Understanding Help-Seeking Behavior in Depression: A Qualitative Synthesis of Patients' Experiences

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<u>**(ACCEPTED MANUSCRIPT)**</u>

Abstract

Despite decades of evidence-based interventions depression remains a great challenge for public health due to enormous treatment gap and lag which, at least partially, result from low professional help-seeking by people suffering from depressive symptoms. In this article we aim to gain a better understanding of help-seeking behavior in depression and how to intervene effectively decreasing treatment gap and delay by using a meta-ethnography approach – an interpretive technique to systematically synthesize qualitative data. It integrates views and experiences of 474 individuals with depression across 20 papers. Findings suggest several interrelated major concepts – help-seeking as a threat to identity, social networks as a conflict or support, and alternative coping strategies as the main factor for treatment delay – as well as multiple relational, structural, attitudinal, cognitive, culture- or gender-specific barriers. A model of help-seeking as a threat to identity is developed and discussed in the context of existing research.

INTRODUCTION

Depression is a strikingly prevalent and disabling condition with substantial social, economic and health burden at individual and societal levels (Katzman, Anand, Furtado & Chokka, 2014; Eaton et al., 2014; Ferrari et al., 2013; Greenberg, Fournier, Sisitsky, Pike & Kessler, 2015; Miret, Ayuso-Mateos, Sanchez-Moreno & Vieta, 2013). The European Study of the Epidemiology of Mental Disorders (ESEMeD) including six European countries found major depression as the most common mental disorder with lifetime prevalence of almost 13% (Alonso et al., 2004). It is generally similar in Canada or the United States, where lifetime prevalence is slightly more than 11% and 16% respectively (Katzman et al., 2014).

Furthermore, major depressive disorder ranked as the 11th leading cause of disability adjusted life years (DALYs) in the Global Burden of Disease Study (GBD) in 2010 but was as high as 4th in Western Europe, 5th in Central and Eastern Europe and 5th in North America (Ferrari et al., 2013). Using the GBD framework, moderate forms of major depressive disorder are comparable to disability caused by multiple sclerosis or deafness

while severe forms match disability associated to blindness (Eaton et al., 2014). Depression is also a source of significant economic burden associated with its direct healthcare and indirect costs (e.g. sick leaves, lost work productivity or suicide-related costs) both at individual and national levels (Miret et al., 2013; Greenberg et al., 2015). Given the early age of onset and that many patients with depression are of working age at which their productivity would normally be high, depression considerably interferes and limits their ability to complete employment tasks or to learn. These presenteeism (i.e., decreased productivity or under-performance) and absenteeism challenges together account for 27 days lost per year per worker (Katzman et al., 2014).

Nonetheless, despite decades of interventions which could substantially reduce the burden of depression, it remains a great challenge for public health as a highly underdiagnosed and undertreated condition. More than 50% of people with diagnosable depression never seek treatment (Kohn, Saxena, Levav & Saraceno, 2004) and even if they do so, the initial contact with health care system is frequently delayed significantly – out of those who eventually seek help 40% do so during the first year of onset but the remaining 60% have a median delay of eight years (Christiana et al., 2000).

Given the improvements in depression treatment options and access to care, the treatment gap and lag indicate that apart from structural barriers there are other important factors to be understood. It is now well known that help-seeking behavior is not a result of individual's impairment solely and there have been multiple theoretical moves aiming to explain decision-making process in treatment-seeking and healthcare utilization (Kadushin's social network perspective (Kadushin, 1969), Andersen's behavioral model of health services use (Andersen, 1995) or Pescosolido's network-episode model (Pescosolido, 1992, 2006), among others). However, as Pescosolido and Boyer (2010, p. 438) argue, "we are far from understanding the nature of the process or the timing by which people reach treatment".

The aim of this study is to explore help-seeking behavior in adult depression, to understand what factors influence (hinder or facilitate) it, and to articulate the most effective means of diminishing treatment gap and delay in seeking care in Europe and North America through meta-ethnography of published qualitative data on working-age patients' experiences and views. Interpretive qualitative studies are more concerned with how people understand their social worlds and, therefore, better represent perceptions and experiences of patients as well as generate "new conceptual understanding and theoretical explanations" (Pope, Mays & Popay, 2007, p. 72).

METHOD
Meta-ethnography
Qualitative synthesis is a systematic study that "involves rigorously examining and interpreting the findings of a number of qualitative research studies" (Finfgeld, 2003, p. 894) and aims to offer a novel and more powerful explanation or interpretation, greater generalizability and an increased level of abstraction than in a case of a single, often isolated research report (Paterson, 2012), i.e. to achieve more, not less (Thorne, Jensen,

Kearney, Noblit & Sandelowski, 2004). We selected meta-ethnography as probably most widely-used method of qualitative synthesis (Campbell et al., 2011; Paterson, 2012).

Developed by Noblit and Hare (1988), meta-ethnography is the form of knowledge synthesis that involves constant comparing across the studies or, in other words, translation of studies into one another. It is interpretive rather than aggregative, inductive rather than deductive and "seeks to go beyond single accounts to reveal the analogies between the accounts" (Noblit & Hare, 1988, p. 13). Noblit and Hare (1988) break the process of meta-ethnography into 7 iterative steps: getting started, deciding what is relevant to the initial interest, reading the studies, determining how the studies are related, translating the studies into one another, synthesizing translations, and expressing the synthesis.

The correct and adequate translation maintains the central concepts of each study in relation to other key concepts in that study and compares them across the papers (Noblit & Hare, 1988). The studies may be related to one another through three different types of translation. If the key concepts and their relations are directly comparable across the studies, the process is called *reciprocal translation* (Noblit & Hare, 1988). However, if the concepts or even studies are implicitly or explicitly contradictory, *refutational translation* should be used aiming to find contradictions and making an attempt to explain them (Dixon-Woods et al., 2006). Finally, *lines-of-argument* involves a move toward a new interpretation, a bigger picture of the phenomenon, or "second-level" inference about the whole based on the individual studies (Britten & Pope, 2012, Noblit & Hare, 1988).

Identification of published work

In order to conduct an exhaustive search and a valid synthesis, a combination of different search strategies, often called "berry picking" (Barroso et al., 2003), was used in this meta-ethnography: first, multiple electronic medical and social science databases (MEDLINE, CINAHL, Scopus, ProQuest, PsycINFO, Web of Science (all databases) and OvidSP) were searched excluding or including studies by title, by abstract and, finally, by reading full text; second, we reviewed and searched reference lists of identified articles and their authors; finally, key journals have been identified during the database and reference lists/authors search – "Qualitative Health Research", "Sociology of Health and Illness" and "Journal of Mental Health" – and the volumes from 1997, which coincided with the earliest study included by this stage of search, were hand-searched. The studies were screened based on the inclusion and exclusion criteria in Table 1.

Table 1. Inclusion and exclusion criteria.

Inclusion criteria	Research conducted in Europe and North America
	Studies including working-age general adult population (approx. 18-64 with some flexibility)
	Focus on patients with major depression and their views and experiences
	Research studying help-seeking behaviour or pathways to care settings (entrance to care)
	Empirical studies that use qualitative methods of data collection and analysis
	Languages: English, Spanish or Lithuanian
Exclusion criteria	Help-seeking for postnatal/postpartum or late-life/geriatric depression
	Mixed method studies if qualitative findings cannot be separated from quantitative
	Mixed sample studies where findings about depression/from patients with depression cannot be separated from other findings

Search terms that included broad terms related to help-seeking behavior, depression and qualitative research were searched in titles, abstracts and keywords. We included the published work (journal articles, theses/dissertations or reports) only and did not explore grey literature in order to keep the number of papers manageable. Studies reported in books, conference papers, editorials and comments were excluded. Multiple articles based on the same investigation could be included if they provided substantial additional interpretations and data. If a dissertation and a peer-reviewed version of the same study were available, we made a decision to include a dissertation as long as it provided significantly more data on our research question.

Possible bias has been reduced through transparency of methodology, use of an established technique of meta-ethnography and including the second reviewer (Eladio Jiménez Mejías) during the entire process (i.e. the stages of search, quality appraisal and analysis). To enhance rigor, the two authors provided consensual validation when/if needed. As far as publication bias is concerned, its magnitude and form differs significantly in quantitative and qualitative research (Finfgeld-Connett & Johnson, 2013): the end product of qualitative research is interpretations and generally considered neither positive nor negative. Hence, publication bias related to non-significant or negative findings is eliminated in qualitative research. Nonetheless, there is another type of publication bias: due to a traditional perception of qualitative research as of less value, it may be published in high quality and easily accessible journals less frequently, although this type of bias seems to be diminishing lately (Finfgeld-Connett & Johnson, 2013) as well as approaching multiple databases should have helped to reduce it.

Analysis and quality appraisal

The analysis followed the 7-step approach of meta-ethnography proposed by Noblit and Hare (1988). Each article was read in full several times and main concepts with relevant citations were passed to electronic data analysis matrices along with memos and diagrams to relate them. Then, these key findings, which became the raw data for the synthesis, were compared across the studies and translated into one another by arranging studies chronologically (as used in Atkins et al., 2008). If any concepts emerged as contradictory at intra- or inter- study level (refutational), the attempt of exploring contexts and finding a possible explanation was made. Finally, we aimed for a higher-level interpretation of phenomenon (*lines-of-argumen*t). In order to enhance trustworthiness and reduce bias all the process was constantly reviewed by the second reviewer who provided critical feedback and insights for possible adjustments.

As far as quality assessment is concerned, we employed quality appraisal procedures from Carroll, Booth and Lloyd-Jones (2012) evaluating whether and how key procedural elements of qualitative research were reported in the papers and arguing that if the study is not adequately reported, we cannot assess trustworthiness and reliability of its results. The criteria were based on the following: the question and study design; the selection of participants; methods of data collection; and methods of analysis (corresponding to questions no. 3, 4, 5 and 8 in the CASP checklist for qualitative studies (http://www.casp-uk.net/)). Any texts from the publications that addressed the quality appraisal questions were extracted, and answers of 'yes' or 'no' were assigned to each criterion. The second reviewer then validated the answers based on extracted texts and/or full publications. The studies that had 'yes' for two or more criteria were recognized as adequately reported and included to the synthesis.

RESULTS
Summary of included studies

We identified 14,066 records through database search, reference lists, author search and hand-searching of key journals. 13,796 records were excluded as duplicates and/or as irrelevant titles. The remaining 270 titles were included for abstract screening, out of which 100 studies were subsequently assessed for eligibility in full-text. 21 papers were identified as eligible: 18 journal articles and 3 dissertations. Selected studies were published between 1997 and 2015 with only one of them before 2000. There is a chance that earlier relevant studies have not been identified due to their poor indexing and abstracting; however, reference lists and author search should have helped to include earlier studies, if any. The studies then were assessed for quality of reporting based on the 4 key elements introduced earlier. One study did not report any element and, therefore, was excluded.

Table 2. Included papers (IDI – in-depth semi-structured interview; FG – focus group).

#	Author(s), year	Setting	Data collection method	Sample
1	Heifner, 1997	US	IDI	14 male participants
2	Rogers et al., 2001	UK	IDI	27 participants + 10 GPs
3	Shin, 2002	US	FG & IDI	57 Korean participants + 13 community leaders
4	Kuwabara et al., 2007	US	IDI	15 participants
5	Feely et al., 2007	Ireland	FG & IDI	13 participants + 2 nurses
6	Biddle et al., 2007	UK	IDI	23 participants
7	Chuick et al., 2009	US	IDI	15 male participants
8	Epstein et al., 2010	US	FG	102 participants with depression + 14 participants with a vicarious history *
9	Rochlen et al., 2010	US	FG	44 male participants with depression + 1 male with depressed partner *
10	Elwy et al., 2011	US	IDI	30 participants
11	Pandalangat, 2011	Canada	long interview	16 Sri Lankan Tamils + 8 service providers
12	Kravitz et al., 2011	US	FG	See sample in #8*
13	Johnson et al., 2012	Canada	IDI	38 male participants
14	Hansen & Cabassa, 2012	US	FG & IDI	19 Latino/a participants
15	Campbell, 2012	US	IDI	17 African American participants
16	Farmer, 2013	UK	IDI	20 participants
17	Tang et al., 2014	Canada	IDI	21 male participants
18	Sierra Hernandez et al., 2014	Canada	IDI	13 male participants
19	Savage et al., 2015	UK	IDI	17 participants + 7 participants with other CMD
20	Augsberger et al., 2015	US	IDI	17 Asian American female participants

*Studies no. 8, 9 and 12 included the same sample/sub-sample

As a result, the final selection of studies included 20 papers (see Table 2). They were based on 18 original investigations that included data from 474 individuals who were officially diagnosed or self-diagnosed with depression and who either had or had not sought treatment. Some investigations also involved other types of participants such as healthcare service providers or participants with a vicarious history of depression (n=54). 9 investigations were conducted in the US (11 papers), 4 – in Canada, 4 – in the UK and 1 – in Ireland. The sample included participants from diverse ethnic backgrounds with 272 females and 256 males in total aged from 16 to 76 with very few younger than 18 or older than 65. Four major and interrelated themes appeared as a result of reciprocal translation: depression and help-seeking as a threat to integral identity; social networks in crisis as a conflict or support; alternative coping strategies as the main factor for treatment delay; and barriers to depression help-seeking.

Depression and help-seeking as a threat to individual's identity

Depression and help-seeking appear as a threat to individual's integral identity: recognition of symptoms as abnormal and interfering with every-day life leads to the identity conflict where an individual aims to guard her central roles as long as possible. Help-seeking is seen as "interruption to identity" (Kuwabara, Van Voorhees, Gollan & Alexander, 2007) or an unpleasant "identity shift" (Biddle, Donovan, Sharp & Gunnell, 2007). In some papers the concept of identity or self-definition is directly introduced by authors (Heifner, 1997; Rogers, May & Oliver, 2001; Kuwabara et al., 2007; Biddle et al., 2007; Rochlen et al., 2010; Elwy, Yeh, Worcester & Eisen, 2011; Johnson, Oliffe, Kelly, Galdas & Ogrodniczuk, 2012; Campbell, 2012; Farmer, 2013; Sierra Hernandez, Han, Oliffe & Ogrodniczuk, 2014) while in others a threat to identity is indirectly observed through other concepts (getting a label, loss of control, etc.). The severity of identity conflict and efforts made by individual to guard it depend on multiple attitudinal, cognitive, gender- or social networks-related factors.

Depression as a threat to hegemonic masculinity. The concept of "manly men do not seek help" (Johnson et al., 2012) appeared as one of the most prominent subthemes and was perceived as a major barrier to men help-seeking in multiple accounts (Heifner, 1997; Rogers et al., 2001; Shin, 2002; Chuick et al., 2009; Rochlen et al., 2010; Johnson et al., 2012; Tang, Oliffe, Galdas, Phinney & Han, 2014; Sierra Hernandez et al., 2014). Men felt social pressure to conform to masculine norms (Heifner, 1997; Sierra Hernandez et al., 2014) and to hide their negative emotions and depressive symptoms (Heifner, 1997; Chuick et al., 2009; Epstein et al., 2010; Johnson et al., 2012; Tang et al., 2014; Sierra Hernandez et al., 2014):

> "It makes me feel less of a man… But, I definitely feel, the pressure from society to be stronger, to be more in control of myself as a man. I feel like… I'm not meeting that ideal, and I feel guilty about it, I feel like a failure in some ways." (a participant, as cited in Sierra Hernandez et al., 2014, p. 349)

Avoiding help-seeking minimised any potential additional harm to their identity that might have been previously created by depressive symptoms (Johnson et al., 2012; Farmer, 2013). Treatment-seeking, in general, was seen as inappropriate for men (Heifner, 1997; Chuick et al., 2009; Sierra Hernandez et al., 2014). For some men, however, professional help-seeking was perceived as an option as long as the threshold of suffering was met and all other solitary coping strategies were tried (Johnson et al., 2012; Tang et al., 2014). In these accounts help-seeking is perceived as a strength-based independent action and, therefore, aligns with hegemonic masculinity. It is a choice and as long as a man maintains the possibility of choice, he has a sense of control (Sierra Hernandez et al., 2014), which is essential for his masculinity.

Another legitimized entry to treatment was through emergency departments or initiation of treatment by significant others when the symptoms were too destructive and severe to be ignored (Heifner, 1997; Rogers et al., 2001; Johnson et al., 2012), both of which minimized damage to man's identity:

> "I remember driving down a hill on 140th or 144th [street]… and thinking, 'If I just didn't touch the brake I could just lose control, it would look like an accident, it would all be over', and that's when I thought… 'I've got to do something about this…', so instead of turning right to go to work I turned left and went to the hospital and I checked myself in…" (a participant, as cited in Johnson et al., 2012, p. 354)

This need for acute and immediate help rather than routine general services that are perceived feminine lets men protect their hegemonic masculinity and aligns how men should manage their health and illness (a need to reach an appropriate stage of suffering) (Johnson et al., 2012).

Help-seeking as admitting that you have a problem, getting a label. Depression itself was perceived as interfering with participants' roles and thus as an abnormal threat to their identity but it could be guarded in privacy (Kuwabara et al., 2007; Biddle et al., 2007; Farmer, 2013). Help-seeking, however, meant admitting the condition (Kuwabara et al., 2007; Feely et al., 2007; Biddle et al., 2007; Sierra Hernandez et al., 2014; Savage et al., 2015) and being labelled as a patient (Heifner, 1997; Campbell, 2012; Tang et al., 2014) which caused a move from private to public and official (Kuwabara et al., 2007; Feely et al., 2007; Biddle et al., 2007; Campbell, 2012; Tang et al., 2014), making depression visible, real and moving away from normalcy (Rogers et al., 2001), that generally caused negative consequences and emotions – shame, weakness, fear or failure (Campbell, 2012; Tang et al., 2014; Savage et al., 2015)

> "…because once you go outside and get some sort of help or treatment it changes the whole thing. The feelings might not change but suddenly it's like official… and it makes it seem more real and permanent… because now you're a patient or whatever, you're being treated…" (a participant, as cited in Biddle et al., 2007, p. 997)

Help-seeking as a final step. Professional help-seeking was perceived as a last resort due to its damage to one's self-definition. The participants would first cope privately and only once the alternative coping strategies have been perceived as ineffective, professional help is sought (Heifner, 1997; Rogers et al., 2001; Shin, 2002; Feely et al., 2007; Biddle et al., 2007; Rochlen et al., 2010).

Depression as weakness, shame, loss of control, failure or guilt. Unwillingness to accept a patient role and consequential identity shift partially results from emotions associated with the concept of depression: perceived weakness (Johnson et al., 2012; Tang et al., 2014), shame of being deficient, faulty or vulnerable (Heifner, 1997; Chuick et al., 2009; Rochlen et al., 2010; Elwy et al., 2011; Campbell, 2012; Tang et al., 2014; Sierra Hernandez et al., 2014; Augsberger, Yeung, Dougher & Hahm, 2015), loss of control (Heifner, 1997; Shin, 2002; Feely et al., 2007; Sierra Hernandez et al., 2014), loss of pride (Shin, 2002), shame of failure in general (Kuwabara et al., 2007; Sierra Hernandez et al., 2014) or failure to succeed as a man (Sierra Hernandez et al., 2014):

"(Moderator: Was there any particular reason why you didn't ask for help?)
Yeah. Because I would have been weak. And that would be a bad thing….
It's better to hate and be angry and miserable" (a participant, as cited in
Elwy et al., 2011, p. 1503)

The feeling of guilt and blaming oneself for depressive symptoms were also noticeable in patients' discourses (Heifner, 1997; Feely et al., 2007; Elwy et al., 2011; Farmer, 2013).

A fear of disclosure, being judged or stigmatised. Stigma of mental illness, in general, and depression, in particular, as well as the undesirable identity of a depressive patient were revealed by fears in multiple accounts, all of which can be summarised as a fear of being stigmatised by others, which shows the importance of social circles in accepting illness identity and seeking help. Participants expressed a fear of being judged by significant others (Epstein et al., 2010; Campbell, 2012; Sierra Hernandez et al., 2014) or by authority (Kuwabara et al., 2007); a fear of disclosure by being seen by others or by information on their medical records (Heifner, 1997; Shin, 2002; Biddle et al., 2007; Farmer, 2013; Savage et al., 2015); a fear to be judged as not being manly (Johnson et al., 2012; Sierra Hernandez et al., 2014); or a fear of employment discrimination (Epstein et al., 2010; Savage et al., 2015). Fear of disclosure and being judged was especially strong among young adults (Kuwabara et al., 2007; Tang et al., 2014).

Role of social networks in help-seeking

Social networks as a barrier to help-seeking. Negative stigmatizing attitudes and messages expressed by family and friends either about depression and help-seeking in general conversations or directly to potential patients and towards their intent to receive support was a significant barrier to help-seeking as encouraging further denial, avoidance and solitary management of the symptoms (Heifner, 1997; Feely et al., 2007; Biddle et al., 2007; Chuick et al., 2009; Campbell, 2012; Tang et al., 2014). In a couple of accounts fathers expressed these attitudes to their sons further strengthening hegemonic masculinity and beliefs about help-seeking being inappropriate for men (Chuick et al., 2009; Tang et al., 2014). Since disclosure of emotions in peer groups is not seen as normal or acceptable, men also felt a lack of peer support (Heifner, 1997; Shin, 2002; Rochlen et al., 2010; Tang et al., 2014):

"You're not supposed to open up to other guys about that. You're supposed to seem confident and strong and you can accomplish things on your own and stuff like that… That's what proves your value to other people I think and so, by discussing it with other people… it just lowers your value…" (a participant, as cited in Tang et al., 2014, p. 221)

Furthermore, participants felt a pressure (either actual or anticipated) to meet family's expectations or a desire not to disappoint them (Heifner, 1997; Kuwabara et al., 2007). Social networks not noticing or ignoring symptoms and/or not willing to discuss them even when directly expressed (including suicidal thoughts) was perceived as a barrier to acceptance of symptoms and help-seeking as well (Heifner, 1997; Epstein et al., 2010;

Pandalangat, 2011; Augsberger et al., 2015). Finally, ethnic minorities' families were more willing to keep depression within family/ 'in-house' (Shin, 2002; Campbell, 2012; Augsberger et al., 2015) which meant both social support and a barrier to professional help-seeking. The importance of maintaining familial privacy or 'saving face' was particularly stressed in the accounts of Asian Americans (Shin, 2002; Augsberger et al., 2015).

Social networks as a source of support and a facilitator to help-seeking. Family and friends were also perceived as a source of support and advice (Shin, 2002; Kuwabara et al., 2007; Pandalangat, 2011; Campbell, 2012; Farmer, 2013; Savage et al., 2015). They facilitated recognition of symptoms and/or encouraged or even demanded to seek help (Biddle et al., 2007; Chuick et al., 2009; Epstein et al., 2010; Pandalangat, 2011; Hansen & Cabassa, 2012; Farmer, 2013):

> "I don't think I recognized when I was depressed quite honestly… it was people telling me to, you, know, maybe you ought to consider that, you, know, you're in a state of depression and you might want to seek help" (a participant, as cited in Epstein et al., 2010, p. 957)

Spousal or partner relationship was the social network demanding men to seek help in some accounts (Chuick et al., 2009; Pandalangat, 2011) where women adopted the role of enablers of care (Pandalangat, 2011) as one man stated: "My wife will make notes of all the dates and remind me" (a participant, as cited in Pandalangat, 2011, p. 133). Finally, some men perceived permission of their social networks (friends, family and especially other men) and knowledge that men also experienced depression as a normalizer and facilitator to help-seeking (Tang et al., 2014).

Role of community. Participants from ethnic minorities also discussed the negative role of community in help-seeking. They felt a fear of shame, rumors and gossips in the community (Shin, 2002; Pandalangat, 2011; Savage et al., 2015 (for Black Africans)) or that people may take advantage if symptoms and/or help-seeking were disclosed (Sierra Hernandez et al., 2014). Participants expressed attitudes that depression was a taboo or 'non-existent' in their community which increased difficulty to recognize and accept symptoms (Campbell, 2012; Augsberger et al., 2015).

Coping strategies as a main factor for treatment delay

Alternative coping strategies as a response to symptoms are the main factor delaying professional help-seeking that is often considered as a final step once all other coping strategies are tried and perceived as ineffective.

Maladaptive coping. It includes such coping strategies as alcohol and drug use and abuse (Heifner, 1997; Shin, 2002; Biddle et al., 2007; Chuick et al., 2009; Rochlen et al., 2010; Elwy et al., 2011; Pandalangat, 2011; Farmer, 2013; Savage et al., 2015; Augsberger et al., 2015), self-harm (Biddle et al., 2007; Farmer, 2013), focusing excessively on work (Chuick et al., 2009; Rochlen et al., 2010) or self-medicating (Elwy et al., 2011):

> "I work 60 hours a week. You drink, smoke pot, and get into reading, you know, novel after novel. And all kinds of behaviors to keep the mind away from it, you know, and I see people, men, do that all the time…" (a participant, as cited in Rochlen et al., 2010, p. 171)

Substance use was an extremely frequent coping strategy and dramatically common among men, which is perceived as an atypical symptom of men depression worth additional attention in healthcare services. Men also considered suicide as a means of taking control and resolving the problem of depression (Heifner, 1997; Chuick et al., 2009; Johnson et al., 2012), which could explain the huge differences of both depression and suicide rates between men and women. A bigger part of men than women never end up in treatment for their depression as well as after unsuccessful attempts to cope choose suicide as a way to retake control.

Normalization. Participants frequently aimed to normalize symptoms by application of non-illness/external explanations or seeing symptoms as every-day life problems (Biddle et al., 2007; Epstein et al., 2010; Elwy et al., 2011; Farmer, 2013), by temporalizing (symptoms are seen as temporary) (Biddle et al., 2007; Elwy et al., 2011; Farmer, 2013), by constantly increasing the limit or threshold of a "real" illness (Biddle et al., 2007) or by comparing oneself to others around and considering that everybody is experiencing the same symptoms and problems (Epstein et al., 2010; Savage et al., 2015).

Concealment, denial and avoidance. Secret-keeping, hiding and maintaining an image of stability and normalcy are considered as another strategy to cope with symptoms or even with consequences of help-seeking once in treatment (Heifner, 1997; Kuwabara et al., 2007; Chuick et al., 2009; Rochlen et al., 2010; Campbell, 2012; Tang et al., 2014). Furthermore, denial and avoidance may be extremely long-lasting (often further using normalization strategies) (Shin, 2002; Kuwabara et al., 2007; Biddle et al., 2007; Rochlen et al., 2010; Elwy et al., 2011; Hansen & Cabassa, 2012; Campbell, 2012; Farmer, 2013; Tang et al., 2014).

Religion as a coping resource. Prayer and faith as a coping strategy was stronger in the ethnic minorities' accounts or among members of fundamentalist churches (Heifner, 1997; Shin, 2002; Pandalangat, 2011; Hansen & Cabassa, 2012; Campbell, 2012; Savage et al., 2015). Religion can be a barrier to help-seeking due to conceptualization of depression as a lack of faith (if your faith is strong enough, you will get better) or emphasis on emotional and behavioral control (self-management):

> "I had to ask for help and felt guilty about that. I was raised in a fundamentalist church and was taught to believe that if your faith was strong enough, if you trusted God enough, you would get better. You don't need help from others." (a participant, as cited in Heifner, 1997, p. 16)

Self-reliance and solitary strategies. Solitary strategies were common in multiple accounts (Shin, 2002; Feely et al., 2007; Chuick et al., 2009; Rochlen et al., 2010; Elwy

et al., 2011; Johnson et al., 2012; Tang et al., 2014; Sierra Hernandez et al., 2014; Savage et al., 2015; Augsberger et al., 2015). They included willpower, positive thinking or self-control in general or such activities as meditation, reading a book, going shopping, gardening or exercising. Participants also discussed alternative remedies/medicine (Feely et al., 2007; Savage et al., 2015), lifestyle changes or relevant information seeking in order to resolve their symptoms (Savage et al., 2015; Augsberger et al., 2015).

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Barriers to depression help-seeking

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Although social networks and alternative coping strategies can be either a barrier or facilitator to treatment-seeking, there are other factors that influence whether, when and where an individual decides to seek help. Structural barriers limiting access to care such as long waiting lists, financial factors, short visits or time commitments were discussed in several papers (Shin, 2002; Kuwabara et al., 2007; Kravitz et al., 2011; Hansen & Cabassa, 2012; Farmer, 2013); however, they were considered as secondary and rarely critical in decision-making process in depression help-seeking in Europe and North America.

Attitudinal and cognitive barriers. Probably the most prominent barrier to acceptance of symptoms and help-seeking is stigma that was clear in the majority of accounts and was reported directly (Shin, 2002; Biddle et al., 2007; Elwy et al., 2001; Pandalangat, 2011; Campbell, 2012; Savage et al., 2015) or through other concepts discussed earlier (e.g. depression as weakness or as a defect). Stigma of taking medications was also reported in several studies (Elwy et al., 2011; Hansen & Cabassa, 2012; Campbell, 2012; Tang et al., 2014). Medications were perceived as an option for extreme cases or '*locos*' (crazy) only (Hansen & Cabassa, 2012). Other participants expressed negative attitudes towards medications as well: there was a fear of medications creating addiction (Rogers et al., 2001; Hansen & Cabassa, 2012; Sierra Hernandez et al., 2014; Savage et al., 2015); distrust of their effectiveness (Kuwabara et al., 2007; Rochlen et al., 2010; Campbell, 2012); a fear of their side effects (Hansen & Cabassa, 2012; Savage et al., 2015) or they were perceived as a temporary fix only (Savage et al., 2015). Several studies reported a belief about ineffectiveness of treatment in general or that depression cannot be treated (Kuwabara et al., 2007; Elwy et al., 2011; Pandalangat, 2011; Savage et al., 2015), which can become a major barrier to help-seeking.

Another important group of attitudinal barriers was related to beliefs about inappropriateness of mental problems in primary care (Rogers et al., 2001; Kuwabara et al., 2007; Biddle et al., 2007; Epstein et al., 2010; Elwy et al., 2011; Kravitz et al., 2011; Johnson et al., 2012; Savage et al., 2015): participants perceived depression as a wrong type of problem, not a "real" illness for treatment-seeking. There was a belief that mental health issues are not part of general practitioners' (GPs) domain (Kravitz et al., 2011). Participants frequently opposed mental and physical problems with physical being a "real" illness due to their tangible symptoms (Rogers et al., 2001; Epstein et al., 2010; Elwy et al., 2011; Johnson et al., 2012):

> "When I get there, I get the feeling that there's nothing wrong with me. I wish I had got something physical to show. Sometimes, when we are in the car, I hope we crash… and that I wouldn't die, but that something would happen that would give me a real reason for being off work and feeling the way I do." (a participant, as cited in Rogers et al., 2001, p. 324)

Nonetheless, psychiatric services, that could be perceived as appropriate for mental health problems, carry additional stigma and fear. Primary care was preferred against the alternative of referral to a psychiatrist which for participants meant a final and absolute loss of control as opposed to primary care (Rogers et al., 2001; Shin, 2002). Finally, low mental health literacy was reported as a barrier too: participants had difficulties defining their symptoms as depression (Shin, 2002; Kuwabara et al., 2007; Feely et al., 2007; Elwy et al., 2011; Pandalangat, 2011) or lacked knowledge how and where to seek help (Heifner, 1997; Shin, 2002; Pandalangat, 2011).

Relational barriers. Relational barriers relate to attitudes and beliefs about healthcare providers in primary care and can be divided in several groups. Perceived limits of GPs' knowledge and skills to treat depression or perceived lack of depression-related expertise was one of the most critical barriers (Rogers et al., 2001; Kuwabara et al., 2007; Rochlen et al., 2010; Kravitz et al., 2011):

> "They're not trained because they read out of a book. And if the book doesn't say that this is a symptom, they don't have it." (a participant, as cited in Kravitz et al., 2011, p. 210)

GPs were also perceived to lack intimacy, empathy and knowledge of sufferer's circumstances which can badly affect fragile patient-physician trust (Rogers et al., 2001; Kuwabara et al., 2007; Kravitz et al., 2011; Campbell, 2012; Savage et al., 2015). The example below with emphasis on "one of those rare things" and a comparison with a typical GP serves as a good illustration:

> "I don't feel ignored. I've got one of those rare things: a doctor who listens to me. I had a beauty before that as you walked through the door he wrote a prescription out." (a participant, as cited in Rogers et al., 2001, p. 329)

Furthermore, participants expressed difficulty to connect verbally with GPs and/or to describe their problem (Rogers et al., 2001; Pandalangat, 2011; Kravitz et al., 2011) which could partially be related to shame presenting mental problems (Rogers et al., 2001), a fear of negative reactions from GPs due to their condition as well as a social distance in general (Rogers et al., 2001; Kravitz et al., 2011; Farmer, 2013).

Culture-specific treatment factors. Cultural inappropriateness of interventions (Shin, 2002; Augsberger et al., 2015), lack of bilingual and bicultural healthcare providers (Shin, 2002; Pandalangat, 2011; Augsberger et al., 2015), lack of more holistic approach (Augsberger et al., 2015) and language itself (Shin, 2002; Pandalangat, 2011;

Hansen & Cabassa, 2012; Augsberger et al., 2015) were perceived as barriers to care by ethnic minorities.

Gender-specific treatment factors. Men emphasized their difficulty and fear talking about their emotions as well as a fear of disclosure or a lack of confidentiality (Heifner, 1997; Shin, 2002; Johnson et al., 2012). Some men perceived medications as creating a loss of control (Sierra Hernandez et al., 2014) while therapies were perceived in a positive light by others as, on the contrary, maintaining the sense of control and providing an active role which aligns with hegemonic masculinity (Johnson et al., 2012; Sierra Hernandez et al., 2014).

Lines-of-argument: **towards a better understanding of help-seeking behavior**
Help-seeking behavior in depression has proved to be a complex, dynamic and often cyclic process (see Figure 1). The central theme which was revealed through reciprocal translation is an identity shift and individual's will to maintain one's identity and roles intact. Depression and help-seeking are perceived as a threat carrying a significant amount of potential changes in one's identity. Thus, once the symptoms are recognized as abnormal and challenging a central part of one's self-definition, an individual aims to cope with them maintaining identity roles as long as possible. At this stage multiple coping strategies are used which may lead either to relief/resolution or to understanding that symptoms remain or even get worse. An individual can either reconsider and use different coping strategies or accept a possible patient role and seek treatment (which itself may involve certain coping strategies, e.g. limiting self-disclosure).
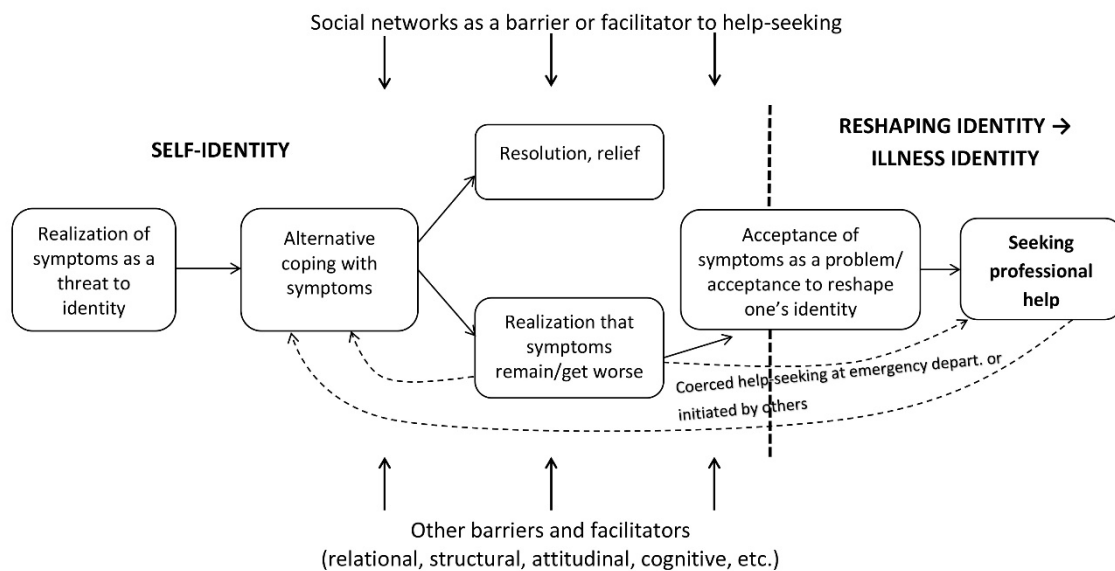

Figure 1. Depression and help-seeking as a threat to individual's identity.

The help-seeking process varies across sociocultural groups due to different influences of social networks and multiple barriers discussed in this synthesis that can determine what symptoms and when are recognized as abnormal, what coping strategies are used as well as how soon and where help is sought.

DISCUSSION
Shame of being labelled 'depressed'

Findings of this meta-ethnography suggest several interrelated major concepts as well as multiple treatment-related barriers/facilitators that help us better understand treatment-seeking behavior in depression (see Figure 1). The synthesis did not reveal any profound particularities in help-seeking across the settings but it did find differences across the ethnic groups and genders. The process of help-seeking tends to be cyclic rather than sequential and moves away from a rational choice.

The main mechanism that drives the whole non-help-seeking process proves to be an avoidance of identity shift or individual's desire to maintain her integral self-definition and normative behavior required by her central role (as a man, as a provider of a family, as a member of ethnic group, as a mother, etc.) with depression challenging it. The theory of structural symbolic interaction posits that individuals have a handful of hierarchized role identities and are most highly committed to the top ones (Lively & Smith, 2011). Commitment here means the number of social relations that an individual would lose with loss of a role, i.e. a role identity is "deeply embedded in one's social networks" (Lively & Smith, 2011, p. 513). Depressive symptoms tend to threaten roles of highest commitment (e.g., masculine identity). Therefore, an individual uses multiple coping strategies aiming to maintain these roles and to avoid a patient's role.

The modified labelling theory developed by Link and his colleagues argues (as cited in Link & Phelan, 2010) that people internalize conceptions or cultural definitions of mental illness early in their life as a result of socialization and if they believe that mental illness means rejection and devaluation of a person (as less competent, weaker, etc.), these negative consequences will become relevant personally once they experience symptoms themselves. However, in spite of suffering from some potentially stigmatizing symptoms, an individual might remain 'normal' as long as she is not labelled as depressed (Lively & Smith, 2011). This explains the views about help-seeking as a final resort and intents to manage depression alone using multiple coping strategies until the symptoms are too destructive and deviating from behavioral and emotional norms too much. Once in treatment and so having been labelled, a patient may use different coping behaviors in order to prevent negative consequences: concealing treatment history, withdrawal from social interactions and education (educating others about mental illness) (Link & Phelan, 2010; Lively & Smith, 2011). The strategies of withdrawal and secrecy appeared in this synthesis as well.

Stigma, defined by Goffman (1963) as a deeply discrediting attribute or blemish of the body, of the character or as being tribal in nature (race, nation or religion), influences beliefs and behaviors of both (potential) patients and their social networks. Stigma,

embracing components of labelling, stereotyping, separating 'us' from 'them' and discrimination (Link & Phelan, 2010), was perceived as one of the strongest barriers to help-seeking in patients' discourses. It depends on power relationship, i.e. stigmatizing group must have social, economic and political power, as well as involves emotional responses: the stigmatized are likely to feel emotions of embarrassment, shame, fear, alienation or even anger (Link & Phelan, 2010) and can consequently shape their behavioral patterns.

According to Thomas J. Scheff (2000), one of these emotions – shame – is strongly related to one's identity or what one is. It is an entirely social emotion that can have many variants such as embarrassment, humiliation or feelings of rejection and failure, all of which are seen as a threat to the social bond (Scheff, 2000) which is the foundation of any self-definition. Shame, embarrassment, feelings of failure, a fear to be judged by your social circles (and so a fear to lose the social bond) have been frequently observed in this synthesis. The sense and anticipation of shame is extremely important for social control – people continuously think about/are aware of shame and aim to avoid it in their social interactions (Scheff, 2000). Not seeking help for the symptoms of depression and trying to maintain one's identity as anticipation of shame is an example of this.

The whole help-seeking process is socially embedded and social networks are more than a source of emotional support or conflict – "interaction in social networks creates cultures of information, beliefs and action scripts" (Pescosolido, 2006, p. 194). This synthesis revealed the importance of social networks in formation of definitions of and attitudes towards illness, depression and help-seeking. They can also facilitate or hinder identity shift and access to care, give permission for help-seeking or sometimes even initiate it. Based on the Network-Episode Model, "the structure and function of networks interact with cultural contexts to influence critical decisions that individuals make through onset and course of a health problem" (Pescosolido, 2006, p. 197). The structure of networks impacts how influential the networks are (the strength of 'push') but the cultural contexts determine the direction of this 'push'. Ethnic minorities in this synthesis, who maintained dense, closed networks and certain cultural beliefs, commonly delayed individual's entrance to care and aimed to manage symptoms within family.

Implications for policies

Relational barriers. Participants perceived GPs to lack depression-related expertise, intimacy, empathy and openness. They expressed distrust and concerns about social distance between GPs and patients. Findings also revealed perceived inappropriateness of mental problems in primary care as not being a 'real' illness. This fear of being a time-waster has been identified in other types of conditions as well, e.g. cancer (see meta-ethnography by Smith, Pope & Botha, 2005). Cross-sectional study of Lithuanian GPs also confirms that GPs' self-perceived competence in managing mental disorders can be low (Jaruseviciene, Sauliune, Jarusevicius & Lazarus, 2014). Therefore, social marketing, health education and physician skills building suggested by Kravitz et al.

(2011) seem appropriate and should alter patient factors by improving their attitudes towards GPs as well as physician factors by improving GPs' depression-related knowledge gaps and communication skills to overcome social distance and distrust by patients. These capacity-building strategies were also found to be one of the most acceptable interventions among GPs themselves (Jaruseviciene et al., 2014).

Attitudinal and cognitive barriers. Mechanic (2002, p. 144) argues that "despite much effort, the public is still only vaguely aware of most types of psychiatric morbidity and the availability of effective treatments". Although knowledge itself is not sufficient for help-seeking, battling low mental health literacy and stigma is important for both potential patients and their social circles. Evidence-based health education programs should raise awareness of depressive symptoms, where and how to seek help as well as combat stigmatic attitudes towards depression, medications and help-seeking. Educational programs could target general population or groups that need particular attention: school- or university-based programs could improve mental health literacy among younger populations and similar programs developed for male-dominant work environments could approach men.

Gender- and culture-specific barriers. Findings also suggest that hegemonic masculine identity limit men help-seeking behavior and entrance to care importantly. Therefore, educational campaigns for primary care providers could inform them about hegemonic masculinity and its influences in men's expressions of emotions, men's skepticism of drug treatment as well as about their particularly harmful coping strategies. Building physicians' skills of effective communication with men in order to identify symptoms and encourage help-seeking should facilitate dialogues between GPs and potential male patients (Rochlen et al., 2011). Finally, physicians should pay particular attention to men suffering "from psychosocial or economic stress, abuse of alcohol or other substances" as well as difficulties with anger (Rochlen et al., 2011, p.173). Furthermore, the conceptualization of help-seeking could be changed by re-branding help-seeking and certain treatment strategies as an active, strength-based action which aligns with masculine identity. The social marketing campaign "Real Men. Real Depression" by US National Institute of Mental Health serves as a good example that targets general public and aims to de-stigmatize men depression as well as to market help-seeking as a strength-based action (more info: http://www.nimh.nih.gov/index.shtml).

As far as cultural barriers are concerned, training of service providers to increase their intercultural competence and awareness of different cultural definitions of illness and health, norms and beliefs as well as hiring bilingual providers could lead to an improvement although this may require significant financial resources. Furthermore, offering medical services in community centers and linking them to alternative wellness programs (yoga, tai chi, etc.) should reduce stigma of help-seeking and offer more holistic services, desire of which was expressed by Asian communities (Shin, 2002; Augsberger et al., 2015). Health education programs for the whole ethnic communities also need implementing to raise awareness of patients and their social networks that proved to be a barrier to help-seeking.

Future research directions

This synthesis suggests several possible directions for further research such as to advance our understanding about illness identity in depression, how individuals strive to maintain their identity in spite of challenging symptoms as well as to further analyze characteristics of social networks (friends, family, neighborhoods, workplace, etc.) and their role in illness identity. Furthermore, few studies aimed to understand the role of social class in this identity conflict and to compare help-seeking across different classes. Moreover, since GPs tend to function as gate-keepers who deliver a growing proportion of treatments in depression and other common mental disorders, future research should approach patient-provider interactions in primary care, how GPs manage common mental disorders and what barriers they experience. Finally, given the current migration situation in Europe, better understanding of help-seeking for mental health concerns in other ethnic and religious minorities seems to be a crucial research area too.

Limitations

Qualitative synthesis allows to integrate data from multiple smaller studies and "to explore a wide range of experiences while simultaneously increasing the size and diversity of the total sample" (Smith et al., 2005, p. 829). Nonetheless, there are several limitations of qualitative synthesis, in general, and meta-ethnography, in particular. First of all, due to poor indexing and abstracting of qualitative studies some important investigations might have been missed; however, using a combination of search strategies should have minimized this possible bias. All the studies are from English-speaking countries with a majority being US-based which could be indicating a possible publication bias in qualitative research.

Furthermore, a concern whether qualitative synthesis is reproducible is frequently expressed as a major limitation. Although meta-ethnography is a highly systematic and rigorous method, it remains interpretive and, therefore, a high level of reproducibility may not be expected – different synthesizers with different backgrounds and levels of experience will likely interpret data in different ways (Campbell et al., 2011). Nonetheless, Campbell et al. (2011) made an attempt to assess reproducibility of synthesis: two syntheses of the same studies were conducted by two synthesizers blindly and, although the final form of the product looked quite different, the main findings were rather similar showing that some level of reproducibility can be achieved.

Critics also express concerns about integration of different philosophical assumptions and data collection methods in one synthesis (Atkins et al., 2008). Others, however, argue that such integration has a potential "to become a respected form of triangulation" (Finfgeld, 2003, p. 902). Finally, loss of explanatory context and details that individual studies can provide is considered as another limitation of synthesis (Atkins et al., 2008; Smith et al., 2005). However, by combining studies this qualitative synthesis offers a higher level interpretation across multiple international settings and social groups that individual qualitative studies can rarely do.

CONCLUSION

Meta-ethnography of patients' experiences reveals that depressive symptoms and help-seeking is a threat to individual's integral identity. Acceptance of illness identity and being labelled as depressed through professional help-seeking is often the final step once alternative coping strategies, both maladaptive and adaptive, have been tried and perceived as ineffective. Avoiding help-seeking and a public label of depression minimizes harm to individual's identity. The timeline of help-seeking in depression depends on diverse relational, attitudinal, cognitive, culture- and gender-specific factors. Finally, social networks can either hinder or facilitate entrance to care. This synthesis also suggests multiple directions for interventions to encourage healthcare utilization in depression. The effective policies should aim to alter attitudes, norms and knowledge of both patients/public and healthcare providers by adopting diverse evidence-based strategies such as health education of general public or certain target groups, social marketing or training/skills building of general practitioners.

References

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., …Vollebergh, W. A. M. (2004). Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica, 109*(Suppl. 420), 21-27. doi: 10.1111/j.1600-0047.2004.00327.x

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does It Matter? *Journal of Health and Social Behavior, 36*, 1-10. Retrieved from http://hsb.sagepub.com/

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*(21). doi: 10.1186/1471-2288-8-21

Augsberger, A., Yeung, A., Dougher, M., Hahm, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC Health Services Research, 15*(542). doi: 10.1186/s12913-015-1191-7

Barroso, J., Gollop, C. J., Sandelowski, M., Meynell, J., Pearce, P. F., Collins, L. J. (2003). The Challenges of Searching for and Retrieving Qualitative Studies. *Western Journal of Nursing Research, 25*(2), 153-178. doi: 10.1177/0193945902250034

Biddle, L., Donovan, J., Sharp, D., Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behavior. *Sociology of Health & Illness, 29*, 983–1002. doi: 10.1111/j.1467-9566.2007.01030.x

Britten, N., Pope, C. (2012). Medicine taking for asthma: a worked example of meta-ethnography. In K. Hannes and C. Lockwood (Ed.), *Synthesizing Qualitative Research: Choosing the Right Approach* (pp. 41-57). Hoboken, NJ: John Wiley & Sons.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., …Donovan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*(43). doi: 10.3310/hta15430

Campbell, R. D. (2012). *When Money Isn't the Issue: Socio-Cultural Factors in Help-Seeking among Black Americans with Depression* (Doctoral dissertation, University of Michigan, US). Retrieved from http://hdl.handle.net/2027.42/91516

Carroll, C., Booth, A., Lloyd-Jones, M. (2012). Should we exclude inadequately reported studies from qualitative systematic reviews? An evaluation of sensitivity analyses in two case study reviews. *Qualitative Health Research, 22*(10), 1425-1434. doi: 10.1177/1049732312452937

Christiana, J. M., Gilman, S. E., Guardino, M., Mickelson, K., Morselli, P.L., Olfson, M., Kessler, R. C. (2000). Duration between onset and time of obtaining initial treatment among people with anxiety and mood disorders: an international survey of members of mental health patient advocate groups. *Psychological Medicine, 30*(3), 693-703. Retrieved from http://journals.cambridge.org/action/login

Chuick, C. D., Greenfeld, J. M., Greenberg, S. T., Shepard, S. J., Cochran, S. V., Haley, J. T. (2009). A Qualitative Investigation of Depression in Men. *Psychology of Men & Masculinity, 10*(4), 302-313. doi: 10.1037/a0016672

Critical Appraisal Skills Programme checklist for qualitative studies. Retrieved from http://www.casp-uk.net/

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, A. A., Harvey, J., Hsu, R., …Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology, 6*(35). doi: 10.1186/1471-2288-6-35

Eaton, W. W., Alexandre, P., Bienvenu, O. J., Clarke, D., Martins, S. S., Nestadt, G., Zablotsky, B. (2014). The Burden of Mental Disorders. In W. W. Eaton (Ed.), *Public Mental Health* (pp. 3-30). New York, NY: Oxford University Press

Elwy, A. R., Yeh, J., Worcester, J., Eisen, S. V. (2011). An Illness Perception Model of Primary Care Patients' Help Seeking for Depression. *Qualitative Health Research, 21*(11), 1495-1507. doi: 10.1177/1049732311413781

Epstein, R. M., Duberstein, P. R., Feldman, M. D., Rochlen, A. B., Bell, R. A., Kravitz, R. L., …Paterniti, D. A. (2010). "I Didn't Know What Was Wrong:" How People With Undiagnosed Depression Recognize, Name and Explain Their Distress. *Journal of General Internal Medicine, 25*(9), 954-961. doi: 10.1007/s11606-010-1367-0

Farmer, C. (2013). *Understanding poor help-seeking rates for major depressive disorder* (Doctoral dissertation, University of Exeter, UK). Retrieved from http://hdl.handle.net/10871/14620

Feely, M., Sines, D., Long, A. (2007). Early life experiences and their impact on our understanding of depression. *Journal of psychiatric and mental health nursing, 14*(4), 393-402. doi: 10.1111/j.1365-2850.2007.01097.x

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J. L., …Whiteford, H. A. (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. *PLOS Medicine, 10*(11), e10001547. doi: 10.1371/journal.pmed.1001547

Finfgeld, D. L. (2003). Metasynthesis: The State of the Art --- So Far. *Qualitative Health Research, 13*(7), 893-904. doi: 10.1177/1049732303253462

Finfgeld-Connett, D., Johnson, E. D. (2013). Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *Journal of Advanced Nursing, 69*(1), 194-204. doi: 10.1111/j.1365-2648.2012.06037.x

Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice-Hall.

Greenberg, P. E., Fournier, A., Sisitsky, T., Pike, C. T., Kessler R. C. (2015). The Economic Burden of Adults with Major Depressive Disorder in the United States (2005 and 2010). *The Journal of Clinical Psychiatry, 76*(2), 155-162. doi: 10.4088/JCP.14m09298

Hansen, M.C., Cabassa, L. J. (2012). Pathways to Depression Care: Help-Seeking Experiences of Low-Income Latinos with Diabetes and Depression. *Journal of Immigrant and Minority Health, 14*(6), 1097-1106. doi: 10.1007/s10903-012-9590-x

Heifner, C. (1997). The male experience of depression. *Perspectives in Psychiatric Care, 33*(2), 10–18. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1744-6163

Jaruseviciene, L., Sauliune, S., Jarusevicius, G., Lazarus, J. V. (2014). Preparedness of Lithuanian general practitioners to provide mental healthcare services: a cross-sectional survey. *International Journal of Mental Health Systems, 8*(11). Retrieved from http://www.ijmhs.com/content/8/1/11

Johnson, J. L., Oliffe, J. L., Kelly, M. T., Galdas, P., Ogrodniczuk, J. S. (2012). Men's discourses of help-seeking in the context of depression. *Sociology of Health and Illness, 34*(3), 345-361. doi: 10.1111/j.1467-9566.2011.01372.x

Kadushin, C. (1969). *Why People Go To Psychiatrists*. New York, NY: Atherton Press.

Katzman, M. A., Anand, L., Furtado, M., Chokka, P. (2014). Food for thought: understanding the value, variety and usage of management algorithms of major depressive disorder. *Psychiatry Research, 220*(S1), S3-S14. doi: 10.1016/S0165-1781(14)70002-2

Kohn, R., Saxena, S., Levav, I., Saraceno, B. (2004). The Treatment gap in mental health care. *Bulletin of the World Health Organization, 84*(11), 858-866. Retrieved from http://www.who.int/bulletin/en/

Kravitz, R. L., Paterniti , D. A., Epstein, R. M., Rochlen, A. B., Bell, R. A., Cipri, C., …Duberstein, P. (2011). Relational barriers to depression help-seeking in primary care. *Patient Education and Counseling, 82*, 207-213. doi: 10.1016/j.pec.2010.05.007

Kuwabara, S. A., Van Voorhees, B. W., Gollan, J. K., Alexander, G. C. (2007). A qualitative exploration of depression in emerging adulthood: disorder, development, and social context. *General hospital psychiatry, 29*(4), 317-324. doi: 10.1016/j.genhosppsych.2007.04.001

Link, B. G., Phelan, J. C. (2010). Labeling and Stigma. In T. L. Scheid and T. N. Brown (Ed.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp. 571-587). New York, NY: Cambridge University Press.

Lively, K. J., Smith, C. L. (2011). Identity and Illness. In B. A. Pescosolido et al. (Ed.), *Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21st Century* (pp. 505-525). New York, NY: Springer.

Mechanic, D. (2002). Removing Barriers to Care Among Persons with Psychiatric Symptoms. *Health Affairs, 21*(3), 137-147. doi: 10.1377/hlthaff.21.3.137

Miret, M., Ayuso-Mateos, J. L., Sanchez-Moreno, J., Vieta, E. (2013). Depressive disorders and suicide: Epidemiology risk factors, and burden. *Neuroscience and Biobehavioral Reviews, 37*, 2372-2374. doi: 10.1016/j.neubiorev.2013.01.008

Noblit, G. W., Hare, R. D. (1988). *Meta-ethnography: Synthesizing Qualitative Studies*. Newbury Park, CA: SAGE Publications.

Pandalangat, N. (2011). *Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems - A Comparative Study using a Gender Perspective* (Doctoral dissertation, University of Toronto, Canada). Retrieved from http://hdl.handle.net/1807/31890

Paterson, B. L. (2012). "It looks great but how do I know if it fits?": an introduction to meta-synthesis research. In K. Hannes and C. Lockwood (Ed.), *Synthesizing Qualitative Research: Choosing the Right Approach* (pp. 1-20). Hoboken, NJ: John Wiley & Sons.

Pescosolido, B. A. (1992). Beyond Rational Choice: The Social Dynamics of How People Seek Help. *American Journal of Sociology, 97*(4), 1096-1138. Retrieved from http://www.jstor.org/stable/2781508

Pescosolido, B. A. (2006). Of Pride and Prejudice: The Role of Sociology and Social Networks in Integrating the Health Sciences. *Journal of Health and Social Behavior, 47*(3), 189-208. doi: 10.1177/002214650604700301

Pescosolido, B. A., Boyer, C. A. (2010). Understanding the Context and Dynamic Social Processes of Mental Health Treatment. In T. L. Scheid and T. N. Brown (Ed.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp. 420-438). New York, NY: Cambridge University Press.

Pope, C., Mays, N., Popay, J. (2007). *Synthesizing qualitative and quantitative health evidence: A guide to methods*. Berkshire, UK: Open University Press.

Rochlen, A. B., Paterniti, D. A., Epstein, R. M., Duberstein, P., Willeford, L., Kravitz, R. L. (2010). Barriers in diagnosing and treating men with depression: a focus group report. *American journal of men's health, 4*(2), 167-175. doi: 10.1177/1557988309335823

Rogers, A., May, C., Oliver, D. (2001). Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. *Journal of Mental Health, 10*(3), 317-333. doi: 10.1080/09638230020023840

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., Brown, J. S. L. (2015). Exploring Professional Help-Seeking for Mental Disorders. *Qualitative Health Research*, 1-12. doi: 10.1177/1049732315591483

Scheff, T. J. (2000). Shame and the Social Bond: A Sociological Theory. *Sociological Theory, 18*(1), 84-99. doi: 10.1111/0735-2751.00089

Shin, J. K. (2002). Help-seeking behaviors by Korean immigrants for depression. *Issues in mental health nursing, 23*(5), 461-476. doi: 10.1080/01612840290052640

Sierra Hernandez, C. A., Han, C., Oliffe, J. L., Ogrodniczuk, J. S. (2014). Understanding Help-Seeking Among Depressed Men. *Psychology of Men & Masculinity, 15*(3), 346-354. doi: 10.1037/a0034052

Smith, L. K., Pope, C., Botha, J. L. (2005). Patients' help-seeking experiences and delay in cancer presentation: a qualitative synthesis. *Lancet, 366*, 825-831. doi: 10.1016/S0140-6736(05)67030-4

Tang, M. O. T., Oliffe, J. L., Galdas, P. M., Phinney, A., Han, C. S. (2014). College men's depression-related help-seeking: a gender analysis. *Journal of mental health, 23*(5), 219-224. doi: 10.3109/09638237.2014.910639

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., Sandelowski, M. (2004). Qualitative Metasynthesis: Reflection on Methodological Orientation and Ideological Agenda. *Qualitative Health Research, 14*(10), 1342-1365. doi: 10.1177/1049732304269888