyone does the same thing. With your background.'• I was in total denial. When people are in total denial, it's almost impossible to help them. No matter what you do. But he just said: 'Come back'. And I liked him. You know, I liked his office. His office was a bit like mine... It was a good environment and I liked him personally. He was a good bloke.• And then I changed. And when I came back, it was actually helping me. He's still a good bloke. But before I came back, I thought, oh, I'll have a bit of a chat... And now, he has helped me tremendously. I don't know how he had the patience to stick with me, really.• And he stuck with it. And he encouraged me to..., I didn't have to come back after the initial three months, I think it was. But I did. So obviously I must have had some feeling of trust, you know, and I liked him. Well, I did trust him too. Which is important.• And I think, the longer I'll stay with him, the better off I'll be. I don't think I'll ever finish completely with him now... I see him more now than I used to. I see him twice, sometimes three times a month now. My need has got stronger.
On transformation : insight into the process of self-realization	<ul style="list-style-type: none">• I collapsed and nearly passed on. And the nurse there, or the matron that I know quite well for many many years, we went to school together, she said, she told me that I was in denial and I have to wake up to myself.• So when I went back to the psychologist I had a different perspective, I started to listen to what he says which I wasn't listening before. I just thought, well, this could never happen to me because I'm too strong-willed and I still find it difficult that it did happen.• And now I'm pretty well straight down the line, I have faith in him.• I still can't understand it a bit, because I keep thinking it never bothered me at all.• Then I started to get slightly aggressive, it's not me to fight somebody... That surprised me a hell of a lot. And actually I think that it was one of the things that I thought at home, that perhaps I did need help. I could have been just a flash but it wasn't me• I was trained not to get angry. You get angry, you lose it... But that was one of the things that came back to me that got me thinking that maybe there is something in this. And then I started to tell him everything.• It depends on the individual, it certainly wouldn't work with me [talking about it] because I didn't believe it. You have to believe it first. You can talk all you like but if you don't believe it...• I came home to my wife and I said: 'My doctor's telling me that I'm suffering from depression and post-traumatic distress, my psychologist is telling me that I'm suffering from post-traumatic distress, the doctor in [town] is telling me that I'm suffering from post-traumatic distress and Leslie there, the matron in [town] is telling me that I'm suffering from it, and I'm the only one that's saying that I'm not.• So I said, the odds are that all of those people can't be wrong. Someone must be wrong

	<p>and it looks like it's me. And then I changed my thinking. And then I went to the psychologist and he ... and that's when I did change around, it's just recently. It took a long time because I was very stubborn.</p> <ul style="list-style-type: none">• It has certainly helped me a lot in the last... since I've become aware that it was doing me good. And I stopped being in denial. Although I still am in denial a little bit. Which I did tell... earlier I said to him: 'I'm still in denial, I still can't understand why it happened to me.'• I had flashbacks, it was like a DVD, just rolled. But it never really concerned me. It happened, it's there, it's over... And that's why I can't understand and why I still have a bit of denial that it's gotta be hard for him to help me... because I've still got that semi, it's only a little bit of denial now.• It wasn't until I nearly died, and Leslie kicked me up the backside and said: 'I've known you all my life, you're in total denial. You gotta wake up to yourself.' Her husband, her partner, he was in Vietnam with me and he's on full TPI and has been through the same thing. So not only was she a matron or whatever they call them, she's also... her partner has the same thing.• I think I was starting to wake up anyway but that was through this realization that all these people were telling things. And there was one person that was saying something else...
Construction of personal identity	<ul style="list-style-type: none">• I came out of those [psychological tests] average, like an average person, not high, not low. Some might come out extremely intelligent which is not true but most of them were just average. Just like everybody else's, just like a person next door.• I just thought, well, this could never happen to me because I'm too strong-willed• I did have some problems in the 80s but I just took myself away and changed my thinking.• No, you don't tell police officers that... I was the team leader and I expected that it would undermine my position.• My background is the army and the police force. You know, we're very rigid, not rigid, we're, what do you call it, regimented, discipline-orientated... Weakness is something you don't accept.• Then I started to get slightly aggressive, it's not me to fight somebody... Even in the police force, I was never aggressive. You know, I always took the calmest way out of situations.• I'm normally quite easy to work with. When I was a team leader, I never really gave an order, I never yelled, never lost a plot, even though there was a lot of stress, demonstrations, I never lost the plot.• I come from a strict methodist family and I was in farming all my life, I've been in a church and I was always told to stand on my two feet.• And if I'd been on a grog and I was sick, I went to work. I didn't go... I didn't stay in bed. You know, it's your fault that you're sick. Even when I was sick I still went to work. You should not do but I used to go to work. My values were... I was taught you've got to work. You know, that's how I was brought up.• People my age, like, we were brought up to be tough. When now, people are brought up to be more sensible, I think. You know, if you wanna cry, you cry, if you want your emotions out, you let your emotions out...• I've always worked long hours. Most of my life. My kids called me a stranger because I would be getting home from work after they'd gone to bed and I would be gone before they got up. And that went on for years, years, years and years... Because we had a lot of work to do... I used to do a lot of extra work I didn't need to do. But I wanted to do it because it had to be done. I should have got someone else to do them.• And Vietnam I actually liked. I liked the fear and I liked the excitement. And I loved the jungle. It was so pretty. You know, I know that sounds strange, we were in a war, but it was. It was a pretty countryside.

Appendix E

Interpretation as the fusion of horizons of meaning

Participant 1: Adam

Journal entry	<p>I was taken aback by the participant’s willingness to do the interview immediately after his session. My expectations were largely based on the literature I had read in preparation for the research. In retrospect, I probably held on too tight to my expectations. I probably paid more attention to the focus of my research (experience of referral) than to what the participant was saying.</p> <p>I was very surprised at the level of disclosure. Because of the connection we had established during our pre-interview talk, I expected the interview to be honest and opened. However, the participant revealed a great deal of personal information, which I did not expect, given that I was a stranger whom the participant only just met. I believe that a certain feeling of trust might have played a role. Also, conducting the interview right after the session might have had an impact. The participant may have been “in a disclosing mode”, started by the therapy.</p> <p>It was clear throughout the interview that the referral in itself played a small role. The participant put more emphasis on the context in which the referral took place.</p>
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ANALYSIS AND INTERPRETATION

Content	Researcher’s horizon of meaning	Participant’s perceived horizon of meaning	Interpretation as fusion of horizons
... one day I was at the doctor, I had my blood taken for uric acid and sugar and all the rest of it, and I was feeling really down that day and I just said to my doctor I can’t see the wood for the trees, I don’t find anything exciting in life...	I immediately thought that the participant may be suffering from depression. I was surprised and a bit disappointed with myself for my attempt to assign a label.	The participant felt desperate and powerless. He had been under a lot of stress and found that his coping skills may have been insufficient. His appointment with the GP was very useful as it allowed him to vent some of his despair.	I listened to the participant’s description of his problem and what I heard was a description of symptoms. I thought to myself that he might be depressed. Even though I am not comfortable with the issue of labeling and diagnosing, my reaction was almost automatic. I was very surprised by my reaction.
I’ve got this... build-up,	I felt empathy because I	The participant felt	I felt at this point that some

<p>build-up, build-up... and I've got nothing left and that's what I used to find, coming back from work, after a day of understanding everybody else's problems and listening to everybody else's side of the story... and motivating people to do what they're supposed to do... you're tired at the end of the day, you come home and everything needs to be right.</p>	<p>understood how overwhelming it is playing multiple roles at once.</p>	<p>overwhelmed by the pressure of his work, being many things to many people. He also might have felt frustration that some people do not take responsibility for their own actions, as he would expect, and rather pass this responsibility on to him.</p>	<p>of his behaviour was driven by perfectionism (which he confirmed later in the interview). My feeling was based on personal experience as I also like things to be done the right way and I sometimes feel overwhelmed by trying to perform all my roles to perfection. I learned some time ago that a person with this need has to learn not to push oneself so hard.</p>
<p>I read a couple of pages [of a self-help book] and I thought, this is not me... and I think a lot of people are like that...</p>		<p>This statement indicated to me that the participant was in denial for a period of time. He might have been fearful because admitting the existence of a problem would mean admitting loss of control. It could also suggest "abnormality".</p>	<p>By adding the last part of the sentence, I felt that he was trying to rationalize his experience: he may have a problem but so do other people, so the problem must be normal. Normalizing it makes acceptance easier.</p>
<p>I like things to be done right, and when I do something and I don't do it properly, I get upset with myself... I was thinking my liking things the right way, would you call yourself a perfectionist, and certainly a perfectionist is somebody who likes to control...</p>	<p>Again, as someone who has similar tendencies (although I am less driven by them), I felt empathy.</p>	<p>The participant may have been a bit defensive, as if trying to find some explanation or justification.</p>	<p>The participant was aware that some of his personality characteristics may act as contributing factors. His perfectionism and need to control are used as partial explanations for his behaviour.</p>
<p>You know, one basically allows this to happen to oneself... I react calmly on the outside, but on the</p>		<p>This was important to hear. This is the first time in the interview that the participant uses more</p>	<p>The participant interpreted his problem as a problem of self-management. He tried to control his emotions by</p>

inside I'm burning up.		concrete description of his emotional experience, other than anger, stress or anxiety.	suppressing them which did not seem to work, since he reported having angry outbursts.
I just didn't say to her that I was depressed because I don't think that I'm depressed as such... I think it just had to do with stress and whatever... probably just stress and situations...	I was quite pleased to hear this statement, whether it signifies denial or empowerment. It suggested that people make their own theories of illness.	The participant expressed his defiance. Perhaps he was fearful that by accepting the diagnosis he would admit weakness.	The participant does not identify with the clinical diagnosis. To me, acceptance of the label is not important. What matters is to acknowledge that there is nothing wrong with accepting help.
I never believed in psychology, I always thought that I was my own psychologist... I never thought psychologists are a waste of time and I had friends who had depression and they used psychiatrists and it's worked pretty well for them... I think for so many years I've always thought that I could use psychologists or somebody else who would listen to my story, my side of things...	These three statements were made at different times during the interview. I could sense a bit of a conflict in his attitude and was pleased that he came to acknowledge psychology as a profession (my profession).	The participant voiced different emotions, from disapproval to acceptance and interest.	First I felt that the three statements somewhat contradicted themselves. However, it is more likely that the participant acknowledged psychology as a science and believed that it could be helpful for other people but not for himself. He then changed his view of psychologists in accordance with his experience. The process of attitude change is congruent with his change in problem recognition/acceptance.
I had no idea that she was going to send me to a psychologist at the end of the day but... from what I can ascertain... if she gave me a tablet, I would have walked out with that tablet or whatever, something to relax, and I would be happy	I felt a bit conflicted about this. On one hand I felt that this was an example of the dominance of the medical model, while on the other hand I knew how important the decision to seek help is.		The participant showed insight. Although he would have accepted medication he was aware that the problem was more complex.

with that... but I don't think it would sort out the deep feelings...			
I think I was ready for, I'm ready for a change, you know, in how I handle situations so I think it's a good thing. I think at the end of the day, I don't know how many sessions I'll go through, I definitely think, it's making me see things in a different way.	I felt pleased that the therapy has made a difference in his life.	The participant communicated hope as he has seen positive changes.	This confirmed my belief that in order for any professional assistance to work, the patient needs to be ready. I also believe that readiness is a process rather than all-or-nothing scenario.
... at the beginning I didn't quite understand, you know, it was just getting to know each other, it's just, it's just... the brain is fascinating... Most people don't know how the brain works, I certainly haven't but I'm starting to get an idea of ... acts that you perform...		The participant showed great interest. It was clear that whatever he learned during the sessions, he took with him. The effects of the therapy spilled beyond the one-hour time frame.	The participant put a great emphasis on the sentence 'the brain is fascinating'. I believe that although all patients want to get better, each individual looks for something a bit different in a therapy: comfort, social support etc. I felt that the participant was a very rational person and that focus on brain functioning would well suit his rationality.
I think a lot of people should go on that journey, especially anger management. We're all running around, thinking that we can solve our problems... and there are people that are trained to explain to you why this is happening to you.	I found the use of the word journey very interesting. I was also pleased that someone who previously did not believe in psychology now acknowledges it.	The participant's acknowledgment of his problem was a process of transformation. There is a sense of acceptance.	I like the description of psychological assistance as a journey. However, I think that the metaphor of journey can be also used for the process he had to undergo to accept that it was OK to get help.

I would never have gone to a psychologist, I don't think. Had I not spoken to her that day and I just kept it all bottled up...			The referral was not planned. The participant was surprised when the suggestion was made. However, had he not been ready to do something about his psychological problems, he could have simply refused to accept the referral. But he did not.
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Participant 2: Barbara

Journal entry	Based on my first interview, I was less surprised at the degree of self-disclosure. I felt a great deal of sadness throughout the interview. From our pre-interview talk, I knew about the participant's voluntary work. She admitted that when she was young, she wanted to be a kindergarten teacher but did not pursue this goal because of family disapproval. She now attends schools and helps students who struggle to keep up with their school work. I found it difficult to accept that a caring person like her receives little care from others. I felt that the health system has failed her. She spoke about some painful issues, such as her daughter's dismissal, without showing much emotion. I felt that she has suffered for so long that she has learned to detach herself from hurtful issues.
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ANALYSIS AND INTERPRETATION

Content	Researcher's horizon of meaning	Participant's perceived horizon of meaning	Interpretation as fusion of horizons
I don't tell many people, I can't be bothered with all the drama that goes on with it...	I felt surprised and sad. Although I did not expect to hear that the client's depression is a common conversational topic, I realized that keeping her problems secret was out of necessity, because of repeated negative experiences.	The participant spoke those words in a matter-of-fact manner, with resignation, as someone who has been dismissed many times in the past. She had to learn when it was safe to self-disclose, otherwise she could risk getting hurt.	Although I had some knowledge of the general lack of awareness of mental illnesses, hearing a first-person account of the isolating consequences of depression was very moving. Her use of the term "drama" suggests how profound and damaging some attitudes can be.

<p>I have to do that [keep busy] otherwise I'd finish up in Graylands if I didn't.</p>	<p>I was quite taken aback by this statement because I realized that she does not use busyness to feel better (recovery) but just to survive another day.</p>	<p>There was a hint of despair in her statement. She does all she can do to cope. She uses "Graylands" as a metaphor for losing her battle with depression. Ending up in Graylands would mean her self-management efforts failed.</p>	<p>I have never visited the Graylands hospital. My horizon of meaning, however biased, is built on pieces of information from friends and acquaintances. I picture Graylands as an old-style institution fenced off from "normal" life, something I disagree with. Thus to me ending up in Graylands signifies a last resort in treatment, even though I know that it is not necessarily true. The participant's statement confirms my biases in a way.</p>
<p>I just feel I have to keep busy. I can't see any other way of coping with life... And sometimes it's hard but sometimes that's the only way I can exist, is to keep busy.</p>	<p>I felt sorrow when I heard this statement. It also confirmed my previous realization that busyness is used as a way of coping with life, to ensure existence.</p>	<p>The participant may have been fearful of not being able to cope with depression. She is driven by this fear because at times depression poses a threat to her existence.</p>	<p>Later on in the interview, the participant acknowledged that her response to depression is different to other sufferers'. Her active coping strategy shows great determination to not give up. However, it also prevents her from sharing her experience with other people affected by depression and thus adds to her sense of isolation.</p>
<p>I feel like somebody cares, I'm not a number... and certainly my GP cares I know that but, and even [my psychologist], I think he cares, he has that</p>	<p>It was quite painful to hear these statements. A patient being reduced to "a number" suggests the dehumanizing effect of the mental health system.</p>	<p>The participant has been dismissed by lay public and professionals alike, so that simply being shown some appreciation and interest is welcomed. The participant</p>	<p>The participant never mentioned recovery or getting better anywhere in the interview. I felt that somewhere along the way she lost hope, even though</p>

attitude, you know, that makes you feel like at least somebody cares...		did not seem to hold high expectations of the therapy.	some of it may be due to the nature of depression as a mental disorder.
... if you get gallstones people go 'oh my goodness what can I do, can I come around and vacuum for you' or whatever, break your leg, any of those things... and if you've got something wrong with your head, nobody wants to do anything...	Although I was aware of the general tendency to differentiate between physical and mental illnesses, the last part of the comment made me feel disbelief. Small chores that people do for each other in times of illness are common amongst friends, family and community members. That these people would step back because of mental illness is difficult to accept. This "hands off" approach suggests stigmatization.		This account was in accord with my presupposition that people tend to differentiate between physical and mental illnesses. It also shows that apart from the impact on an individual's help-seeking decisions, this differentiation also influences the way a person treats others. Being known as suffering from mental illness leads to exclusion.
... I know I've been sick ever since I was a teenager, or younger than teens, when I was eleven or twelve, I can remember... and with no support from family at all... just get on with your life, you'll be alright, you know...	I felt sad and a bit upset. Sad because having no support is difficult, especially when you are a teenager. Upset because of the realization that this woman has suffered from depression for more than 50 years and over that period of time, little seemed to have been accomplished in terms of her getting better.	The participant communicated sadness. I felt that the lack of support would have affected her relationship with her family, something that probably caused her a lot of grief.	The participant mentioned previously that her daughter had little appreciation of the participant's experience. Now she said that her own family dismissed her when she was a teenager. I believe that repeated rejection from those closest to her may be one of the driving forces for her voluntary work. Being appreciated by the children she works with may serve as a partial compensation for lack of family support.

Participant 3: Charles

Journal entry	<p>In the early part of the interview, the participant’s answers were brief and appeared rehearsed. The participant himself admitted that he did some research in preparation for the interview – reading about issues related to referral and reflecting on his experience. However, as the interview progressed, the participant became markedly calmer and more comfortable. He showed more confidence, maintaining eye contact with me. I felt that he trusted me enough to disclose the nature of his disorder which allowed him to talk more freely and to elaborate on his experiences. His responses became longer and more complex.</p> <p>In retrospect I understand that his agreement to participate in the research was a major decision for him. This is a sort of activity that he would normally avoid, due to the nature of his problems. I can understand why he needed time to think about it and why he tried to prepare himself for the interview. That he decided to take that step indicates how much progress he has made since starting the therapy. He himself said to me that had the research opportunity occurred a few weeks earlier, he would not have participated. I was very happy that he made that decision and felt proud of his progress.</p>
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ANALYSIS AND INTERPRETATION			
Content	Researcher’s horizon of meaning	Participant’s perceived horizon of meaning	Interpretation as fusion of horizons
I’ve been to a psychologist before... but not in any... mainly like at the school that I attended, and they weren’t very good. They were just... I could just talk their ear off, basically. They didn’t put any input in. They just were there to talk to.	I was curious about what “good” meant to the participant. He later provided more examples of what he considered good and bad professionals.	The participant may have felt disappointed and perhaps frustrated by the lack of adequate care.	This comment is one of several made throughout the interview. The participant had seen several professionals and was quite clear about the attributes he looked for in a therapist: an active listener who is skilled and knowledgeable, warm and caring, and who can suggest concrete coping strategies. Activity seemed especially important.
Yeah, [I have seen a psychiatrist] for a diagnosis and things... well, he dispensed stuff, pills and	I felt quite sad hearing this. Although I know that medication can be very effective, the participant		Another evaluation of the participant’s treatment experience. This and other comments showed that he

such, medication. And he was quite... didn't really seem to care about what was happening, actually, and he just dispensed things.	clearly expected (and needed) more in terms of treatment.		was very consistent in his evaluations and he was clear about what he valued.
Officially I was diagnosed with GAD, generalized anxiety disorder and it's just been getting more obvious that it was much larger in my life, that it was really... prevalent and it became really... That's when I came to the university first semester and doing that and I was thinking, you know, I can't get through this, I need some sort of help.	I was amazed by the futility of the whole treatment process. Although having been seen by health professionals for years, prior to him coming to university, the treatment did not seem to produce any changes. The sentence "I need some sort of help" felt to me like "I need some help that finally helps". It meant starting again, a new help-seeking process.	The transition to university introduced new challenges. Together with the realization of the problem severity, the sense of being overwhelmed may have contributed to the help-seeking decision.	By the time the participant started attending university, he had already been suffering from anxiety problems for several years. The challenge of adapting to a new culture might have served as the final prompt to seek help. Although I am not in a position to speculate, it made me wonder what would have happened, had there been no transition. (Later in the interview, the participant indicated that the possibility of becoming housebound was very real to him.)
Yeah, I'm definitely making some progress... I've actually only been there for the last six weeks so it started to help challenge the things for my anxiety disorder which is mostly what this is about.	I was very happy to hear him say this. The goal of therapy is to help a patient get better and this participant seemed to be heading towards recovery.	The participant was very positive about his progress and demonstrated it later by providing examples of behavioural, affective and cognitive changes.	This statement was very good from intrapersonal and interpersonal perspectives. First, the participant has seen several professionals in the past but with seemingly little results. He could finally see some improvement. Second, I was reminded of my second participant who has also seen many clinicians, unsuccessfully, but who

			seemed to hold little hope of recovery.
But I'm becoming more... even just talking to you about it, it's pretty good.	I was pleased to hear this because it indicated that in spite of talking about very personal, potentially distressing issues, the participant felt comfortable during the interview.	The participant felt positive about both the treatment progress and the interview.	The participant mentioned elsewhere in the interview how difficult it used to be for him to disclose the nature of his problems to others. I was glad that the treatment was working for him and that he used the interview as an example of the progress he had made.
I told a lecturer that I had it... I was thinking... I told the lecturer I wasn't going to do my presentation in front of the class at all, then I thought about it and I thought, you know what, maybe I should just do it, you know. It doesn't matter, you know, it's all anxiety, it's not actually someone's looking down at me... then I said it to you as well that I have anxiety disorder, so it's less severe, it's much more comfortable now.	This ties in with the previous statement. Again, I felt very happy for him and for the positive changes in his life.	The participant showed great determination. Even though tasks such as public speaking must be very daunting to him, he decided to overcome his fear.	This was a great example of the transformation that has occurred within the participant as a result of successful therapy. He described behavioural changes (doing a presentation, disclosing to others), cognitive changes (challenging negative thoughts) and affective changes (feeling comfortable).
I think there needs to be better counselors at school... I think that's like... haven for people who... with problems... I mean I stewed over for a couple of years, you know, at school where by far I had the worst	This was sad to hear. Given his current progress, it is clear that his problems can be dealt with effectively. The fact that it was not done so earlier, which could have prevented extended suffering, is		The participant's use of the phrase 'I stewed over for a couple of years' reminded me of another participant's expression of 'being cooked'. This to me suggests a sense of being in a very unpleasant, painful

symptoms. I had the worst symptoms of my anxiety disorder at school yet they didn't seem to help.	regrettable.		situation that the person is unable to control or get out of.
So that was actually a good thing in a way that even though the psychologist I saw at school seemed pretty useless, she actually did do one thing which was put me on to another person to another person to another person that got me my first diagnosis even if that seems not very important any more, the ADHD.	On one hand, I was happy that the participant was able to find a positive angle to what must have been a frustrating situation. On the other hand, I was a bit upset as I do not consider being sent from one professional to another a good care.	The participant showed insight and ability to evaluate his experience from a broader perspective.	I looked at this in view of what I have learned about the system of care. Health care system has been described as underfunded, yet a person has to see a number of professionals (only to be given what seems to be a wrong diagnosis). Better access to psychologists could, hopefully, address some of these issues.
I mean, of course it was also self-realization of, hey, you know, you're not supposed to be terribly scared just walking to get a cup of water or something like that.	This was very confirming as I was becoming aware of how important self-realization is.	This comment was made in the context of help-seeking decisions. The participant self-reflected on his experience and tried to reinterpret his responses.	This was my third interview and I started noticing the role of self-realization in help-seeking: self-realization as a process that leads to acceptance. However, I do not mean passive acceptance. Rather acceptance of 'yes, I am living with a condition (illness, disorder, problem) that impacts on my functioning but there is something I should and can do about it'.
He seems determined to actually help me, he's not cold or anything, he's got a certain part of... he's got determination to help me	This was one of many evaluations of therapists (see earlier sections). What surprised me was the comment on the		I always believed that the determination to help is essential for all helping professions. However, in view of the participant's

and he also does want to talk, unlike the first person, he actually wants to talk to help, not just talk about anything.	determination to help.		other comments about a psychiatrist who appeared burned out, it is quite possible that the perceived lack of determination can be explained by skill shortages and consequent exhaustion of overworked professionals.
I mean, being in school was like hell, basically, it was like... It's not like there were bullies or anything, it was just because, like, it's everyone around me and it was terrifying, just getting up in class and getting out of class... I can't actually concentrate during workloads at all, basically, because I'm always thinking about this and I'm always so nervous, so I can't think of what to do.	This description was moving, yet I was glad to hear it, simply because it made the experience so real. Far from objective, detached description of symptoms, it gives the experience details and depth.	The participant communicated great sadness. Although he started talking about past experiences (high school), he switched to speaking in present tense. In spite of the progress he has made so far, there are still many issues that he needs to address before he reaches recovery.	The use of words in this section is important. Describing high school experience as "hell" and "terrifying" illustrates the profound effect of the disorder. Especially given that the effect involved the most basic tasks: getting up in class, getting out of class, getting a glass of water (mentioned elsewhere in the interview). Tasks that are performed by other people almost automatically made the participant terrified.
I actually myself thought about, if this CBT treatment gets even better that I might actually publicly speak about it myself which is kind of, you know, difficult for someone in my position.	I was very happy and proud of the participant as he indicated how positive he was about his recovery.	The participant showed determination and empowerment.	This sentence was linked to previous statements where the participant expressed the need for more public awareness. He not only showed determination to seek help and follow through with the therapy but he also wanted to help others in a similar situation.
... and then people started to put in some videos of	I found this very interesting. The participant		Being able to compare his story with other people's

<p>themselves [on YouTube] and they were all quite similar. They mainly just talked about their stories, they didn't say, like, about coping strategies or anything, they were just people like me, and also it put things into perspective because some of them are, I mean, some people are really, like, housebound or, you know, some have had it for 30 years. Well my disorder is, like, half dead now and theirs is still going. So it was also hopeful for me and also even they themselves have hope.</p>	<p>indicated earlier that he used the Internet for self-education to further his knowledge of the anxiety disorders. This added the dimension of social support. I also liked his expression about his disorder being half dead – again another suggestion of improvement.</p>		<p>ones put the participant's experience into perspective and gave him a sense of hope. Being one of many could also somewhat counterbalance the feelings of "abnormality" and exclusion that are often linked with the experience of living with mental illness. What I also found interesting is comparing this coping strategy with that of another participant who said that knowing people with the same disorder does not help because their coping strategies differ. It is possible that the Internet provides more opportunities and represents experiences that vary greatly. Thus the chances of interacting with someone who the person can connect with are much greater.</p>
<p>They'll [parents] take us until I finish my education but if I hadn't, if they hadn't done that I probably would have actually become... I can certainly imagine myself actually becoming a housebound person because I couldn't handle the responsibilities. I've never had a job or</p>	<p>I found the prospect of the participant becoming housebound quite terrifying.</p>		<p>I found it difficult to reconcile the idea of being housebound with the image of the participant. He was sitting in front of me, talking about his progress and contemplating speaking publicly about his experience. Yet the outcome could have been different, if it was not for a</p>

anything like that before. Prospects like that truly terrify me.			number of factors that formed the context of his life, such as supportive family, access to information, or social support from other sufferers.
... Not actually be thinking I have some problems and it's because I'm a loser or something, it's because this is real and it's wrong and I can't exactly go on like this...I mean, as a person to realize this sort of thing, you've got to realize that this is all, this is not normal...You need to make them realize somehow that what they're feeling isn't actually normal... The rationality seems to work for people like me. It's only, it takes a while but it can actually sink in...			I felt that this provided further support for my assertion that the process of self-realization is extremely important. And as indicated in the last statement, it takes time. I believe that individuals who successfully complete the process are more likely to seek help and accept referral. Whether the experience is described as something abnormal, as an illness or a problem in functioning, it is real and needs to be addressed.

Participant 4: Deborah

Journal entry	The interview was very friendly and opened and featured a great deal of self-disclosure. The participant seemed relaxed and often laughed throughout the interview. However, her tone of voice changed every time she spoke about her husband. It was clear that the relationship with her husband was central to her existence and that the problems they experienced in their marriage caused her a lot of pain. The issue of problematic marriage was something she kept returning to in the interview. She also expressed hurt when talking about the loss of friends due to her move from New Zealand to Perth. Although my research question focuses on the process of referral, the participant often moved off the topic. I felt that she missed chats with her friends and partially used the opportunity of the interview to have a friendly talk. Although she
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openly disclosed her diagnosis right at the beginning of the interview, she needed more prompting to talk about her experience than my previous participants.			
ANALYSIS AND INTERPRETATION			
Content	Researcher's horizon of meaning	Participant's perceived horizon of meaning	Interpretation as fusion of horizons
It was very hard when I came to Perth because I left many long-time friends behind. I mean when I first came here I thought: What have I done?	I felt sorrow. I felt I could relate to her in a way because my own move to Perth had rather dramatic beginnings. But my move had a different purpose and occurred under different circumstances.	The participant communicated pain caused by a loss of substantial social network. Later in the interview she described the experience as unbelievably painful.	This was a significant life change that had a major impact on the participant's well-being. It was clearly a stressful life event that contributed to the onset of depression.
Anyway, that just hit me and I didn't know what to do. I felt like getting on the next plane and leaving it all behind here. You don't realize how important your friends are. I mean we're talking about twenty, thirty, forty years, even more... and they are your family because there's no family... It was so painful leaving my friends...	This put things in a better perspective for me. It was clear that losing friendships that had lasted forty years must have been traumatic.	The participant was still grieving the loss.	The participant decided to move to be closer to her two daughters and their families living in Perth. She had to weigh in the advantages of having interactions with close family members with the disadvantages of losing friends. I felt that she was still contemplating whether she made the right decision.
I think that my husband is... he's starting to have dementia because sometimes he's... It's always something that he can't remember. But that's not so bad, I can learn to cope with that but he's very very nasty, he's cruel. He shouts ...	This was very sad to hear.	The participant was expressing a great deal of hurt. Her expression and tone of voice changed which was a common pattern. Although she often laughed throughout the interview, when she spoke about her husband, her expression always changed.	This was the first time in the interview that the participant talked about her husband. She kept returning to this topic. It was clear that her relationship with her husband was central to her existence. The fact that the relationship was difficult caused her a lot of

			pain.
It's just all the anger this man has inside. I said to [the psychologist], he's like a dragon. He's got fire coming out of his mouth... I can't stand it.			Hearing this, I recalled another participant I interviewed: another elderly female suffering from depression. However, while the other participant found the <i>symptoms</i> of depression difficult to live with, in this case it was rather the causes of depression that the participant wanted to learn to cope with better.
I've got macular degeneration I was told, so it was difficult for him, he had to make adjustments too... I don't ask for help unless I really need it. I've got a magnifier and I just do the best I can... And at the end of the day I think it's good because I've learned skills that I didn't have before. And your hearing and your smell, actually, gets stronger.	This was important to hear because it helped me understand some of the issues. For example, when the participant first walked to me before the interview, she appeared a bit disorientated. Although loss of vision was not directly related to her psychological problems, it was an important part of her context.	Although loss of vision must be a traumatic experience, the participant showed great strength.	This helped me better understand the participant as a person. She was a strong woman with a great determination who was able to find the positive side of things. As she said later, she was generally a happy person. I believe that such characteristics make recovery more likely.
I mean, we're old, we should support each other... I would have left if I had somewhere else to go...	I found it very sad. For me, having a sense of choice and a sense of control is important.	The participant expressed a strong need for support but the need was not met.	The sense of despair and entrapment were very strong. This to me violates basic psychological needs – need for autonomy and relatedness.
I've had, not a psychologist but I've had counseling before and it always helped because if you really talk to	To me the choice of the word "unburdening" was very interesting.		This statement added to the list of therapeutic experiences. After the previous three interviews it

a psychologist, you unburden yourself better.			was becoming clear that different patients have different expectations of therapy: some look for social support, others for knowledge. For this participant, it was being able to unburden herself.
I started to cry, dear! I was in a deep hole and I was hanging on by my feet...	I found this a very real description of an inner experience.		This was very interesting because when the participant said this, she was laughing. I felt that her response might have indicated improvement and perhaps feelings of relief that she was no longer in that state.
I've got a doctor who doesn't communicate at all... Absolutely. It [communication] IS a problem, it wasn't a problem, no, it is a problem. I'd like to change but I don't know...		The participant communicated frustration and disappointment.	Communication was very important for the participant. She valued communication and interpersonal interactions.
I think that a lot of people think that if you go and see a psychologist, you must be a nutcase. People still think that. You don't tell everybody that, no, no, no, no. My youngest daughter knows.	This was confirming in view of what I have learned from my previous interviews: disclosure of mental illness is always considered carefully.	The participant did not seem particularly upset. Perhaps she has learned from past experiences and has accepted the issue of disclosure as a fact of life.	The issues of disclosure did not seem to play a big role. It is possible that it was because the illness was not central to her identity. Her identity was strongly defined by her relationships – she was clearly able to maintain those relationships in spite of the illness.
A great deal of people still think, ah, snap out of it.		There was a sense of acceptance (as above). The	I have heard many descriptions of common

<p>You can snap out of it. They think that depression is an indulgence or something. Because they never experienced it before, they don't know. You don't want to be in that place, you don't want to feel that way. But I think that it's in your nature, some people do and some people never really do</p>		<p>participant clearly felt that some people naturally believe that depression is a real illness while other do not.</p>	<p>misconceptions related to depression. I felt that the word "indulgence" summarized it nicely. It illustrates the contrast between the reality (depression as a painful, unpleasant experience) and the misconception.</p>
<p>It seems to be up when my husband and I have a big session, I just feel, you know, it's hard to get away from it.</p>	<p>This confirmed my assertion that the relationship problems with her husband were strong contributing factors of depression.</p>		<p>As mentioned earlier, the participant indicated a sense of entrapment.</p>
<p>He's always the victim. I say to him: 'Look, I'm a good wife. I do lots of little things to make you happy, why do you treat me like a bad wife, why do you treat me like that?'... I feel hurt, I feel hurt because... I know what he went through when he was young, I'm a mother, and I don't know why he treats me like that.</p>	<p>I felt a great deal of sadness. The participant has been putting a lot of effort into her relationship, yet with little results.</p>	<p>This was clearly very painful for the participant to talk about. She was trying to understand why it was happening, despite all the energy she put into the relationship.</p>	<p>This provided further support for my belief that the participant's personal identity was largely centered around her relationships (I'm a good wife, I'm a mother). Apart from the direct consequences of being mistreated (feeling hurt, unappreciated and depressed), the husband's behaviour also threatened her identity, her relational self.</p>

Participant 5: Edward

<p>Journal entry</p>	<p>The interview was very honest and opened. The participant needed little prompting – there were whole periods of him talking without a pause. He admitted towards the end</p>
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	<p>of the interview that talking about his problems actually helps him now. Having known of his army background, I was not surprised that he talked about some of his war experiences. His tone of voice was rather unemotional, even when recounting some truly horrific events. I believe that he has learned to suppress his emotions or learned to put a distance between the events and his own emotional response to them as a way of self-preservation. Although not immune to tales of suffering, I did not feel distressed because of my personal interest in the history of the 20th century. However, I did find his accounts very moving as this was the first time I heard someone talking about it in person. I have never spoken to a Vietnam veteran before.</p>
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ANALYSIS AND INTERPRETATION

Content	Researcher's horizon of meaning	Participant's perceived horizon of meaning	Interpretation as fusion of horizons
<p>I was sent there by Veteran Affairs. I went there and I told them I didn't believe in psychology and as far as I was concerned, it was all a lot of bullshit. I was there only because I had to be there.</p>	<p>This was an opening statement of the whole interview and I was a bit taken aback by it. At the same time I was very pleased that he was so honest with me.</p>	<p>The participant was empowered, he sounded like an individual who would not settle for the second best.</p>	<p>This statement was also important for another reason: the patient's reluctance to accept referral was a very different response to what I have learned in my four previous interviews and thus added another dimension to my data.</p>
<p>I just thought, well, this could never happen to me because I'm too strong-willed and I still find it difficult that it did happen. It happened to everyone on my section in Vietnam, ten, fifteen years ago... So I come along fifteen years later with the same stuff that they had ten, fifteen years ago. Because they rung me and said, yes, this is what we went through and this is what we did. But</p>	<p>I first felt that the participant was simply stubborn. Later I realized that the issue was more complex and that admitting mental illness had more to do with his personal identity.</p>	<p>The participant self-reflected on his journey from denial to awareness.</p>	<p>Throughout the interview, the participant stated repeatedly that he was in denial. He could not accept that he had a psychological problem. He experienced many physiological changes but he put them all down to his war injury. He could not (and still cannot to a degree) reconcile the idea of suffering from this problem with his personal identity. He showed great insight and was able to</p>

I didn't listen to them then and I should have...			describe the cognitive changes that marked his transformation.
I did have some problems in the 80s but I just took myself away and changed my thinking... I tried the same thing with this but it didn't work.	This confirmed my impression of the participant as a very rational person.	The participant stated this in a matter-of-fact manner, as if change in thinking was like a light switch. This showed to me how powerful his rationality was.	The participant's rationality served him well in the past but could not help him this time until he made the self-realization that what he experienced was perhaps too large or severe for his self-management attempts.
No, you don't tell police officers that... I was the team leader and I expected that it would undermine my position. They do know now but they didn't when I left. I never told anyone, I never told my wife for a long time...	I was not surprised by the issue of self-disclosure as such but I was surprised that it included his wife as well. However, he did mention later that his wife is fully aware now and is very valuable in her support.	The participant felt that to admit that he had a psychological problem would mean to admit weakness.	This told me more about his sense of identity. He was a leader, a strong figure. To him, mental illness signified a weak mind.
I enjoyed his company after a while because I liked him. And I said to him: 'I'm very sorry about my early days.'	I was pleased to hear that he established a connection with the psychologist.		I thought this was significant. The participant has not only started acknowledging the problem but he built a rapport with his psychologist and respected him enough to apologize for his previous behaviour.
My background is the army and the police force. You know, we're very rigid, not rigid, we're, what do you call it, regimented, discipline-orientated... Weakness is something you don't accept.		The participant showed insight.	This confirmed my previous assertion about the participant's refusal to accept that he had a psychological problem. Acknowledging his background as a possible contributing factor showed

			insight.
Then I started to get slightly aggressive, it's not me to fight somebody... I realized what I was doing and stepped back. I couldn't sleep because this is not me, I've never done that. Even in the police force, I was never aggressive. You know, I always took the calmest way out of situations. That surprised me a hell of a lot. And actually I think that it was one of the things that I thought at home, that perhaps I did need help.	The participant talked about his aggressive behaviour several times. I was surprised because he did not strike me as an aggressive person. And as he himself admitted, the aggressive behaviour was very out of character for him.	The participant talked about the impact his change of behaviour had on him.	The participant was well aware of the changes he was experiencing. This was another factor that helped his cognitive transformation from denial to awareness. However, it needed a person who was well aware of who he was as a person.
I came home to my wife and I said: 'My doctor's telling me that I'm suffering from depression and post-traumatic distress, my psychologist is telling me that I'm suffering from post-traumatic distress, the doctor in [town] is telling me that I'm suffering from post-traumatic distress and Leslie there, the matron in [town] is telling me that I'm suffering from it, and I'm the only one that's saying that I'm not. So I said, the odds are that all of those people can't be wrong. Someone must be wrong	I really liked this description. Even though I know that his transformation was complex and involved, this description was very neat and clear.	This showed the participant's rationality and ability to analyze.	The participant used his rationality to come to a conclusion that maybe he did have a problem. Although his description looks as if the change in his thinking was sudden, it is clear that it was a long process that involved several "hints" on the way. His behaviour and affective changes (aggressive behaviour) were some of them.

and it looks like it's me. And then I changed my thinking.			
I come from a strict methodist family and I was in farming all my life, I've been in a church and I was always told to stand on my two feet... Even when I was sick I still went to work.			He acknowledged his upbringing (he talked about his professional background earlier) as one of the factors that impacted on his denial.
Younger people are different, I think. They think differently than older people. People my age, like, we were brought up to be tough. When now, people are brought up to be more sensible, I think. You know, if you wanna cry, you cry, if you want your emotions out, you let your emotions out... In the modern world, I think, it might be different.	I was quite surprised to hear this, it showed a great insight. I was also pleased because this was probably the only acknowledgment of my perception of the participant as someone who learned to control his emotions and who relied on rationality.		Again, another reflection on possible factors that contributed to his difficulty to accept his illness and the therapy.
And there was massive enemy in the area, and there was helicopters and airplanes, blood trails all the way up, bodies all the way up, everywhere you looked, if you'd dug in a hole, you would find a body. And the things went on and kids were killed... So, they were terrible things but they never concerned me.	I was taken aback by this account. Not so much for its content as for the lack of emotionality in the participant's voice. It made me wonder what type of cognitive processes a person puts in action in order to protect oneself from emotional harm.	The participant spoke without showing emotions, as if telling a story from a position of an impassive observer.	The participant spoke in a very even, unemotional voice throughout the whole interview. I was not fully aware of it until the sentence "and the kids were killed". The tone of voice was so much in contrast to what was said that it stuck in my memory. Although the participant said that the things that happened in Vietnam did not concern him, earlier in the interview

			he admitted that they (the soldiers) were very young and that those events affected their minds. I felt that putting a distance between the events and his emotional response to them might have been an attempt at self-preservation.
I had flashbacks, it was like a DVD, just rolled. But it never really concerned me. It happened, it's there, it's over... And that's why I can't understand and why I still have a bit of denial that it's gonna be hard for him to help me... because I've still got that semi, it's only a little bit of denial now.	I felt that this statement was another sign of denial. I found it a bit hard to believe that a person can experience flashbacks of war and not be disturbed by it. On the other hand I know that as someone who has no direct experience with any of these issues, I can never fully understand them.	The participant was puzzled by his experience. If flashbacks are a sign of mental illness but he does not mind them, then why does he suffer from mental illness...	The participant has learned to accept flashbacks as part of his life. To him, flashbacks were probably the only sign that his illness may be psychological in nature and because the flashbacks did not concern him, he struggled accepting that he had a psychological problem.
I was in total denial. When people are in total denial, it's almost impossible to help them. No matter what you do.		The participant was very convinced by this argument, he felt very strongly about it.	The participant described himself as a very difficult person at the beginning of the therapy, which made any improvement difficult. His view that the process of self-realization is important is in accordance with my view.
I'm never ever going to beat it. It's always going to be there but at least it will make it easier. And talking about it makes it easier. Where I wouldn't talk before. I would answer questions but I wouldn't	What pleased me was the statement that talking about his problems makes it easier. With each interview, I was aware of the sensitive nature of the discussed issues and tried to make sure that the participants		I found this a bit intriguing. On one hand the participant still struggled to accept his mental illness while on the other hand he resigned himself to the fact that he will never achieve recovery, in spite of the

talk.	felt comfortable.		improvements he was making.
It wasn't until I nearly died, and Leslie kicked me up the backside and said: 'I've known you all my life, you're in total denial. You gotta wake up to yourself.'	I felt sad, realizing that it has to take a life-threatening event for some people to finally decide to seek help.		The participant's denial was very strong. His identity was based on leadership, strength and rationality, while mental illness to him represented none of these. Admitting that he suffered from mental illness thus meant changing certain aspects of his identity which would have been difficult for many people.

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