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Relational Barriers to Depression Help-Seeking in Primary Care

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Abstract

Objectives—To identify attitudinal and interpersonal barriers to depression care-seeking and disclosure in primary care and in so doing, evaluate the primary care paradigm for depression care in the United States.

Methods—Fifteen qualitative focus group interviews in three cities. Study participants were English-speaking men and women aged 25–64 with first-hand knowledge of depression. Transcripts were analyzed iteratively for recurring themes.

Results—Participants expressed reservations about the ability of primary care physicians (PCPs) to meet their mental health needs. Specific barriers included problems with PCP competence and openness as well as patient-physician trust. While many reflected positively on their primary care

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experiences, some doubted PCPs' knowledge of mental health disorders and believed mental health concerns fell outside the bounds of primary care. Low-income participants in particular shared stories about the essentiality, and ultimate fragility, of patient-PCP trust.

Conclusion—Patients with depression may be deterred from care-seeking or disclosure by relational barriers including perceptions of PCPs' mental health-related capabilities and interests.

Practice Implications—PCPs should continue to develop their depression management skills while supporting vigorous efforts to inform the public that primary care is a safe and appropriate venue for treatment of common mental health conditions.

Keywords

Depression; Qualitative Research; Focus Groups; Physician-Patient Interaction; Access To Care; Trust; Primary Care; Disparities

1. Introduction

Depression is the most prevalent and costly mental health disorder[1] and is commonly treated in primary care.[2] Although identification and treatment rates are improving, at least 25% of primary care patients with clinically significant depression remain undiagnosed.[1,3] Experimental evidence suggests that patient requests for treatment can sharply reduce under-diagnosis and promote the initial treatment of depression.[4] Therefore, encouraging patients to seek care and ask about treatment may be an effective strategy for improving depression care in general medical settings.

Most patients with symptoms of depression desire help from their physician[5,6] but face significant obstacles.[7,8] Among those who want help, disclosure of distress may be impeded by organizational barriers, including impaired access to care, short visit times, and scant resources. However, interpersonal barriers such as social distance[9–11], patient-physician collusion[12], and low patient-physician trust may also be important. Such barriers may be especially salient for individuals with lower incomes, who bear higher levels of disease burden and hold more stigmatized attitudes toward care for mental health issues. [13,14]

In the current study, we explored potential challenges and barriers to depression care-seeking and disclosure in a diverse sample of working-aged adults. The project was part of a larger investigation of strategies for enhancing depression care-seeking in primary care practice. Strategies of interest are demographically-targeted public service announcements (PSAs) and an interactive multimedia computer program tailored to patients' attitudes and beliefs about depression. As part of the foundational work required to produce these tools, we convened focus groups of people who had experience with depression. We asked participants in broad terms about individual, interpersonal, and organizational barriers to care-seeking. As primary care clinicians and researchers, we began this work assuming that patients would share our perception of primary care physicians in the modern era as ready, willing, and able to diagnose and treat depression.

2. Methods

2.1. Study design and rationale

Focus groups are advantageous when “there is a power differential between participants and decision makers...when there is a gap between professionals and their target audience...and when investigating complex behavior and motivations”[15]. These conditions apply well to depression in primary care. We anticipated that interaction among focus group members

would allow us to capture the diversity of patient care-seeking experiences in a supportive environment and to seek out areas of consensus.

2.2. Study sites and participants

The Institutional Review Boards at each of the three study sites (Rochester, New York; Austin, Texas; and Sacramento, California) approved all study procedures. Participants were recruited using a variety of strategies, including Craigslist, flyers, and neighborhood canvassing. Study participants were English-speaking men and women aged 25–64 who reported a history of depression in self or in a close friend or relative. We focused on working aged adults because this group is both understudied and likely to contribute disproportionately to the economic burden of depression.[16] We recruited patients with firsthand knowledge of depression so that they could relate actual stories of coming to terms with depressive symptoms and successfully or unsuccessfully seeking care. To ensure diverse ethnic representation, we placed advertisements in local publications, worked with diverse community leaders and clergy, and conducted neighborhood canvassing. Study participants received a \$35 stipend.

2.3. Data collection

After providing informed consent, participants completed a preliminary questionnaire that included questions about demographics, general health status, healthcare access, and treatment for depression, including perceived benefit and perceived stigma. Guiding questions, based on literature reviews and the expertise of study investigators from various disciplines (sociology, clinical psychology, counseling psychology, internal medicine, family medicine, and psychiatry), were developed and then tested in one pilot focus group per site. Following the pilot focus groups, modifications were made to the interview guide to simplify and decrease the number of questions. Guiding questions focusing on patient willingness to seek depression care from a primary care physician (PCP) are shown in Table 1.

An additional 12 focus groups (4 at each geographic site) were conducted between February and April of 2008. Focus groups were stratified by gender and the median household income level corresponding to the participant's zip code, which was designated as "low" or "middle" based on percentiles relative to the median. We stratified on gender because of prior research suggesting that the depression care seeking experiences of the sexes differs, [17] and on income as a proxy for socioeconomic status (which is likely related to social distance in medical settings).[18]. Focus groups lasted 75–110 minutes and were digitally recorded.

2.4. Data Analysis

Digital recordings were transcribed line-by-line and reviewed for accuracy by research team members. Using the method of constant comparison,[19] relevant themes for coding were identified based on iterative review of the 15 transcripts (12 "regular" focus groups plus the 3 pilots), summaries of recurrent data, and consensus generated in multi-disciplinary meetings. Two of the authors systematically coded all 15 transcripts according to the parameters established by the team. For this paper, transcript segments were extracted and grouped into four general categories: beliefs about providers, beliefs about treatments, access to care, and experience with care. During recurring discussion, amendments were made to the general codes and code book definitions. Strategies for more nuanced coding were developed by the first and second authors, including more detailed attention to emergent categories of organizational and relational barriers to care seeking. To further identify persistent themes, the first author examined each coding category, split code data into coherent subcategories, and compared data within and across subcategories.

In situations where categorization was unclear, coded excerpts were examined within the larger context of the transcript and discussed by the coding team. Theoretical relationships among codes and themes were identified and disconfirming data were considered. Data that did not fit thematic characterizations were considered for potential re-categorization. Exemplary quotations were noted throughout the iterative analysis. Results were presented to the study team and assessed for theoretical and clinical relevance.

3. Results

3.1. Characteristics of study participants

Of 183 potentially eligible participants responding to our recruitment strategies, 37 were unavailable or deemed ineligible. Among the 146 remaining, 116 (79%) attended one of 15 focus groups of whom 88% had a personal history of depression (Table 2). The majority were white and female, but minorities and men were well represented; 47% participated regularly in a religious community. Nearly half had college degrees, but 75% had annual household incomes below \$50,000. While 78% were insured, 36% reported financial barriers to care, and 14% lacked a usual source of care. Eighty percent reported needing help for emotional or mental health issues in the past 12 months, and 62% received such care (Table 2).

3.2. Results overview: relational barriers to depression help-seeking

As in prior studies,[20–22] focus group participants in the current study identified several *organizational* barriers to depression help-seeking in primary care, including difficulties with accessing care, maintaining continuity with a single physician, and negotiating the complexities of health care organizations. However, participants also emphasized three distinct *relational* barriers: concerns about competence, openness, and trust (Table 3). We elaborate upon these three relational barriers in Sections 3.3–3.5.

3.3. Perceptions of PCP competence

This theme concerned perceptions about what doctors *know* and how doctors *think*. At times, participants conflated physician's technical preparation with their own willingness to engage in meaningful, trusting dialog and to adhere to a treatment plan. Some felt that primary care physicians lacked the knowledge and skills to adequately care for depression (“*what they know*”):

“So you have to really trust this doctor to know everything. And the fact is, a GP is not going to know everything.” [female, pilot]

“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.” [female, pilot]

“I feel a primary care doctor is not going to be qualified psychiatrically or therapy wise to deal with depression.” [male, mid-income]

These comments focus on different dimensions of PCP competence. The first quote underscores the considerable cognitive demands inherent to generalist practice. The problem is a perceived lack of condition-specific expertise. The second emphasizes the distinction between formal and practical knowledge[23] and the third centers on PCP’s lack of training in psychotherapy or perhaps competence to prescribe complex psychotropic regimens.

A second aspect of perceived competence was related to physicians’ theoretical orientation or depression-related worldview (“*how they think*”). Some patients observed that physicians too frequently adhere to a reductionist, biomedical model. As one mid-income female focus group participant described it, “He’s, like, you know, ‘It’s a chemical thing.’ I was, like,

‘No, it’s not.’ He’s, like, ‘Yes, it is.’ Another (man, low-income focus group) commented: “But it’s their way, because doctors are, that’s their training, to diagnose and treat. That’s it. Just diagnose and treat.” In these examples, incompatible mental models of depression impeded relationship building and provision of effective care.

3.4. Perceptions of PCP openness

Discussants shared how perceptions of PCP openness to psychosocial concerns affected their willingness to disclose emotional distress. In discussing PCP openness, participants identified three broad concerns: *domain*, *distance*, and *discourse*. In addressing *domain*, some participants questioned the propriety or appropriateness of emotional disclosure in general medical settings. A low-income male focus group participant said, “I think maybe they [other patients] might not know that a primary care doctor could actually address that issue.” A low-income female group attendee concurred, saying, “I told her [the physician] ‘I felt like I had to have some excuse to come and see you – a physical reason to come and see you and talk to you.’” Middle income male group members likewise compartmentalized the roles of general physicians and mental health providers, tending to see primary care physicians as irrelevant to depression in the absence of an underlying physical problem. When asked to comment on “the average person’s ability to talk with their doctor about depression,” one responded: “I don’t think it’s very good, to be honest with you, I really don’t. People are not--well--that’s not part of the scene or the plan...when you have emotional or mental problems that you seek out help [from a doctor].” These quotes suggest uncertainty as to whether disclosure of emotional distress or depressive symptoms is expected, normative, or appropriate in primary care settings.

Some participants in the mid-income female groups stressed the need to be heard and understood. Women in these groups questioned PCPs’ interest in delving into the intimate details of their lives; they felt that by virtue of temperament, training, treatment philosophy, and time availability, a therapist or psychiatrist would be better placed to deliver the care they needed. As one said, “I--I don’t think physicians--average medical doctors really understand this so much.” The issue is not just skills and capabilities (competence). It is also a matter of interest, curiosity and empathy (openness).

Other participants, especially low-income men, felt stigmatized by depression and separated from their physicians by social *distance* [18]. For two participants, the question was not so much a matter of social norms (patients’ perceptions of how the system worked) as attitude (patients’ perceptions of how the physician viewed them):

The doctors and the staff treat some of the people with a mental health problem like they’re scared half to death. They don’t listen to what they have to say....I mean, they just flat out don’t pay any attention.

I feel that doctors are in the upper stratosphere of society, and you as the patient, you’re in the lower stratosphere. And maybe you’ll get a good doctor, maybe you won’t. But either way, he’s going to go home to his mansion and have a nice dinner. You might be locked in seclusion.

Other discussants experienced problems with *discourse* – difficulty connecting verbally with their physician around depression. Several spoke of needing to “warm up” by discussing less emotionally salient topics as a prelude to disclosing depression. As described here, sometimes the clock runs out.

Maybe there are people who are ready, willing and able to say as soon as the doctor comes in the door, ‘Hey Doc can you talk about depression?’ But for a lot of us, it would be more like, well after we’ve talked about the blood pressure, after we’ve talked about the cholesterol, after we’ve talked about this, maybe you might be

feeling warm enough to say, ‘you know, I’m not sure about this. Can you talk about what does it really mean to be depressed?’ But half the time I think doctors need to get out of the door and on to the next patient. [male, mid-income]

Other participants had trouble articulating their distress or understanding physicians’ attempts to explain their condition. With these participants, skilled physicians were sometimes able to develop a shared vocabulary, connecting the medical perspective to the participant’s pre-existing mental representations of illness.[24–26]

I sort of remember him just saying, “It’s okay.” And then he used the word, he goes, “X, depression is an *illness*,” and it was like he was trying to get through to me...because I had come from a family system that anything to do with your mental health was ignored--denied, ignored, don’t talk about it. That’s our own business.[female, low-income]

3.5. Patient-physician trust

Trust in the physician is a multi-dimensional concept that includes fidelity (also called “agency”), capability, honesty, and confidentiality.[27,28] All participants wanted to trust that the physician would care about them personally, would put their interests first, and would have sufficient skill to address their problem adequately. In particular, lower income women considered trust an absolute pre-requisite to disclosure.

Comments from focus group members suggest that physicians can build interpersonal trust by being, saying, and doing. *Being* (an idea related to Goffman’s concept of empathy “given off”[29] means listening, attending, and connecting. How do you know when someone cares? “They really listen....I mean, with their eyes...With their whole being, they listen. They’re really present and there with you, that’s how you know.” [female, pilot]

Saying means educating and supporting (empathy “expressed”). The initial response can be crucial: “I might tell my doctor now but it would depend on if I didn’t get--if I got a negative response right away.” [female, mid-income] And, questions can be more important than answers: “The time she takes to really ask me how I’m doing [makes such a difference.]. And listen, even though that’s not what I’m even there for.” [female, low-income] For this participant, the physician’s willingness to engage on issues that transcend the ostensible visit agenda is highly valued.

Doing means coming through when it counts. Some, like this female pilot focus group participant, suggested that trust can be “banked” in the context of a longstanding relationship.

He saved my life at one point. I almost died of pneumonia. And so I--I had no problem whatsoever telling him, ‘Look, I--I’m depressed. I’m really depressed and I need some medication. I need something that’s gonna, you know, help me now.’

Some participants dealt with the fragile nature of trust indirectly. Several were overtly suspicious of conflict of interest (“Maybe they’re in cahoots through the pharmaceutical companies, you know? You know, a lot of Medicaid kick-backs and things like that.” [male, low income]), while others emphasized the importance of backing up words with knowledge, skill, and action:

“They should know the resources. So if someone comes to them and they’re not able, they go their primary doctor and the psychiatry department or the community mental health agency is overwhelmed...then you have to be able to [say] ‘well, that’s full, but you can go here or here or here.’[female, pilot]

4. Discussion and conclusion

4.1. Discussion

The principal finding of this study is that despite increasing recognition of primary care as the *de facto* source of mental health services for the majority of Americans[30], increased emphasis on the evaluation and treatment of mental health conditions in primary care residency training[31,32], and the emergence of effective models for the delivery of high quality depression care[33–35], many participants reported gaps in care and regarded the primary care paradigm for diagnosis and treatment of depression with some skepticism. Part of the reason (not emphasized in this article) is surely the inability of many patients to successfully negotiate systemic and organizational barriers such as lack of health insurance and poor access to care. However, our data suggest that less tangible factors also represent formidable obstacles to depression care-seeking. If primary care is to deliver on the promise of first-line care for patients with common mental disorders such as depression, these relational barriers must also be addressed.

Overcoming relational barriers related to competence, openness, and trust will require altering both patient/family factors (e.g. perceptions of their physicians, willingness to raise their concerns assertively) and physician factors (e.g., knowledge gaps, communication skills). For example, patients' beliefs that primary care physicians as a group lack sufficient knowledge to treat depression may result from lack of familiarity with the scope of primary care training – but also the reality that post-graduate medical training in the United States (particularly in internal medicine) favors biomedical illnesses and underemphasizes the longitudinal follow up that is necessary to ensure good care of depression. A campaign to improve perceptions requires: (1) continuing to educate physicians about recognition and treatment of depression; (2) building communication skills to overcome social distance and distrust; (3) educating patients about the role of PCPs in depression diagnosis and care; (4) activating patients to help them bring their concerns to medical attention; and (5) helping physicians learn about community resources.

Primary care is the *de facto* delivery system for the majority of mental health care in the United States. Thus it was surprising that many participants in this U.S. study – the majority of whom were quite experienced with care-seeking for depression – regarded depression as falling outside the primary care domain. Similar beliefs have been described among patients in the United Kingdom.[36] For these individuals, bringing problems with mood, morale, and interest in usual activities to the attention of their PCP felt inappropriate, off-topic, or a potential boundary violation. Changing these perceptions may require a combination of social marketing, physician education, and restructuring of the primary care environment to reward listening without interruption as a valued activity leading to deeper understanding of patients' concerns.[37] Physicians should be aware that some patients may be reluctant to speak of mood symptoms out of the belief that it is not the physician's job to deal with these issues. Such misconceptions may leave patients stuck in the position of choosing between specialized mental health services (which may be stigmatizing)[38] and not seeking care at all.

Beyond concerns about PCPs' ability and willingness to address depression, patients were deterred by social, economic, and cultural factors that undermined trust. Social distance has been identified as a mediator of health care disparities and an obstacle to effective and satisfying care.[18] Low-income participants in our study were particularly concerned that primary care physicians seemed aloof from the day-to-day struggles attached to poverty, unemployment, and stigma. By contributing to a sense of hopelessness and futility among the most vulnerable, such perceptions might disrupt healing and deepen health disparities. Possible systemic solutions include supporting continuity of care (which allows for

formation of long-term, trusting relationships),[39] fortifying community health centers,[40] and diversifying the socioeconomic composition of the health care workforce.[41] In addition, communication skills training can enhance physician-patient communication and may reduce socioeconomic disparities.[42,43] Finally, considerable evidence suggests that system-based strategies for improving depression quality of care can improve outcomes for diverse populations.[44,45]

These results bolster confidence that the results of several smaller studies apply to the contemporary care environment in the United States. Cape et al. conducted interviews with 83 patients receiving care from nine general practices in the United Kingdom; 45% said they hesitated to seek care for psychosocial issues in primary care due to psychological embarrassment or hesitation to trouble the general practitioners (GP), and 19% were mainly deterred by the doctors' interview behaviors.[46] Similarly, in a qualitative study of 27 urban English patients with "stress," Kadam et al. found that many had reservations about approaching their GP with psychosocial problems, found it difficult to access a counselor/listener, and harbored important reservations about pharmacotherapy.[47] In the United States, Cooper-Patrick et al. interviewed 16 patients and seven health care professionals, identifying four sets of concerns that overlap with data presented here: importance of openness, empathy, and trust; the fragility of access; and the shadow of stigma.[48] In a small interview study, Saver et al. also identified missed opportunities for diagnosis and suboptimal patient education.[8]

The unique contribution of the current study is three-fold. First, the work is part of a formative research program including focus groups, conjoint analysis (a regression technique borrowed from marketing), and a population-based survey, specifically aimed at identifying educational and marketing themes to be addressed by the planned interventions. [49,50] Second, the results were obtained from a relatively large number of focus groups in multiple U.S. locations, increasing confidence in their robustness and generalizability. Third, the findings elevate the importance of perceived competence and interest as a critical psychological gateway to care-seeking for depression and perhaps other stigmatized conditions. It is a testable hypothesis that patients are less likely to divulge symptoms indicative of depression if they harbor doubts that the treating clinician has the requisite knowledge, skills, and attitudes to handle the problem. In a single study of 314 patients, Lewis et al. found that 65% thought that specialists were better able to care for depression. [51] More research is needed to understand the critical links among actual competence, perceived competence, and care seeking.

Our findings, while derived from a large, diverse qualitative research sample, should be interpreted in light of several limitations. First, the experiences of participants were likely different from the general population of depressed patients seen in primary care. In particular, due to self-selection, our patients may have been more seriously depressed, more likely to have been hospitalized, and more prone to complications. Second, histories of depression were self-reported; medical records were not reviewed and structured psychiatric interviews were not conducted, so the validity of their depression diagnoses is unconfirmed. Third, many themes could not be explored in the kind of depth that would have been afforded by individual interviews. In addition, focus groups may foster collective thinking which can lead to reinforcement of some themes and avoidance of others. Nevertheless the focus group format permitted dynamic engagement with the issues and generated hypotheses to be tested in future research, including a population-based survey currently underway. More broadly, our sampling strategy may have limited our ability to understand the experiences of depressed individuals who *never* sought or received diagnosis and treatment. However, many of our participants went months and years before seeking care; their pre-

treatment experiences arguably offer an important window into the experiences of those who never sought care at all.

4.2. Conclusion

Patients with depression may be deterred from care seeking or disclosure by relational barriers, including negative perceptions of PCPs' mental health-related capabilities and interests or lack of trust. Though not widely discussed in policy circles, these beliefs challenge the paradigm of treatment of mental health conditions in primary care and should stimulate clinicians and investigators to meet patients "where they are."

4.3. Practice Implications

To the extent that patients' reservations about PCPs' competence, openness, or trustworthiness inhibit communication of critical clinical information, recognition and treatment of depression in primary care could be undermined. Physicians may have to directly seek clues to depression in populations at risk, particularly low-income groups [52,53]. At the same time, PCPs should continue to develop their depression management skills while supporting vigorous social marketing efforts to inform the public that primary care is a safe and appropriate venue for treatment of common mental health conditions. Most importantly, patients need to know that help for depression is available, treatment is effective, and recovery is possible – but that achieving good outcomes may take considerable persistence. Insights derived from these focus groups will guide future efforts to design targeted and tailored messages to enhance primary care-seeking for depression.

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Table 1

Guiding questions related to patient care-seeking for depression and primary care physician

Clinical stage	Guiding Questions
Appearance of depressive symptoms	If you thought you were depressed, <i>who would you tell?</i>
Perceived need for action	What kinds of things do you think should be said <i>to someone who was depressed</i> and who you thought needed treatment?
Care-seeking	<p>If you were feeling depressed, <i>where would you go to seek care/get help?</i></p> <p>What kinds of things might make it <i>difficult for people to get help/seek care?</i></p> <p>Tell me your thoughts about the average person's <i>ability or willingness to seek care for depression from the doctor</i> who cares for their general health concerns. We will call this doctor the "main doctor." How might these expectations impact your willingness to seek care?</p>
Request-making	<p>Let's talk now about specific kinds of care for depression.</p> <p>⇒ Please tell me how you feel about the usefulness of antidepressant medication for the treatment of depression.</p> <p>⇒ Please tell me how you feel about the usefulness of counseling or psychotherapy for the treatment of depression.</p> <p>Tell us about other issues that may be important to identifying and managing depression? Are there certain beliefs, values, or personal characteristics that are important?</p> <p>Tell me how your own beliefs, values, or personal characteristics might influence your interaction(s) with your main doctor. Are there things in addition to your own beliefs, values, or personal characteristics that make a difference in how your doctor should help you with depression?</p>

Table 2

Demographic characteristics of participants

Variable	Participants (N=116)									
	Pilot FG (N=19)		Low-income Female (N=26)		Mid-income Female (N=26)		Low-income Male (N=28)		Mid-income Male (N=17)	
	No.	%	No.	%	No.	%	No.	%	No.	%
Respondent type										
Personal Experience	11	58	14	54	10	38	13	46	8	47
Family member or friend	2	10	2	8	3	12	5	18	2	12
Both personal and family/friend	6	32	10	38	13	50	10	36	7	41
Female sex	13	68	26	100	26	100	0	0	0	0
Age, years										
25–45	9	47	10	38	18	69	13	46	4	24
46–64	9	47	16	62	8	31	15	54	13	76
Race/Ethnicity										
White	8	42	17	65	16	62	15	54	14	82
African-American/Black	4	21	4	15	4	15	6	21	1	6
Latino	3	16	4	16	5	19	3	11	1	6
Asian	1	5	1	4	0	0	1	3	0	0
Other	3	16	0	0	1	4	3	11	1	6
Educational Attainment										
Some high school	0	0	1	4	0	0	3	10	1	6
High school graduate/GED	4	21	5	19	0	0	7	25	2	12
Technical school/some college	8	42	11	42	4	15	10	36	5	29
College graduate	3	16	6	23	16	62	7	25	6	35
Postgraduate	3	16	3	12	6	23	1	4	3	18
Annual household income (US Dollars)										
>80,000	1	5	1	4	7	27	0	0	4	23
50,001–80,000	4	21	0	0	4	15	0	0	7	41
<=50,000	13	68	25	96	15	58	28	100	6	35

Variable	Participants (N=116)									
	Pilot FG (N=19)		Low-income Female (N=26)		Mid-income Female (N=26)		Low-income Male (N=28)		Mid-income Male (N=17)	
	No.	%	No.	%	No.	%	No.	%	No.	%
Regularly practice religion/participate in religious community	10	53	14	54	11	42	11	39	8	47
In general, would you say your health is...?*										
Excellent	2	11	1	4	4	15	4	14	1	6
Very good	4	21	7	27	14	54	6	21	10	59
Good	8	42	9	35	5	19	9	32	4	23
Fair	4	21	6	23	3	12	7	25	2	12
Poor	1	5	3	11	0	0	2	7	0	0
Have any kind of health coverage	14	74	18	69	23	88	20	71	14	82
Did not see a doctor in the past 12 months because of costs	9	47	15	58	5	19	10	36	3	18
Have a particular person or place to go to when sick or need health advice	17	89	22	85	22	85	25	89	14	82
Needed help in the last 12 months for emotional or mental health issues	15	79	22	85	19	73	25	89	14	82
Treated for emotional or mental health issues in the last 12 months	10	53	17	65	15	58	19	68	11	60
(If yes) How beneficial was the treatment you received?										
Not at all beneficial	1	10	0	0	1	6	1	5	0	0
Somewhat beneficial	6	60	9	53	6	35	7	37	7	64
Beneficial	3	30	8	47	9	53	11	58	4	36

* Some percentages do not add up to 100% due to rounding

Table 3

An Empirical Taxonomy of Relational Barriers to Depression Help-Seeking in Primary Care

Barrier	Problem Statement
Competence	Deficits in PCP knowledge or inflexibility in characterizing the clinical issues: <i>what they know</i> and <i>how they think</i>
Openness	Perception that mental health issues are not part of the PCP's <i>domain</i> ; social <i>distance</i> separating doctor and patient; deficits in depression-related <i>discourse</i>
Trust	While essential for supporting useful dialogue, trust is fragile, readily undermined by problems in <i>being</i> , <i>saying</i> and <i>doing</i> .

PCP=primary care physician