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Understanding Help-Seeking in Academic Medicine: A Phenomenological Study of the Help-
Seeking Process of Medical Students in Distress

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Education

by

Jason Abella Rock

2019

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ABSTRACT OF THE DISSERTATION

Understanding Help-Seeking in Academic Medicine: A Phenomenological Study of the Help-Seeking Process of Medical Students in Distress

by

Jason Abella Rock

Doctor of Education

University of California, Los Angeles, 2019

Professor Robert T. Teranishi, Chair

Students in U.S. medical schools experience a high occurrence of psychological distress which can impact their health, professional behavior, and ability to succeed academically (Dyrbye et al, 2005). Despite the growing attention to this topic and the increased provision of mental health services available to medical students, many obstacles still remain for the achievement of student well-being (Givens & Tija, 2002). In addition, little research has been reported on medical students' views on the help-seeking process; thus the aim of this study is to explore the attitudes of medical students regarding the process of seeking help for issues of distress encountered during medical school.

For the purposes of this study, in-depth interviews of medical students were used to examine the individual, interpersonal, sociocultural, and institutional factors that distressed medical students cite as reasons for their help-seeking decisions. The interview data and

subsequent analysis provided the following key findings: (1) help-seeking behavior is a result of not only deliberate, reasoned decision-making but also of spontaneous, reactive decision-making, (2) a positive help-seeking attitude and prototype increase willingness to get help, (3) the stages of the help-seeking process can be experienced non-linearly, (4) external and internal factors can cause delays at any stage of the help-seeking process, and (5) the way in which each student defines his or her own distress impacts his or her help-seeking behavior.

This study introduced the Integrated Model of Help-Seeking Behavior (IMHSB), which combined existing models to depict the help-seeking process as an intersecting array of circumstances, various systems, and personal and social meaning, all of which interact within the four distinct stages of help seeking. The findings support this revised model as a suitable framework for viewing help-seeking behavior and also as a flexible model for future research. The IMHSB provides an integrated approach which can assist educators and policy-makers in considering all the possible barriers and drivers that influence students' help-seeking behavior when planning strategies for supporting the mental health of medical students.

The dissertation of Jason Abella Rock is approved.

Federica Raia

Kristen Lee Rohanna

Margaret L. Stuber

Robert T. Teranishi, Committee Chair

University of California, Los Angeles

2019

DEDICATION

To all those in need of help; may you receive what you ask for, find what you seek, and encounter open doors wherever you knock.

TABLE OF CONTENTS

Chapter One: Introduction.....	1
Background and Context of Distress.....	2
Overview of the Research Design.....	9
Significance of the Study.....	11
Chapter Two: Literature Review.....	13
Distress among Physicians.....	13
Medical Students in Distress.....	15
Types of Student Distress.....	16
Consequences of Medical Student Distress.....	20
Contributing Factors to Medical Student Distress.....	23
Mental Health Treatment for Medical Students.....	29
Help-Seeking Behavior Model.....	31
Definition of Help-Seeking.....	32
Evolution of Help-Seeking Models.....	33
Integrated Model of Help-Seeking for Medical Students in Distress.....	36
Chapter Three: Methodology and Research Design.....	39
Research Questions.....	40
Research Design.....	40
Population.....	42
Site.....	44
Data Collection Methods.....	47
Data Analysis Methods.....	51
Ethical Issues.....	51
Credibility and Trustworthiness of the Study.....	53
Summary.....	54
Chapter Four: Findings.....	56
Summary of Participants.....	56
Theme 1: Help-seeking behavior may be influenced by more than deliberate reasoning processes...58	
Theme 2: Lack of time and confidentiality are common barriers to seeking help.....65	
Theme 3: Positive help-seeking attitude and prototypes improve willingness to seek help.....69	

Theme 4: Delays in the help-seeking process can occur at any stage.....	77
Theme 5: Help-seeking decisions are affected by how the student defines his/her distress....	90
Chapter Five: Discussion.....	96
Introduction.....	96
Pt I: Help-seeking behavior is a dual pathway process.....	97
Pt II: Positive help-seeking attitude and prototypes increase willingness to seek help.....	98
Pt III: Personal meaning has an impact on help-seeking behavior.....	100
Pt IV: Help-seeking can be a continual and non-linear process.....	101
Pt V: Internal and external factors cause delays at each stage of the help-seeking process.....	102
Pt VI: The Integrated Model of Help-Seeking Behavior.....	103
Limitations of the Study.....	104
Conclusion.....	105
Appendix.....	107
References.....	111

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To my son, Gavin. I look forward to spending more time with you, buddy. I hope all of my hard work will inspire you to push yourself in your academic career.

Last, but far from least, my deepest gratitude goes to my cherished partner, my best friend, and the love of my life, Kelley. None of this would have been possible without your constant help, tireless support, and unending love. For the longest time I've been saying how I can't wait to get our lives back. Well, the day is finally here. Let's make it awesome.

VITA

Education

2005 Bachelor of Arts (History)
University of California, Los Angeles

Professional Experience

1999-2007 Multimedia Developer
Center for Digital Innovation
University of California, Los Angeles

2007-present Instructional Designer
David Geffen School of Medicine
University of California, Los Angeles

Chapter One: Introduction

Students in U.S. medical schools experience a high occurrence of psychological distress which can impact their health, professional behavior, and ability to succeed academically (Dyrbye et al., 2005). In addition to the ethic that it is morally appropriate to help those in distress, it is also important to provide support and guidance to these students as undesirable habits that develop as coping mechanisms in medical school can carry over first into residency and then into the physician's career, thus lowering the quality of public health care in general (Shanafelt et al., 2002). Despite the growing attention to this topic and the increased provision of mental health services available to medical students, many obstacles still remain for the achievement of student well-being (Givens & Tija, 2002). In addition, little research has been reported on medical students' views on the help-seeking process; thus the aim of this study is to explore the attitudes of medical students regarding the process of seeking help for issues of distress encountered during medical school.

For the purposes of this study, in-depth interviews of medical students were used to examine the individual, interpersonal, sociocultural, and institutional factors that distressed medical students cite as reasons for their help-seeking decisions. The identification of key factors will contribute to a holistic model of help-seeking that will improve understanding in areas of the process that may be ignored with a generic, linear model of help-seeking. The findings from this qualitative study will provide a much-needed perspective about this population and could have practical implications for the development of targeted programs to better assist medical students.

Background and Context

Impairments related to distress among medical professionals have been well documented in the past several decades (Levey, 2001). Possible responses to this distress include depression, burnout, anxiety, substance abuse, and suicide, which is much higher among physicians than the general population; specifically, it is 40% higher among male doctors and 130% higher among female doctors (Schernhammer, 2005). Patients also suffer from physician distress as it can lead to a higher incidence of medical errors (West et al., 2009; Fahrenkopf et al., 2008) and suboptimal care (Shanafelt et al., 2002). Studies suggest that distress is most commonly experienced during periods of learning acquisition such as early in a physician's career, residency training, and throughout medical school (Shanafelt et al., 2009; Shanafelt et al., 2012). It is also suggested that the distress experienced during residency and beyond may originate in medical school (Krakowski, 1985). Thus, helping distressed medical students learn healthy coping strategies early in their training can help improve their well-being as well as prepare them to better manage the stress encountered throughout the different stages of their training and career.

The Impact of Distress

The issue of distress experienced by medical students has concerned researchers for decades and is a problem that recent studies such as Goebert (2011) and Dyrbye et al (2011) suggest is still prevalent. Dickstein (1990) estimated that 4% to 18% of medical students seek help for mental health problems while Cockrell (1991) estimated 10% to 20% of all medical students who become physicians will experience a psychiatric disorder during their career. A more recent study by Dyrbye et al (2008) suggests that more than half of the medical student

population might be in some form of psychological distress, with up to 25% suffering from depression and 10% experiencing thoughts of suicide. In addition to these numbers are all of the students, residents, and practicing physicians that experience undiagnosed or unreported suffering and impairments. The rate of mental illness observed in medical students is higher than that of their peers (Schwenk et al., 2010) despite the similarity in mental health profiles between matriculating medical students and their same age counterparts in the general population (Brazeau et al., 2014). This disparity may result from various stressors specific to medical school such as the clinical training environment (Colford, 1989), abuse by clinical faculty (Kassebaum and Cutler, 1998), ethical issues (Christakis and Feudtner, 1997), and introduction to death and suffering (Binienda et al., 2001), all of which can compound the institutional factors present in any demanding school program as well as personal factors experienced by individual students. The contributing factors to medical student distress will be discussed more in Chapter Two.

Types of Student Distress

Stress. Stress can be defined as “a physical, mental and emotional response to a challenging event,” (Mayo Clinic, n.d.). It can be positive or negative and is a normal part of life; negative stress, however, can reduce the quality of one’s life. Stress is inherent in the demands of medical education and while a certain amount of it can be useful as motivation for some students, in others it can be so intense that it can cause serious psychological and physical issues (Park and Adler, 2003; Mosley et al., 1994). The negative effects from stress may then lead to a decline in self-esteem and academic performance. A student that deals with stress by utilizing negative coping mechanisms that promote disengagement, “such as problem avoidance, wishful thinking, social withdrawal, and self-criticism,” (Dyrbye, 2010) is more likely to experience

anxiety, depression, and poor mental health as a consequence. Medical students in particular typically experience higher levels of stress than non-medical students (Guthrie, 1995), which highlights the necessity for proper stress management in medical school and appropriate intervention and aid when high stress levels cause a medical student to become distressed.

Burnout. When negative work-related stress continues for an extended period of time, the length of which may vary among individuals, then burnout may occur. Burnout is considered a state of poor mental health characterized by emotional exhaustion, depersonalization, and a decreased sense of accomplishment (Mayo Clinic, n.d.). According to the estimates from major studies of US medical schools, burnout has affected at least half of all medical students at some point in their training (IsHak et al., 2013; Dahlin and Runeson, 2007). Studies show a correlation of burnout with psychiatric disorders which may continue on past medical school and into residency and the physician's career (IsHak et al., 2013). More generally, there is speculation that when doctors experience burnout that it is not just because of the stress that they have experienced as practicing physicians, but rather it is due to a culmination of all the negative stress that they have experienced first as medical students, then as residents, and then finally as practicing physicians. Given the domino effect of untreated distress in medical school throughout residency and a physician's career and the detrimental effect this ultimately has on patient care, early recognition and intervention of distressed medical students is advantageous for both the students and the patients that they will eventually treat.

Depression. Clinical depression is a mood disorder characterized by a persistent feeling of sadness and loss of interest which can lead to various emotional and physical problems (Mayo Clinic, n.d.). High rates of depression have been reported among US medical students (Moffat et al., 2004; Guthrie et al., 1998). Rosal et al (1997) suggest that prevalence for depression

increases disproportionately over the course of medical school despite entering medical students sharing the same rate of depression as their same-age peers in the general population. Givens and Tija (2002) surveyed first and second-year US medical students and found that 24% of them were depressed according to the Beck Depression Inventory (BDI). Clark and Zeldow (1988) found that median BDI scores increased threefold during the first two years of medical school and that a quarter of the students were dysphoric with some even being clinically depressed. Not only does depression lead to negative consequences for the student during medical school, but it may also have a negative impact on patient care down the line.

Whatever the form student distress takes, prolonged experience of it has consequences. For medical students, these consequences include (1) dropping out (Dyrbye et al., 2011), (2) suicidal ideation (Dyrbye et al., 2008), (3) inadequate professionalism (Dyrbye et al., 2010), (4) decline in empathy (Woloschuck et al., 2004), and (5) poor health (Dyrbye et al., 2010). These consequences will be discussed in more detail in Chapter 2.

Contributing Factors to Medical Student Distress

Medical school students experience a higher rate of mental illness than their peers (Schwenk et al., 2010) even though they have similar mental health profiles when they begin medical school as their same age counterparts in the general population (Brazeau et al., 2014). Thus, it is worthwhile to consider the types of factors that lead to medical student distress. These factors can be categorized as personal, institutional, and those specific to medical school.

Personal factors. Research has shown that many non-school factors impact the mental health of a student such as pre-existing medical or mental illness, interpersonal stressors (e.g., death or illness in the family; relationship issues, and financial pressures) or an individual's

demographics (e.g., age, gender, race) (Goebert et al., 2009; Dunn et al., 2008; Hojat et al., 1999; Zoccolillo et al., 1989). A student may have less capacity for dealing with personal factors that contribute to distress when institutional factors and those specific to medical school are also present.

Institutional factors. Although medical schools cannot control personal factors for the students, they are responsible for the aspects of the learning environment that can have a positive or negative effect on the students. Institutional factors are those related to the school and are common to other high-level non-medical graduate programs such as (1) intolerable stress due to high workload, (2) concern for academic performance, and (3) attempting to master a large volume of information. However, according to the literature on stress in graduate school, students in medical school perceive higher levels of stress compared to their non-medical counterparts (Dyrbye et al., 2008). It follows that the greater degree of stress may be attributed to elements unique to the medical school curriculum that can challenge the well-being of a student throughout the different years of his training.

Factors specific to medical school. There are challenges medical students must face that are unique to medical school which can vary year by year and also by institution. The most unique feature of medical school compared to other graduate programs is the clinical portion of the curriculum which usually takes place in the students' third year. During clinical training, students are rotated into new work environments at various hospitals that require different knowledge and skills that can highlight their deficiencies as opposed to their progress (Colford, 1989). In addition to this stress during clinical training, students can find themselves separated from their peer-support group and exposed to unfamiliar levels of human suffering amidst an unstructured learning environment. Firth (1986) identified four events that are most likely to

impact medical student distress: (1) talking to psychiatric patients (2) presenting cases (3) dealing with death and suffering and (4) effects on personal life. Of the four events identified by Firth, the first three are particular to the medical school curriculum. Verbal abuse of students by doctors and ethical issues are also factors that contribute to medical student distress. In a study by Silver et al (1990) 40% of the medical students said that verbal abuse caused them stress. Feudtner's (1997) study of 3rd and 4th year medical students showed that more than two thirds of a population of 3rd and 4th year medical students experienced guilt from participating in unethical behavior by physicians.

Barriers to Treatment of Mental Health of Medical Students

Although medical students are aware that they will experience a significant amount of stress during their medical training and that high levels of stress can lead to poor mental health, most of them are still unwilling to seek the help of mental health professionals when their stress levels are dangerously high. Some reasons for this undertreatment of depression are common to the general population (e.g., incorrect diagnosis, little or no access to treatment, stigmatization, and cost). In addition to these factors, a study by Givens and Tija (2002) found other barriers to treatment as reported by medical students that include: lack of time, lack of confidentiality, and fear of a negative impact on their career as a medical professional. The stigma associated with using psychological counseling may affect a student's ability to obtain a position as a resident (Oppenheimer et al., 1988). Unfortunately, depression can present significant short-term, as well as long-term consequences (due to its recurrent nature), when an appropriate level of treatment is absent (Givens and Tija, 2002). Stress should be identified and attended to as early as possible in

a medical student's career in order to prepare them for the demanding nature of training and practicing in the medical field.

Existing Interventions. Medical schools across the country have become more aware of the causes and consequences of student distress which has prompted the development of programs to address the issue. One way schools have approached the problem is through curricular reform such as decreasing class size and lecture hours, increasing problem-based learning approaches (Kiessling et al., 2004), and adoption of pass/fail grading systems (Bloodgood et al., 2009). In addition to changes made to the curriculum, schools have also implemented a variety of interventions including: (1) cognitive behavioral training, (2) psychotherapy, (3) counselling, (4) adaptive and communication skills training, (5) social support, and (6) relaxation and physical exercise. Increasing attention has been paid to the promotion of student well-being by medical schools (Peisah et al., 2009) and the Liaison Committee on Medical Education (LCME) requires that schools provide medical students with access to diagnostic, preventive, and therapeutic health services, timely access to needed services in reasonable proximity, information about where and how to access health services, and policies that permit students to be excused from class or clinical activities to seek needed care (LCME, 2013). Despite their availability, these resources may be under-utilized by medical students due to an inability or unwillingness to identify their issues and seek treatment (Givens and Tija, 2002).

Help-Seeking Behavior. The unwillingness of people to pursue professional mental health care is one of the most significant barriers that face interventions designed to prevent and treat mental health problems (Rickwood and Thomas, 2012). Research by Cornally and McCarthy (2011) suggest that a lack of understanding of the intricacies of the help-seeking

process may play a role in the ineffectiveness of interventions designed to improve help-seeking for health-related issues. Because of the need to examine the reasons why most people do not seek professional help, it is essential to patient advocacy and care that we increase our understanding of help-seeking behavior (Macnee et al., 2006).

Research Questions

In order to gain a better understanding of the help-seeking process as experienced by medical students in distress, the following research questions are proposed:

1. How do medical students perceive the experience of seeking help for distress?
 - a. What precipitates the students considering seeking help for their distress?
 - b. What obstacles to getting care are perceived by the students?
 - c. What helps students to decide to seek help, if they do, despite the perceived obstacles?
2. How do students experience and understand the stages of delay in the help-seeking process?
 - a. Are there particular stages in the process where significant delay is encountered (e.g., from recognition of symptoms to making a decision to seek help)?
 - b. Does the delay, if any, come from external factors (e.g., slow response from potential helpers) or from personal ones?
 - c. Are there any stages in the process that students go through repeatedly before accessing help?
3. How does the meaning that a student attaches to his or her experiences influence his or her process of help-seeking?
 - a. How does a student define their distress and does this definition change throughout the help-seeking process?
 - b. What is the relationship, if any, between the way a student defines his or her distress and the decisions he or she makes?

Overview of the Research Design

Help-seeking is a multi-layered experience that varies depending on a broad range of individual, interpersonal, and sociocultural factors (Liang et al., 2005). Although some of the

reasons that students give for not seeking help have been described in prior research, the interviews from this study will reveal the significance for medical students of such factors as they relate to an overall process of help-seeking. To gain this understanding, a phenomenological approach was employed as this type of study identifies the meaning of the lived experiences of a specific concept by several individuals in order to find a composite description of the phenomenon (Creswell, 2007). Through the use of in-depth, semi-structured interviews, students were allowed to describe in detail the specific events that were influential throughout the various stages of seeking help. The collection and analysis of the responses of what the participants experienced and “how” they experienced it will help to develop a clear and comprehensive portrait of the help-seeking process. The elements of my research design are summarized in the following sections, details of which are provided later in Chapter Three.

Sample Selection

The site for this study was the David Geffen School of Medicine at UCLA (DGSOM), a four-year public institution that is ranked among the nation’s elite medical schools and recognized as a leader in research, medical education, and patient care. This site was selected because of its (a) diverse student body (b) availability of resources for distressed students, and (c) presence of typical curricular stressors. My eleven years of service for DGSOM has enabled me to gain access to and support from various colleagues and gatekeepers regarding this study. At the conclusion of my study, I will present the findings to the Office of Student Affairs in order to discuss any possible interventions. Any intervention plans that are developed may then be brought to the leaders of the appropriate programs for feedback and possible implementation.

The targeted population for this study consisted of 10 students who had started their second year of instruction. In order to yield as much useful data from a small sample as possible, I used a purposeful sampling technique in which I selected students with experience at any of the following stages (1) accessed formal or informal support, (2) actively seeking support, (3) identify as experiencing distress but have not sought support. I also considered additional qualifications considered important such as availability, willingness to participate, and the ability to expressively, reflectively, and articulately communicate experiences and opinions (Bernard, 2002; Spradley, 1979). This sample provided data regarding the challenges experienced in using the support services as well as what experiences prompted these students to get help when they did.

Significance of the Study

The value in helping students in distress early on is twofold. Firstly, it is morally desirable to help those in need and as these medical students experience distress, it is appropriate to provide them with adequate support. Secondly, if distressed students receive assistance early on and develop positive, rather than negative, coping mechanisms, then they will develop into better doctors and provide better patient care, thus raising the quality of public healthcare overall.

The purpose of this study is to address the gaps in our knowledge about the process that medical students go through while seeking help for their distress. The findings from this study will assist educators and policy makers in medical education by increasing our understanding as to how various individual, interpersonal, sociocultural, and institutional factors have helped these students in distress to seek and utilize help. This new knowledge may be useful in determining

how to better help other students in distress to find appropriate assistance earlier on in their medical careers.

Chapter Two: Literature Review

Students in U.S. medical schools experience a high occurrence of psychological distress which can impact their health, professional behavior, and ability to succeed academically (Dyrbye et al., 2006). Despite growing attention to this topic and the increased provision of mental health services available to medical students, many obstacles remain that impede support of student well-being (Givens, 2002). This literature review begins by explaining how distress impacts members of the healthcare community including medical students, residents, physicians, and patients. Next, I discuss the various manifestations of distress (e.g., stress, burnout, and depression) and the characteristics that differentiate them from one another. The next section will focus on the consequences of student distress in areas such as academic performance, professionalism, empathy, student health, and suicide. To better understand what causes student distress, I will then discuss possible contributing factors including personal factors (e.g., demographics, learning disabilities and approaches) and institutional factors (e.g., curriculum and faculty abuse of students) and sociocultural. Finally, I will present the barriers to treatment that medical students are most likely to encounter, as well as the existing interventions that institutions have implemented to mitigate student distress. This literature review will conclude with a discussion of help-seeking models from existing research.

Distress among Physicians

In healthcare systems throughout the world, physicians have faced increasing pressure from work-related stressors that include long work days and other time pressures, high performance expectations (Rutledge et al., 2009; Stucky et al., 2009) as well as emotionally challenging situations (e.g., difficult interactions with patients and their families, fear of failure,

and exposure to death and suffering) (Lee et al., 2009; Wallace et al., 2009). The impact of these factors on physicians has led to high rates of distress which can manifest in various forms such as burnout, anxiety, and depression. A study of 704 physicians in the UK showed that 31.1% reported excessive anxiety and 61.7% experienced exhaustion and stress (Chambers and Belcher, 1994). The majority of physicians in a large national study in Canada reported that their careers caused suffering in their lives (55%) and that the ability to switch careers was difficult (65%) (Sullivan and Buske, 1998). Twenty-four percent to seventy-six percent of physicians report burnout, the wide range being attributed to differences in setting and specialty (Grassi et al., 2000; Shanafelt et al., 2002; Visser et al., 2003). Other forms of physician distress include substance abuse, broken relationships, disillusionment, and suicide. Suicide specifically is 40% higher among male doctors and 130% higher among female doctors than it is in the general population (Schernhammer, 2005). Moreover, compared to the general population, physicians are more likely to experience distress (Shanafelt et al., 2012) yet less likely to effectively manage their distress on their own or to seek professional care (Wallace et al., 2009).

The individual physician is not the only one who suffers if he or she is distressed. If the physician's ability to provide optimal patient care is compromised by distress, as the data suggest, then the impact on the overall healthcare field is significant. Studies have shown that physician burnout can lead to lower patient satisfaction rates and a higher incidence of medical errors (Shanafelt et al., 2002; Fahrenkopf et al., 2008; Williams et al., 2007). Burnout, along with anxiety, has also been attributed to increases in absenteeism, job turnover, and early retirement (Brown et al., 2009; Rutledge et al., 2009; Van Den Hombergh et al., 2009). The pressure on physicians is likely to increase as long as the medical care industry continues to see rises in managed care malpractice premiums, and restrictions to physician autonomy and

reimbursements (Murray et al., 2001). Further compounding this issue is an impending physician shortage in the United States that the Association of American Medical Colleges (AAMC) estimates will grow as large as 90,000 physicians by 2025.

Studies suggest that distress is most commonly experienced during periods of learning acquisition such as early in a physician's career, residency training, and throughout medical school (Shanafelt et al., 2009; Shanafelt et al., 2012). It is also suggested that the distress experienced during residency and beyond may originate in medical school (Krakowski, 1985). Thus, a possible approach to mitigate physician stress is to facilitate the development of healthy coping strategies as early as possible in the physician's career, possibly as early as the first year of undergraduate medical education.

Medical Students in Distress

The distress experienced by medical students has concerned researchers for decades and is a problem that recent studies suggest is still prevalent (Goebert, 2011; Dyrbye et al., 2011). Dickstein (1990) estimated that 4% to 18% of medical students seek help for mental health problems while Cockrell (1991) estimated 10% to 20% of all medical students who become physicians will experience a psychiatric disorder during their career. A more recent study by Dyrbye et al. (2008) suggests that more than half of the medical student population might be in some form of psychological distress, with up to 25% suffering from depression and 10% experiencing thoughts of suicide. In addition to these numbers are all of the students, residents, and practicing physicians that experience undiagnosed or unreported suffering and impairments.

The rate of mental illness observed in medical students is higher than that of their peers (Schwenk et al., 2010) despite the similarity in mental health profiles between matriculating

medical students and their same age counterparts in the general population (Brazeau et al., 2014). This disparity may result from various stressors specific to medical school, such as the clinical training environment (Colford, 1989), abuse by clinical faculty (Kassebaum and Cutler, 1998), ethical issues (Christakis and Feudtner, 1997), and introduction to death and suffering (Binienda et al., 2001), all of which can compound the institutional factors present in any demanding school program, as well as personal factors experienced by individual students.

Types of Student Distress

Stress. Stress can be defined as “a physical, mental and emotional response to a challenging event,” (Mayo Clinic, n.d.). It can be positive or negative and is a normal part of life; negative stress, however, can reduce the quality of one’s life. Stress is inherent in the demands of medical education and while a certain amount of it can be useful as motivation for some students, in others it can be so intense that it can cause serious psychological and physical issues (Park and Adler, 2003; Mosley et al., 1994).

The negative effects from stress may lead to a decline in self-esteem and academic performance. Whether stress affects a student positively or negatively is largely a function of how the student deals with it. If the student turns to positive coping mechanisms that keep her engaged, “such as positive reinterpretation, reliance on social support, and expression of emotion,” (Dyrbye, 2010) then the student is more likely to adapt and thus maintain good mental and physical health. On the other hand, if the student utilizes negative coping mechanisms that promote disengagement, “such as problem avoidance, wishful thinking, social withdrawal, and self-criticism,” (Dyrbye, 2010) then she is more likely to experience anxiety, depression, and poor mental health as a consequence. Medical students in particular typically experience higher

levels of stress than non-medical students (Guthrie, 1995), which highlights the necessity for proper stress management in medical school and appropriate intervention and aid when high stress levels cause a medical student to become distressed.

Burnout. Burnout may occur when work or school related stress continues for an extended period of time, the length of which may vary among individuals. The concept of burnout was first conceptualized by Freudenberger (1974) to describe the experience of fatigue and dissatisfaction which led physicians to walk away from the healthcare profession (Kacmaz, 2005). Physicians, in particular, are likely to experience high stress and work overload combined with an inadequate amount of support and resources that produce a situation more likely to lead to burnout (Santen, Holt, Kemp, Hemphill, 2010). A revised model of burnout was developed by Maslach and Jackson (1981) that consisted of the following three dimensions: (1) *Emotional exhaustion*: “feelings of busyness, tiredness, exhaustion, and overload” (Duru, Duru, & Balkis, 2014), (2) *Depersonalization*: “negative, rigid, and/or unemotional attitudes and behaviors of a person against others in the interaction” (Kacmaz, 2005), and (3) *Poor personal accomplishment*: “negative personal evaluation of oneself as unsuccessful, insufficient, and powerless when dealing with problems” (Duru, Duru, & Balkis, 2014).

Researchers have looked beyond professional environments and discovered the prevalence of burnout among students in higher education (Cushman & West, 2006; Jacobs, Dodd, 2003) as well as medical education (Santen, Holt, Kemp, & Hemphill, 2010; Balogun, Pellegrini, Miller, & Katz, 1999). According to the estimates from major studies of US medical schools, burnout has affected at least half of all medical students at some point in their training (IsHak et al., 2013; Dahlin and Runeson, 2007). In a medical school setting, a typical student may encounter elements such as a tremendous workload, inadequate support, loss of control, and

a diminished sense of personal accomplishment, all of which can contribute to burnout in at least two dimensions, emotional exhaustion and depersonalization (Santen et al., 2010). An emotionally exhausted student may feel overwhelmed and powerless which leads to cynicism, apathy, and indifference toward the academic process and, in turn, a decrease in academic achievement (Duru, Duru, & Balkis, 2014). Studies show a correlation of burnout with psychiatric disorders which may continue on past medical school and into residency and the physician's career (IsHak et al., 2013).

More generally, there is speculation that when doctors experience burnout, it is not just because of the stress that they have experienced as practicing physicians, but rather it is due to a culmination of all the negative stress that they have experienced first as medical students, then as residents, and then finally as practicing physicians. A study by Santen et al. (2010) supports the idea that burnout in the medical profession is initially developed in medical school and increases as a student progresses through training and practice. Given the domino effect of untreated distress in medical school throughout residency and a physician's career and the detrimental effect this ultimately has on patient care, early recognition and intervention of distressed medical students is advantageous for both the students and the patients that they will eventually treat.

Depression. Depression, one of the most common medical disorders in the world (Kessler et al., 2003), is characterized by a persistent feeling of sadness and loss of interest which can lead to various emotional and physical problems (Mayo Clinic, n.d.). The stress faced by medical students and residents during the course of their training can take a toll on their physical and mental health, cause decreased academic performance, and ultimately, cause these individuals to be more vulnerable to depressive symptoms (Mosley et al., 1994). Discerning whether a medical student is clinically depressed or reacting normally to the stress inherent in the

curriculum is problematic for faculty and students alike (Rosenthal & Okie, 2005). It is not uncommon for depressed students to discount their feelings and neglect adequate self-care and some will even continue to do so after being taught the appropriate, evidence-based diagnoses and treatments for depression (Whitcomb, 2004). Tija et al. (2005) found that students are more likely to be treated when there is an actual diagnosis of depression. It was therefore suggested by Tija et al. (2005) that medical schools should periodically screen students for possible mental health issues rather than relying on students to self-diagnose and seek help independently.

Although there is a wider range (2%-35%) of prevalence rates for depression among medical students and residents compared to non-medical graduate students or same-aged members of the general population (8% to 15%), there is evidence that depression is more common for those studying medicine (Mosley et al., 1994; Clark et al., 1984; Dyrbye, Thomas, & Shanafelt, 2006). Moffat et al. (2004) and Guthrie et al. (1998) reported high rates of depression among medical students. Givens and Tija (2002) surveyed first and second-year US medical students and found that 24% of them were depressed according to the Beck Depression Inventory (BDI). Rosal et al. (1997) suggest that despite matriculating medical students sharing the same rate of depression as their same-age peers in the general population, the prevalence for depression increases disproportionately over the course of medical school. Clark and Zeldow (1988) found that median BDI scores increased threefold during the first two years of medical school and that a quarter of the students were dysphoric with some even being clinically depressed. According to Dyrbye, Thomas & Shanafelt's (2006) review of the literature, symptoms of depression among medical students are most common in the second year of training. Depression at any point during medical training can lead to negative consequences for the student, and may also have negative consequences for their future patients.

Consequences of Medical Student Distress

Whatever the form student distress takes, prolonged experience with it has consequences. For medical students, these consequences include low academic outcomes, inadequate professionalism, decline in empathy, poor health, and suicide.

Academic Underperformance. Anxiety and stress can have a detrimental effect on cognitive function (e.g., declarative memory, concentration, and processing), leading to poor academic outcomes (Sarason & Sarason, 1990; Zeidner, 1998). Failure on high stakes licensing exams, such as the USMLE (United States Medical Licensing Examination), has been attributed to high levels of anxiety (Powell, 2004).

Professionalism Deficits. Professionalism in the medical community is a core competency during all levels of medical training (i.e., undergraduate medical education, residency, and physicianship) and brings together the following attributes: honesty, integrity, responsibility, sense of duty, compassion, respect for others, teamwork, professional demeanor, and accountability (Dyrbye et al., 2010). Guerrasio, Garrity, & Aagaard (2014) observed that professionalism deficits in medical professionals increased throughout the training process. The researchers provide possible explanations for this finding including: (1) increasing rates of burnout, (2) increasing expectations of professional behavior, and (3) decreasing restraint on behavior by attendings and fellows. Findings from a cross-sectional study by Rennie & Rudland (2003) suggest that as medical students progress through different years of training they are more likely to consider cases of academic dishonesty as acceptable, and be more willing to engage in that type of unethical behavior. Dans (1996) asserts that dishonest behaviors related to patient care, such as lying about tests ordered or tasks performed, may be a result of a student's fear of

appearing neglectful or unintelligent. A large, multi-institutional study by Dyrbye et al. (2010) found that medical students experiencing burnout were more likely to engage in academic and clinical dishonesty and less likely to have an altruistic attitude towards the profession (e.g., willingness to care for medically underserved populations).

Empathy Decline. Empathy, which is a central component of professionalism, is an important quality for any physician as it has been shown to improve the therapeutic effect, the patient's quality of life, and diagnostic accuracy. In a clinical setting, empathy is defined as the physician's ability to recognize and understand a patient's perspectives and experiences, and convey that understanding back to the patient (Hojat et al., 2004). Empathy is key to a good doctor-patient relationship as it can facilitate patient trust and thus help the doctor obtain a thorough history. An empathic doctor is more receptive to the biopsychological, rather than the biomedical, model of disease and thus seeks a more complete understanding of the patient (Engel, 1990). Moreover, empathy contributes to the physical, mental, and social well-being of the patient. Kim et al. (2004) showed that patient-perceived physician empathy significantly influenced patient satisfaction as well as compliance in regard to information exchange, perceived expertise, interpersonal trust, and partnership. On the other hand, lack of empathy increases patient dissatisfaction and the risk of malpractice suits.

The AAMC considers empathy to be an important quality that all medical students should possess by the completion of their undergraduate medical degree (Medical School Objectives Writing Group, 1999). In a study of third-year medical students (n = 371) at Jefferson Medical College, Hojat et al. (2002) found that empathy scores were associated with clinical competency ratings suggesting that a student's ability to understand the feelings and experiences of a patient has a direct relationship with his degree of clinical competency; or, in other words, the more

developed a student's empathy, the more clinically competent he tends to be and the less developed a student's empathy, the less clinically competent he tends to be. Despite the emphasis on empathy in the context of medical education, studies have shown that medical students experience a decline in their empathic behavior throughout their training, especially in the third year when clinical training begins (Hojat et al., 2004, Hegazi & Wilson, 2013). Similarly, Bellini and Shea (2005) showed a decline in empathic concern that persisted through residency. The results of a multi-institutional, cross-sectional survey by Thomas et al. (2007) showed that students enter medical school with empathy levels similar to those of their same-aged counterparts in the general population. Thomas et al. (2007) also found that the decline in student empathy throughout the course of medical school was associated with student distress and quality of life.

Poor Health. Researchers have shown significant interest in student health issues as positive health habits can improve academic performance, psychological adjustment, and physician competency (Ball & Bax, 2002). A survey of medical students (n = 54) at the Indiana University School of Medicine found that students changed their health habits significantly during their adjustment to medical school and were more likely to consume more alcohol, exercise less, and experience decreased socialization; these changes increased the likelihood of depressive symptoms (Ball & Bax, 2002). According to data from a longitudinal study of a cohort of medical students by Newbury-Birch, Walshaw, & Kamali (2000), increased alcohol consumption can be a response by medical students to anxiety and stress. The suicide rate of practicing physicians is higher than the general population and may be partly explained by the effect of depressive symptoms that endure after undergraduate medical education and remain untreated (Frank, Biola, & Burnett, 2000).

Contributing Factors to Medical Student Distress

Medical school students experience a higher rate of mental illness than their peers (Schwenk et al., 2010) even though they have similar mental health profiles when they begin medical school as their same age counterparts in the general population (Brazeau et al., 2014). Thus it is worthwhile to consider the types of factors that lead to medical student distress. These factors can be categorized as personal, institutional, and those specific to medical school.

Personal Factors. Research has shown that many non-school factors impact the mental health of a student such as a pre-existing physical or mental illness, interpersonal stressors (e.g., death or illness in the family; relationship issues, and financial pressures) or an individual's demographics (e.g., age, gender, and race) (Goebert et al., 2009; Dunn et al., 2008; Hojat et al., 1999; Zoccolillo et al., 1989). A student may have less capacity for dealing with personal factors that contribute to distress when institutional factors and those specific to medical school are also present. For example, the significantly more demanding academic workload of medical education is a well-recognized source of distress for students, especially those with a learning disability, inefficient learning approach, or a learning deficit. As these personal factors relate to learning and can be directly addressed by the institution, they will be looked at in more detail.

Learning Disabilities. Learning disabilities (LD) refer to a group of disorders believed to be caused by dysfunction in the central nervous system resulting in difficulty with certain cognitive skills (e.g., listening, speaking, reading, writing, reasoning or math) (Rosebraugh, 2000; National Joint Committee on Learning Disabilities, 1987). These disorders are particular to each individual making the process of defining and diagnosing a learning disorder subjective and ambiguous in nature and, thus controversial (Horgan, 1996). It is estimated that 10% of the

population have learning disabilities. According to Ricketts et al. (2009), 6% of undergraduate students will declare a learning disability by the time of graduation. Paul, Hinman, Dottl, & Passon (2009) estimate that 9% of students in medical school will seek assistance through learning disability accommodations.

For students with learning disabilities, the adjustment to higher education can prove to be a difficult process (Enright, Conyers, & Syzmanski, 1996). LD students often have a work ethic in which they believe that effort correlates with achievement. For them, hard work equals high grades, while poor grades must be the result of either stupidity or laziness (Rosebraugh, 2000). Ineffective study habits plague LD students at the start of medical school and because increased effort on their part does not produce the desired outcomes, many suffer a loss of self-esteem or become clinically depressed (Rosebraugh, 2000). These feelings further compound the problem, and students can ultimately be left feeling trapped in a negative feedback loop (Rosebraugh, 2000). Stress and the “feeling of being misunderstood” are possible factors contributing to the issue of lower academic performance by these learning-disabled students entering postsecondary education (Denhart, 2008; Hoy et al., 1997; Mellard & Hazel, 1992). Adults with LD are more likely to experience significant anxiety and have difficulty coping with stress (Spekman, Goldberg, & Herman, 1992). Gregg, Hoy, King, Morelan, and Jagota (1992) found that, in higher education and rehabilitation settings, adults with LDs experienced levels of anxiety analogous to posttraumatic stress.

Janiga & Costenbader (2002) state that it is relatively common for learning disabled students to enter higher education without having received a formal diagnosis for their condition. Only after being confronted with a new style of learning and assessment does a problem emerge. When this happens, undiagnosed students must perform a cost/benefit analysis as to whether they

will seek a diagnosis in order to formally declare a learning disability. According to Walters & Croen (1993), some students develop coping strategies that mask their LD during undergraduate course work, but those same strategies are ineffective at dealing with the increased demands of medical school, thus exposing their disability. LD students who are made aware of their disability and begin to understand it will often become highly motivated to overcome the LD (Rosebraugh, 2000). Although they may have weaknesses with mental processing, LD students also possess well-developed reasoning abilities that allow them to identify their strengths and weaknesses in order to develop effective compensatory strategies for learning, test taking, and working cooperatively with educators (Grantham, Endicott, 1995).

Types of learning approaches. Of the various factors that can determine success in postsecondary education, a student's particular approach to learning is one of the most significant (Romanelli, Bird, & Ryan, 2009). Many researchers have observed this relationship between a student's learning approach and learning outcomes, but have also noted that the assessment type is an important factor in this relationship (Van Rossum & Schenk, 1984; Trigwell & Prosser, 1991; Marton & Saljo, 1997; Provost & Bond, 1997; Tait et al., 1998). The three main approaches to learning are (1) deep, (2) surface, and (3) strategic (Entwistle, 1997). In a deep approach to learning, the student attempts to gain understanding and construct meaning of the learning material, relates new ideas to previous knowledge and experience, and critically examines arguments and evidence (May et al., 2012). A student using a surface approach looks to memorize factual content in order to reproduce it later without understanding the content in a wider context or reflecting on the purpose of study (Reid, Duvall, & Evans, 2005). Students who demonstrate a strategic approach are motivated by competition with others to get better grades and will use whatever learning approach, deep or surface, that they believe will lead to success

(Newble & Clarke, 1986). Learning approaches are affected by different variables that include: (1) student characteristics, (2) learning environment, (3) student's perceived importance of the learning task, (4) lecturer's attitudes and enthusiasm, and (5) assessment type (Beattie, Collins, & McInnes, 1997). Learning difficulties can occur when there is a lack of congruence between the student's learning approach and the institution's instructional methods (Kassab, Al-Shboul, Abu-Hijleh, & Hamdy, 2006).

Medical students and learning approaches. With the highly competitive nature of medical school admissions, one would expect that a student accepted into an accredited medical school would possess the appropriate learning approach and skills necessary to succeed at this level of education. However, research indicates that medical students tend to begin their training using the same learning approaches they utilized as undergraduates even if these approaches are not the best ones for medical school (Haught & Walls, 2004; Mattick, Dennis, & Bligh, 2004). For example, students expecting to use a surface approach in medical school encounter difficulty organizing and integrating extensive amounts of content and will use their study time inefficiently by devoting it to the memorization of content (Paul, Hinman, Dottl, and Passon, 2009). As a result of lower test scores from this surface approach, students may then start to experience anxiety on tests or overall stress (Powell, 2004). Some studies propose that a deep learning approach by itself may not lead to success unless it is combined with other skills such as time management, effort regulation, and resource management (Crede & Philips, 2011; West & Sadoski, 2011). Medical students also experience a lower sense of control and higher anxiety about failure as the amount of learning material increases (Grover & Smith, 1981). Overall, many students are experiencing high levels of anxiety and stress regarding learning approaches, high workload, and management of study time (Olmesdahl, 1999).

Physicians and learning approaches. Students with a deep learning approach during undergraduate medical education are more likely to show a deep approach in their work as physicians which increases their chances to be highly satisfied with their career (McManus, Keeling, & Paice, 2004). These deep approach physicians also tend to view learning as a lifelong process and are more likely to continue academic training throughout their careers (Newble, Hejka, Whelan, 1990). Schon (1977) suggests a deep learning approach may improve the quality of a physician's practice by helping to develop her reflective and adaptive capacities. A study by Ferguson, James, O'Hehir, and Saunders (2003) suggests that a physician's learning approach and personality are significant predictors of stress, burnout, satisfaction, and approaches to work.

Learning deficits. At some point throughout undergraduate medical education or residency, an estimated 7% to 28% of learners will find remediation necessary in order to address deficits in competency (Hinman, Dottl, & Passon, 2009; Reamy & Harman, 2006). The most common problems for medical students include "inability to integrate large amounts of material, poor time and stress management, and poor test-taking skills" while residents are most likely to demonstrate "insufficient medical knowledge, poor clinical judgment, inefficient use of time, inappropriate interactions with patients and colleagues, and unacceptable moral behaviors" (Hinman, Dottl, & Passon, 2009; Olmesdahl, 1999). Although a large population of learners in medical education require remediation, the identification and unbiased assessment of underperforming learners and their deficiencies are problematic (Williams, Roberts, Schwind, & Dunnington, 2009). In a survey of 36 Midwestern medical schools, Paul et al. (2009) found that only 59% of schools assessed the learning styles of their students and one third of the schools assessed reading comprehension. Haught & Walls (2004) suggest that more medical institutions should implement reading comprehension assessments as about a third of medical students have

shown difficulty in this area. Medical students with learning deficits are more likely than other learners to be identified as distressed (Guerrasio, Garrity, and Aagaard, 2014).

Institutional Factors. Although medical schools cannot control all of the personal factors for the students, they can influence the aspects of the learning environment that can have a positive or negative effect on the students. Institutional factors that contribute to students' mental health problems and are common to other high-level non-medical graduate programs include: (1) excessive stress due to high workload, (2) high performance expectations, and (3) attempting to master a large volume of information. Various aspects of the curriculum (e.g., pedagogical methods, material, sequence) can cause a great deal of stress to students especially when they perceive that the lectures, syllabi, or content presented to them are disorganized and inadequately prepared (Dunn et al., 2009). Additionally, if student expressions of dissatisfaction with how a course is run is perceived by faculty as laziness or entitlement on the part of the students, this stress can be compounded (Dunn et al., 2009). While some students need to feel as if their professors are invested in their educational outcomes, others respond to the effects of curricular stress by developing increased resilience by becoming "more self-reliant in their study habits, time management, and self-directed learning" (Dunn et al., 2009). Another possible source of stress that comes from the learning environment is found in the attitudes of faculty and residents who, suffering from their own burnout, may display depersonalization and emotional exhaustion. Clinical and non-clinical faculty experiencing burnout can have a negative impact on the students who view them as role models (Santen et al., 2010).

According to the literature on stress in graduate school, students in medical school perceive higher levels of stress compared to their non-medical counterparts (Dyrbye et al., 2008). It follows that the greater degree of stress may be attributed to elements unique to the medical

school curriculum that can challenge the well-being of a student throughout the different years of his training.

Factors specific to medical school. There are challenges medical students must face that are unique to medical school which can vary year by year and also by institution. The most unique feature of medical school compared to other graduate programs is the clinical portion of the curriculum which usually takes place in the students' third year. During clinical training, students are rotated into new work environments at various hospitals that require different knowledge and skills that can highlight their deficiencies as opposed to their progress (Colford, 1989). In addition to this stress during clinical training, students can find themselves separated from their peer-support group and exposed to unfamiliar levels of human suffering amidst an unstructured learning environment. Firth (1986) identified four events that are most likely to impact medical student distress: (1) talking to psychiatric patients, (2) presenting cases, (3) dealing with death and suffering, and (4) effects on personal life. Of the four events identified by Firth, the first three are particular to the medical school curriculum. Verbal abuse of students by doctors and ethical issues are also factors that contribute to medical student distress. In a study by Silver et al. (1990) 40% of the medical students said that verbal abuse caused them stress.

Mental Health Treatment for Medical Students

Barriers to Treatment. Although medical students are aware that they will experience a significant amount of stress during their medical training and that high levels of stress can lead to poor mental health, most of them are still unwilling to seek the help of mental health professionals when their stress levels are dangerously high. Despite the ability to treat issues like depression, the usage of effective services, such as mental health counseling, by medical students has been low (Seigle et al., 1983). A study by Zoccolilo et al. (1989) found that only 40% of

students with depression had sought treatment with a counselor. Some reasons for this under-treatment of depression are common to the general population (e.g., incorrect diagnosis, little or no access to treatment, stigmatization, and cost). In addition to these factors, a study by Givens and Tija (2002) found other barriers to treatment as reported by medical students that include: lack of time, lack of confidentiality, and fear of a negative impact on their career as a medical professional. The stigma associated with using psychological counseling may affect a student's ability to obtain a position as a resident (Oppenheimer et al., 1988). Unfortunately, depression can present significant short-term, as well as long-term consequences (due to its recurrent nature), when an appropriate level of treatment is absent (Givens and Tija, 2002). Stress should be identified and attended to as early as possible in medical students' careers in order to prepare them for the demanding nature of training and practicing in the medical field.

Existing Interventions. Medical schools across the country have become more aware of the causes and consequences of student distress which has prompted the development of programs to address the issue. One way institutions have approached the problem is through curricular reform such as decreasing class size and lecture hours, increasing problem-based learning approaches (Kiessling et al., 2004), and adoption of pass/fail grading systems (Bloodgood et al., 2009). In addition to curricular changes, schools have implemented interventions such as: (1) cognitive behavioral training, (2) psychotherapy, (3) counselling, (4) adaptive and communication skills training, (5) social support, and (6) relaxation and physical exercise. Increasing attention has been paid to the promotion of student well-being by medical schools (Peisah et al., 2009) and the inclusion of well-being programs (e.g., wellness interventions, burnout prevention/reduction education, and instruction to improve self-care skills) is one of the mandates by the Liaison Committee on Medical Education (LCME), the

accrediting authority for medical schools in the United States. However, more research is required to adequately determine the efficacy of these interventions in producing long-lasting improvements (Finkelstein et al., 2007). The LCME also requires that schools provide medical students with access to diagnostic, preventive, and therapeutic health services, timely access to needed services in reasonable proximity, information about where and how to access health services, and policies that permit students to be excused from class or clinical activities to seek needed care (LCME, 2013). However, under-utilization of available resources has been reported which suggest an inability or unwillingness of students to identify their issues and seek treatment (Givens and Tija, 2002).

Help-Seeking Behavior Model

The unwillingness of people to pursue professional mental health care is one of the most significant barriers that face interventions designed to prevent and treat mental health problems (Rickwood and Thomas, 2012). There is a high incidence of mental health problems and an unmatching low level of service use and accompanying help-seeking behavior. This pattern is prevalent not only in the United States, but internationally as well (Zachrisson et al., 2006; Mauerhofer et al., 2009). Even in places where access to health care is good, people are reluctant to utilize professional help for mental health issues. One problem is that some mental health conditions have a gradual onset making the symptoms hard to recognize, which, in turn, makes it difficult for an afflicted individual to identify the problem as requiring medical attention. Help-seeking decisions made by those with these type of conditions owe more to the voluntary process of help-seeking rather than the nature of the health condition (Rosenstock et al., 1988).

Interventions designed to improve help-seeking for health-related issues have been shown to be less effective than expected (Cornally and McCarthy, 2011). For example, Tullman et al. (2007) postulate that the reason that the low success rate of mass-media campaigns designed to generate more help-seeking behavior in those experiencing the symptoms of Myocardial Infarction has been due, in part, to a misplaced emphasis on knowledge and awareness rather than the social cognitive factors that chiefly affect help-seeking behavior. This suggests that a lack of understanding in the intricacies of the help-seeking process may play a role in the ineffectiveness of interventions designed to improve help-seeking for health-related issues (Cornally and McCarthy, 2011). Because of the need to examine the reasons why most people do not seek professional help, it is essential to patient advocacy and care that we increase our understanding of help-seeking behavior (Macnee et al., 2006). Thus, the topic of help-seeking has become a higher priority for researchers and policymakers (Rickwood and Thomas, 2012).

Definition of Help-Seeking. Help-seeking, sometimes referred to as ‘health-seeking’, is considered to be a component of illness behavior and health behavior. Help-seeking is a dynamic concept that has evolved over the decades within the literature and has increasingly become more of a focus in recent research and intervention design models. The term ‘help-seeking’ emerged from the study of illness behavior, an area of medical sociology research that examines the behavior of people regarding their health, which includes “the way people monitor their bodies, define and interpret their symptoms, take preventive or remedial action, or utilize the health care system,” (Mechanic, 1982). As early as 1976, a study showed that people saw a doctor for only about 10% of their medically significant symptoms (Tuckett, 1976). The study of illness behavior examines the reasons why individuals choose not to seek help from health care professionals after encountering symptoms. Cornally and McCarthy (2011) analyzed a large

body of help-seeking literature in order to present the following description of the term ‘help-seeking’:

“Help-seeking behaviour represents intentional action to solve a problem that challenges personal abilities. The complex decision-making process begins with the recognition and definition of a problem, which leads to the decision to act, and this is influenced principally by social-cognitive factors. Once a behavioural intention is formed, the person moves to selecting a source of help, makes contact and discloses the problem in exchange for help.”

In other words, help-seeking is a problem-focused and planned behavior that involves interpersonal interaction with a selected source of support.

Evolution of Help-Seeking Models. Help-seeking is a complex process of decision-making prompted by a personally challenging problem (Cornally and McCarthy, 2011). Many researchers (e.g., Andersen, 1995; Goldsmith, Jackson, & Hough, 1988; Pescolido, 1992; Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005) have developed models to assist in understanding help-seeking behavior by determining how, where, and when people seek help for mental health problems. Several of these models stem from the same basic assumption that the first step of help-seeking for individuals is the acceptance that they have a problem, followed by an evaluation of the pros and cons of the help options available to them and an assessment of their willingness to seek help. Finally, a source of support is selected and applied. Veroff, Kulka, and Donovan (1981) describe this help-seeking process in four distinct stages: (1) recognition of the problem, (2) decision to seek help, (3) selecting a source of support, and (4) utilization of the support.

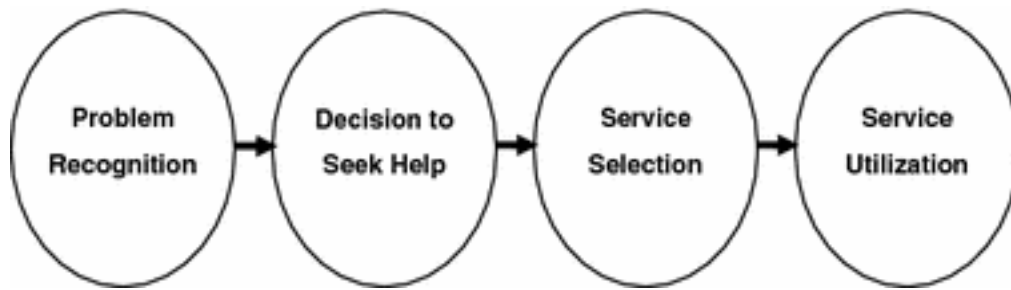


Figure 1. Stages of help-seeking behavior. Adapted from "Service Utilization among Ethnic Minority Children with ADHD: A Model of Help-Seeking Behavior" by Eiraldi, Mazzuca, Clarker, and Power, 2006. Copyright 2006 by Springer Science+Business Media, Inc.

Given the multitude of variables involved in modern help-seeking behaviors, including social, psychological, and cultural influences, it is difficult to imagine a single model that would perfectly describe every nuance of help-seeking behavior. However, although Andersen's (1995) Revised Behavioral Model of Health Services Use is not completely immune to this problem, it has proven to be versatile, adaptable, and widely used in the study of the help-seeking process.

Behavior Model of Health Service Use. Andersen's Behavioral Model of Health Service Use (BMHSU) was originally developed to investigate equity in health care access, but has been revised numerous times within the fields of public health and mental health in order to include all components of modern health seeking behavior (Andersen, 1995). The BMHSU provides researchers with a multidimensional model that combines societal and individual factors which affect each other throughout the help-seeking process. In this model, the process of help-seeking is a function of four key elements: (1) environmental component (e.g., health care system, political, economic), (2) population characteristics (e.g., social, health belief factors, perception of need), (3) health behaviors (e.g., personal practices, health service usage) and (4) service outcomes (e.g., perception of health status, evaluation of service). For many researchers, Andersen's model has been effective as a conceptual framework for studying the help-seeking

process (Bradley et al., 2002). Several modifications and expansions to this model have been made to emphasize the influence of various factors on the help-seeking process, for example, the development of the dual-process model which examines an individual's help-seeking behavior at a cognitive level.

Dual-Process Model. In the past, most research into the help-seeking decision-making process for those in need of professional psychological care has been based on the assumption that such decisions are made only by cognitive processes that are intentional and based on reason (Hammer and Vogel, 2013). This assumption ignores the fact that reactionary processes (e.g., heuristics and immediate impulses) are an equal, if not greater, influence on help-seeking decision-making (Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008). When used to explain variances in health-related behaviors, for instance, we find that a reasoned-choice model is only around 31% accurate (Armitage & Connor, 2001), whereas a model that factors in both reasoned and reactionary processes is 79% accurate (Gerrard et al., 2002). Thus, by using a dual-process model that combines both reason-based processes and reactionary processes, researchers have been more successful in accounting for help-seeking behavior for many health-related concerns (Gerrard et al., 2006; Gibbons et al., 2004).

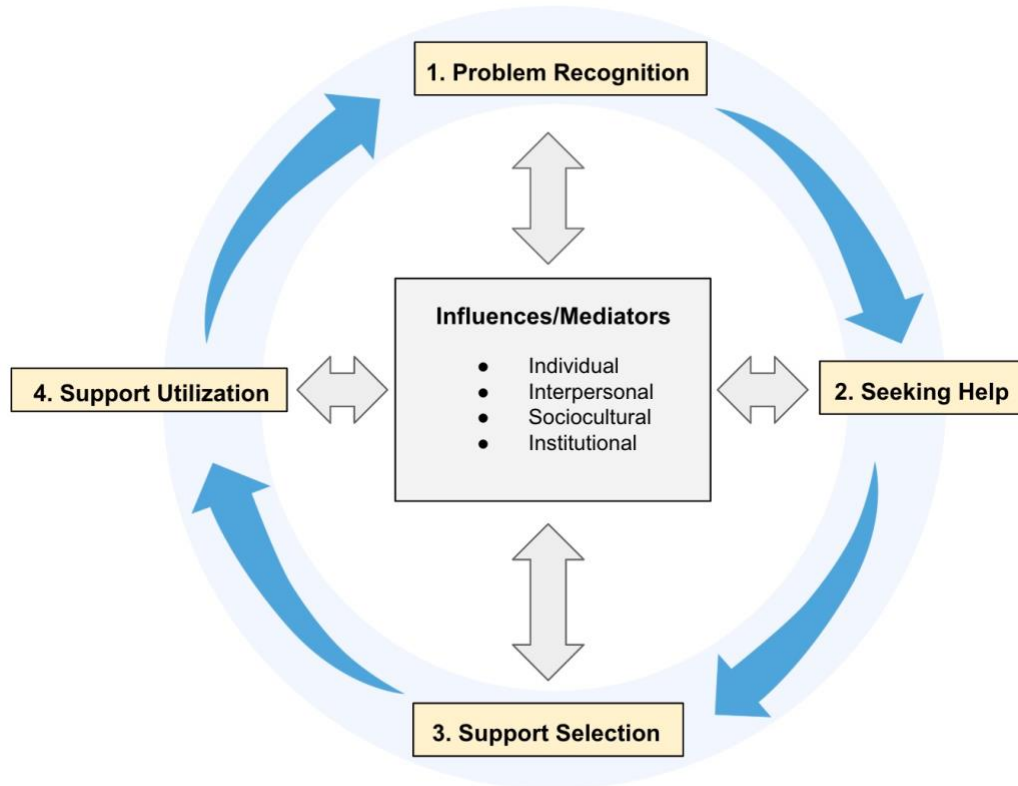
Prototype/Willingness Model. Of the various dual-process models used to examine help-seeking, the Prototype/Willingness Model (PWM) has been one of the most widely utilized by researchers. Hammer and Vogel (2013) describe the PWM as having two separate information-processing pathways: (1) “a reasoned path that impacts behavior through intention, akin to the pathway described by reasoned-choice models”, and (2) “an image-based social reaction path that impacts behavior through willingness.” An individual's willingness is generated through that individual possessing a positive prototype, or general idea or concept, of the target behavior

(e.g., help-seeking) or role (e.g., help-seeker). Willingness differs from intention to the extent that it describes an individual's openness to behavioral opportunity under the right circumstances, but does not signify a specific plan to engage in these behaviors (Gibbons, Houlihan, & Gerrard, 2009). In a health behavior context, willingness is often a greater predictor of an individual's choices than intention. Willingness is particularly more effective at predicting behavioral decisions when the behavior in question is unfamiliar (Gibbons et al., 2006; Pomery et al., 2009) or socially undesirable (Gibbons et al., 2003). Eiser, Eiser, & Pauwels (1993) have also found that reasoned-choice models are less accurate when there is an emotional component to a help-seeking behavior. In cases where individuals might benefit from counseling, willingness can be an important predictor of the decision to ultimately engage in such a service. Not only is it an emotionally loaded decision, but also often a novel and thus unfamiliar activity (Olfson & Marcus, 2010) that comes with public and personal stigma and thus is socially undesirable. When the possible negative effects of seeking help deter an individual from developing an intention to pursue help, willingness then becomes a much more predictive factor than intention in the help-seeking process when this individual is unexpectedly presented with a spontaneous opportunity to seek help, most often arising from a situation in which the individual experiences an unanticipated crisis (Hammer and Vogel, 2013).

Integrated Model of Help-Seeking for Medical Students in Distress. This study proposes a model of help-seeking that combines elements from prior models to represent the interconnectedness between the stages of the help-seeking process and the factors that influence them while also accounting for the possibility of the stages being experienced in different orders, simultaneously, or repetitively. The stages of this new model are the same as those proposed by Veroff, Kulka, and Donovan (1981): (1) recognizing the problem, (2) deciding to seek help, (3)

selecting a support source, and (4) utilizing the support. Although initial versions of this type of help-seeking model created the impression that these stages occur successively and that help-seeking is a linear process, this new model represents the idea that an individual can experience the process in different ways. For example, stages sometimes may occur simultaneously, appear in a different order, or be rapidly skirted. This model also depicts the stages as a cycle which suggests that help-seeking may be a continuous process. Individuals with very complex issues may need to go through numerous cycles of help-seeking as they may have to utilize different sources of support until they find a strategy or combination of strategies that work for them. In addition, there may be individuals with lifelong issues (e.g., learning disabilities or addiction problems) that require continual assessment of symptoms in order to manage their conditions and any related distress.

Inspired by the way in which Anderson's BMHSU framework demonstrates the relationship between the individual and external factors that lead to health service use, this new model organizes the different factors that influence the help-seeking process into four categories: individual, interpersonal, sociocultural, and institutional. By combining the two different help-seeking models mentioned, this new model makes it possible to show the relationship between the influencing factors and the stages of the help-seeking process thus providing a useful interpretive lens that can help identify patterns related to significant delay in the help-seeking process as well as guide reflection on the process as a whole.



The 4 Stages of the Help-Seeking Process	Factors that may influence the process
<p>Stage 1: Problem Recognition</p> <ul style="list-style-type: none"> • Symptom detection (physical, emotional, academic) • Interpretation of symptoms • Emotional reaction • Reappraisal of problem • Defining/Redefining problem <p>Stage 2: Seeking Help</p> <ul style="list-style-type: none"> • Problem is seen as undesirable • Use of own sources to fix problem • Recognition that outside help is needed to fix problem • Can I get help? (efficacy, accessibility) • Should I get help? (acceptability, prioritization, cost-benefit analysis) • How do I get help? (developing strategy, activation of social and institutional network) <p>Stage 3: Support Selection</p> <ul style="list-style-type: none"> • Identifying sources of support (formal or informal) • Selecting source of support • Contacting source of support <p>Stage 4: Support Utilization</p> <ul style="list-style-type: none"> • Initiation of support (eg treatment, medication, advice, referral) • Evaluation of support • Improvement 	<p>Individual</p> <ul style="list-style-type: none"> • Complexity of problem • Severity of problem • Individual's knowledge of problem • Coping style (problem or emotional focus) • Exhaustion of personal resources to deal with problem • Personal qualities (empathy, self-control, reflectiveness, openness) <p>Interpersonal</p> <ul style="list-style-type: none"> • Definition of problem by others (family, friends, faculty) • Level of support from social relationships <p>Sociocultural</p> <ul style="list-style-type: none"> • Access to resources • Stigmatizing attitudes held by public <p>Institutional</p> <ul style="list-style-type: none"> • Institutional recognition of problem • Stigmatizing attitudes in academic medicine culture • Providing resources to help students recognize problems (eg present individual success models; time for personal reflection) • Access to services • Privacy concerns and fear of effect on career (eg residency positions) • Lack of cultural sensitivity • Fear of unwanted intervention • Fear of documentation • Lack of availability of services

Figure 2. Integrated Model of Help-Seeking Behavior

Chapter Three: Methodology and Research Design

The discussion in the first two chapters brought to light the issue of medical student distress (i.e., an erosion of mental health that can manifest as stress, depression, and/or burnout) and its impact on student health, professional behavior, and academic performance. Despite the growing attention to this topic and the increased provision of mental health services available to medical students, many obstacles still remain for the achievement of student well-being (Givens and Tija, 2002). Research suggests that there is resistance within the profession to seeking help and, as a result, there is an ad hoc approach to dealing with stress and distress (Chew-Graham et al., 2003). In addition, little research has been reported on medical students' views on the help-seeking process; thus the aim of this study is to explore the attitudes of medical students regarding the process of seeking help for issues of distress encountered during medical school.

For the purposes of this study, in-depth interviews of medical students were used to examine the individual, interpersonal, sociocultural, and institutional factors that distressed medical students cite as reasons for their help-seeking decisions. The methods used in this study led to new interpretations of previously recognized factors and helped to identify emergent ones. The findings will contribute to a holistic model of help-seeking that will improve understanding in areas of the process that may be ignored with a generic, linear model of help-seeking. The research from this qualitative study will provide much-needed perspective about this population and could have practical implications for the development of targeted programs to better assist medical students.

Research Questions

In order to gain a better understanding of the help-seeking process as experienced by medical students in distress, the following research questions are proposed:

1. How do medical students perceive the experience of seeking help for distress?
 - a. What precipitates the students considering seeking help for their distress?
 - b. What obstacles to getting care are perceived by the students?
 - c. What helps students to decide to seek help, if they do, despite the perceived obstacles?
2. How do students experience and understand the stages of delay in the help-seeking process?
 - a. Are there particular stages in the process where significant delay is encountered (e.g., from recognition of symptoms to making a decision to seek help)?
 - b. Does the delay, if any, come from external factors (e.g., slow response from potential helpers) or from personal ones?
 - c. Are there any stages in the process that students go through repeatedly before accessing help?
3. How does the meaning that a student attaches to his or her experiences influence his or her process of help-seeking?
 - a. How does a student define their distress and does this definition change throughout the help-seeking process?
 - b. What is the relationship, if any, between the way a student defines his or her distress and the decisions he or she makes?

Research Design

Help-seeking is a multi-layered experience that varies depending on a broad range of individual, interpersonal, and sociocultural factors (Liang et al., 2005). Although quantitative methods have been used in past research to identify barriers that keep students from seeking support, quantitative data does not capture the voices of medical students that may provide a better understanding of the importance of these factors, the complex relationships between them, and the best possible approaches to overcoming them. A qualitative approach allows for “exploratory investigations” into the help-seeking process that can provide insight on what

factors determine help-seeking decisions (Scott and Walter, 2010). Looking at a distressed medical student's lived experience (i.e., first-hand accounts and impressions of everyday experiences as they are lived) uncovered themes that a quantitative approach would have missed. For example, as with medical records, questionnaires do not provide an opportunity for additional inquiry "into the type and timing of symptom onset"; more in-depth and detailed responses can be acquired using interviews (Scott and Walter, 2010). As the goal of this study was to gain a deeper understanding of the subjective process of distressed medical students regarding help-seeking, qualitative methods were the most appropriate for acquiring student narratives.

In order to collect the data necessary to develop a deep level of understanding, this study employed a phenomenological approach. Phenomenology, according to Svenaueus (2013), "explicates the meaning and structure of the activities carried out in the everyday world" and is a particularly useful approach in the investigation of health cases as it "explicates features that would otherwise have remained hidden in an exclusively natural scientific approach to the subject." Interviews or observations of individuals who have experienced the phenomenon are typically used in phenomenological research to answer research questions (Davison, 2014). In-depth, semi-structured interviews were used in this study to reveal the interrelation of help-seeking timing and behavior with the perceptions of the students for why they did or did not seek help. The interview questions in this study focused on the participants' descriptions of their own background and experiences as they relate to the challenges, as well as the supporting factors, to seeking help. The interview process allowed students to describe in detail the specific events that were influential throughout their help-seeking process. The responses were collected and then developed into a composite description of what the participants experienced and "how" they

experienced it (Moustakas, 1994). It was only through the participants' own stories that a clear and comprehensive portrait of the help-seeking process could be constructed. By using a phenomenological interview process, I was in a better position to provide data that was useful for answering the research questions posed in this study and broadening the understanding of help-seeking behavior.

Population

According to phenomenological research, the only valid and rational sources of data are the individuals that have experienced the phenomenon of interest (Baker, Wuest, & Stern, 1992). As typical help-seeking studies have excluded individuals who have not sought help, our understanding of a critical component of the help-seeking process, that is, the initial experience and detection of symptoms has been limited (Hay, 2008). Studies that only focus on individuals who have already sought help will measure perceptions of experiences that may have taken place months to years earlier which creates difficulty in accurately identifying the relationship between help-seeking factors and the amount of delay in accessing help (Scott et al., 2008). Typical sample populations in help-seeking research consist of those who have already sought help, yet it is not guaranteed that patients will seek help for their conditions, especially those that may not be perceived as life threatening. Therefore, for the purpose of this study, "the phenomenon of interest" must not only include those who have actively sought help or who are actively seeking it, but it must also include those who are experiencing distress at a level as high as others who did seek help. This study is important partly because there are distressed medical students who do not seek help and thus are at risk of becoming subpar doctors who provide subpar patient care. The goal of this study is to improve the understanding of this population which may lead to

the development of programs to support these students in actually getting help while they are in medical school so that they can become the best doctors they can be and thus provide the best patient care possible. Hence, the participants from this study included those with experience at any of the following stages (1) accessed formal or informal support, (2) actively seeking support, (3) identify as experiencing distress but have not sought support.

The sample for this study consisted of ten students from the population of students beginning their second year of instruction in medical school so as to gain insight relevant to catching problems that arise from student distress early on in a student's medical education and career. To select participants, a common technique in qualitative research was used called purposeful sampling (Patton, 2002) in which study participants were purposely, rather than randomly, selected because they had experienced the phenomenon of interest (Creswell, 2009). While a probabilistic or random sample is advantageous because it ensures the generalizability of findings, it requires a large sample size to ensure that results are representative of the population. For small samples, purposeful sampling is more effective at providing representativeness (Maxwell, 2005). In selecting participants I looked to include students that had utilized formal or informal sources of support, were actively seeking help, or had identified themselves as experiencing distress. However, as the additional qualifications of availability, willingness to participate, and the ability to expressively, reflectively, and articulately communicate experiences and opinions were also important to obtain useful and informative data (Bernard, 2002; Spradley, 1979), I also considered these characteristics when I selected participants. This sample provided rich data regarding all stages of the help-seeking process from symptom detection and interpretation to service utilization.

In this study, voluntary participation was sought from second year students at DGSOM. In order to identify participants, I used a combination of flyers and email invitations to the second-year student class. Students who responded to these requests received a brief survey via email. The survey included questions regarding their experiences with distress in medical school, the types of support services they selected, and basic demographic information. Data from the survey helped identify ideal candidates for the interview process who fulfilled a predetermined set of criteria. In order to be considered for an interview the participants had to be willing to openly talk and reflect on their experiences, be available for the interview process, and have experience in at least one of the following: (1) utilization of informal or formal support services, (2) seeking help, and (3) distress in medical school. Additionally, I selected participants with diverse characteristics (e.g., gender, socio-cultural background) in order to ensure maximum variability within the sample.

Site

The David Geffen School of Medicine at UCLA (DGSOM) was the site for this study. DGSOM is a four-year public institution that has a current student body of 722 full-time students (AAMC, 2016) and 3,216 full and part-time faculty on staff (DGSOM, 2015). Ranked among the nation's elite medical schools, DGSOM is recognized as a leader in research, medical education, and patient care. This site was selected because of its (a) diverse student body, (b) availability of resources for distressed students, and (c) presence of typical curricular stressors.

Diversity. Diversity is important so as to provide a sample that includes students from varying genders and ethnicities. The table below illustrates the diversity present in the population of all enrolled students at DGSOM at the start of the 2016-17 academic year. Although

participants will be sought out primarily by virtue of having personal experiences with distress in medical school that they are willing to recount, demographic characteristics will be considered as a secondary factor in selection of participants. The purpose of this sample, however, is not to be able to make generalizations based on similar demographic factors. The small sample size will make it statistically non-representative, but the ability to collect data from a diversity of participants makes the sample informationally representative (Troost, 1986).

Diversity of 2016-17 DGSOM Student Body (AAMC, 2016)	
Gender	
Men	366 (51%)
Women	356 (49%)
Ethnicity	
Asian	254 (35%)
White	215 (30%)
Hispanic/Latino/Spanish origin	77 (11%)
Multiple Race/Ethnicity	75 (10%)
African-American or Black	49 (7%)
Other	23 (3%)
Unknown Race/Ethnicity	19 (3%)
Non-U.S. Citizen and Non-Permanent Resident	9 (1%)
American Indian or Alaskan Native	1 (0.1%)

Resource availability. Considering that formal services provided by the institution are an important component of the conceptual model of help-seeking developed for this study, the site for this study must provide resources for its student body. Medical students at DGSOM have access to the Behavioral Wellness Center (BWC) as well as the UCLA Center for Psychological Services (CAPS). In addition, DGSOM provides other resources in order to support the physical, mental and emotional well-being of students including: optional events and workshops, a student well-being committee, a mindfulness program, and a graduate resilience peer network.

Curricular stressors. As certain aspects of a medical school curriculum provide additional stressors for students, the selection of the site must include some of the following well-recognized stressors seen at medical schools.

Matriculation. Students at DGSOM face the same stressors common to medical students at other schools who have to adjust to the first-year learning environment which can be both demanding (Dyrbye et al., 2005) and rapidly changing (Ball and Bax, 2002). The beginning of the year is more distressing due to the initial demands and the volume of course materials (Ball and Bax, 2002). Students in this transition encounter a significantly expanded amount of academic work (Guthrie et al., 1995) and concern for scholastic achievement (Supe, 1998). Students who encounter academic difficulties at the beginning of their first year are more likely to develop symptoms of distress by the end of the year (Stewart et al., 1999).

High-Stakes Examinations. A high-stakes exam, one that must be passed to advance throughout the program, frequently leads to performance anxiety (Kidson and Hornblow, 1982) and higher levels of stress (Rosenthal et al., 1990). In order to complete the MD program, students at DGSOM must pass several computer-based exams and clinical performance exams spread throughout the first two years of the curriculum and a Clinical Performance Examination at the end of the third year. In addition, DGSOM students must pass the National Board Examinations (USMLE Step 1, USMLE Step 2 Clinical Knowledge and USMLE Step 2 Clinical Skills) before they can graduate.

Site Access. I have worked at the David Geffen School of Medicine for over a decade as an instructional designer, multimedia producer, and educational technologist. Throughout my service, I have had an opportunity to work closely and develop relationships with many of the faculty, staff, and students from different departments within the organization. For the past few

years I have had many discussions with others throughout our institution regarding the topic of student distress. It was through these conversations that I became aware of the prevalence of student distress at our site, as well as the considerable amount of interest in finding better solutions to address it. My access to and support from various colleagues and gatekeepers regarding my study is an important asset in my ability to conduct research on this topic. At the conclusion of my study, I will first present the findings to the Office of Students Affairs in order to discuss any possible interventions. Any intervention plans that are developed may then be brought to the leaders of the appropriate programs for feedback and possible implementation.

Data Collection Methods

Interviews with Students. The data collection phase of this study included in-depth, semi-structured (i.e., guided) interviews with students in order to better comprehend the experience of help-seeking through the students' lived experiences and the meanings attached to them. The process of recounting stories is itself part of the meaning-making process (Seidman, 2013). Thus, the purpose of the interviews was to provide the participants with space and freedom to recount their stories and explain any meaning they have already constructed, as well as to reflect on any additional meaning that is developed as they do so. Toward this end, open-ended questions were used and, as some participants needed more encouragement than others to proceed with the reconstruction of their experience, an interview guide was used so as to enable the interviewer to keep the interview within the appropriate parameters determined by the purpose of the study (Wenden, 1982). During the interviews I strove to find the right balance between adhering to the guide and letting the participants talk freely as allowing them to discuss

matters which they wished to discuss, so long as these matters were related to the topic of study, yielded better data than an approach that strictly adhered to the guide (Weiss, 1994).

The interview guide for this study listed the main areas to be covered in the interview and also included a list of subtopics and questions to prompt the interviewee when it was necessary. Throughout the course of the interviews, certain topics arose that were then added to the interview guide to discuss with later participants. In addition to a list of general questions and some guiding questions, the interview model in this study followed Seidman's (2013) three stage process, which is based on the following themes: (1) establishing the context of the interviewee's experience, (2) construction of the experience, and (3) reflection on the meaning it holds. The principle behind this structure is that each stage "provides a foundation of detail that helps illumine the next" (Seidman, 2013).

The focus of the first stage of the interview was on providing a context of the participants' lives before starting medical school. Without this context it would be more difficult to explore the meaning of the participants' experiences (Patton, 1989). It was also the objective of this stage of the interview to develop good rapport and mutual trust with the participant which then allowed him or her to feel comfortable describing his or her personal experiences. The questions at the start of the interview aimed to put the participants' experiences during medical school in context by asking them to reconstruct their past help-seeking experiences prior to medical school. A general question was, "Could you describe an instance before medical school when you were experiencing emotional distress and what you did or didn't do to seek help for your distress?" When more guided questions were necessary during this section of the interview, they were asked something like "Can you describe a time when asking for help was a negative or positive experience?".

The second stage of the interview concentrated on the details of the participants' present lived experiences of help-seeking while in medical school by asking them to reconstruct a typical day and to include descriptions of their relationships with others (e.g., faculty, administrators, classmates and other peers, as well as others in the greater community outside of medical school). Participants were asked to recount stories of their present lives to encourage a reconstruction of their help-seeking experiences to assist in developing further understanding and meaning (Seidman, 2013). A general question in this stage was, "Could you describe an experience you had during medical school related to seeking help for distress?". A guided question was "Could you describe the moment when you first noticed you were struggling in medical school?".

In the third stage of the interview, I asked them to reflect on the "meaning" of the experience. The question of "meaning" will address the intellectual and emotional connections between the participants' work in medical school and their lives (Seidman, 2013). Such meaning may play a part in the student's help-seeking decisions. An example general question in the third stage was, "Could you describe what getting help means to you?". A more guided question example was "Could you describe the relationship between your distress and how you viewed yourself?".

Throughout the interview I used certain techniques (e.g., reflecting back what the participant said, positive body language, and verbal cues) to help the participant feel confident that he was being heard and that he was also free at any moment throughout the interview to provide any clarification or additional details. Some of these techniques (reflection, clarification, and requests for examples and descriptions) have been identified by researchers as essential components of the phenomenological interview process (Jasper, 1994; Polit and Hungler, 1991).

Although some structure was necessary in the interview to keep the focus on the phenomenon of interest, the nature of the interaction that occurred guided the progression of the interview (Seidman, 1991). The interview intended to promote reciprocity in the researcher-participant relationship and allow them to explore and reflect on stories in order to develop meaning. In this role, the researcher was a crucial factor in the research process and essential in drawing out and developing the reflective content from the participants (Wimpenny & Gass, 2000). As the interview process can employ various techniques and elements to elicit rich and detailed accounts of the participants' experiences, it is considered to be the primary method of data collection in phenomenological research (Kvale, 1996). I believe that among the data collection methods used in phenomenological research (e.g., interviews, diaries, visual art, and observation), the interview process was best suited for answering the research questions of this study.

To improve the effectiveness of my interview techniques and the usefulness of the interview guide, I conducted a short series of pilot interviews with colleagues so that I could practice the interview process. This allowed me to make adjustments to the design and my techniques before I started collecting data. Once I was ready to collect data, I identified participants for my study and sent them a request to schedule an interview. Most interviews were around 90 minutes in length, but a few were as long as 120 minutes. Participants were asked to choose a time and place that was convenient for them. Two audio recording devices were used during interviews to prevent loss of data. The recordings of the interviews were used to construct written transcriptions for coding and analysis of themes. Fictitious names were designated for participants to maintain anonymity.

Data Analysis Methods

The data collected from the in-depth interviews provided a rich depiction of how students understand and experience the help-seeking process. Following Glense's (2006) recommendation for analysis, I reflected upon the data as it came in and began preliminary analysis before I concluded my collection of data. According to Moustakas (1994), a phenomenological analysis of data is made through reflection and insightful meaning making. By immersing myself in the interview data through repeated examinations of audio recordings and verbatim transcripts, I was able to reflect upon the data as it unfolded throughout the data collection process. I coded the data in order to find common themes from the participants' stories. I re-examined the recordings and transcripts to search for new insight and new connections between participants. This method facilitated the refinement of categories until the major themes and subthemes emerged. I discuss the findings within these themes in Chapter Four. The next section will go into more detail regarding the steps taken to maintain the integrity of this study in the research design.

Ethical Issues

Prior to the collection of data, I took into account ethical considerations regarding this study. The project was submitted to the Institutional Review Board (IRB) and received approval once all IRB requirements were met. In addition, I upheld researcher standards and guidelines throughout my contact with participants. Perhaps the most significant ethical consideration for this study is the need to protect the confidentiality of each participant. As the context of my study explores the personal experiences and attitudes of students regarding the topic of distress, some

of the responses may cause harm to the participants if anonymity is broken. I had safeguards in place in order to ensure confidentiality was maintained.

Before interviews were conducted, participants were asked to sign an informed consent form that included information that described the (1) purpose of the study, (2) time commitments involved for each participant, (3) participant's rights, (4) researcher's responsibility to do no harm, (5) use of information in the study, and (6) safeguard procedures for maintaining privacy and confidentiality. Each participant was given this information about the research study until he or she fully understood it. This understanding allowed each potential participant to make an informed decision about whether or not to sign the consent form.

Once I began to collect data from the interviews, I coded material by using pseudonyms and by managing any identifying information in order to prevent someone from identifying a participant. Digital data was stored securely on encrypted machines and physical data was kept in a locked cabinet. At the end of the study the data will be deleted or destroyed.

Lastly, I considered any personal desire to have this study generate findings that would support a complex model of help-seeking which might lead to the identification of areas that could be targeted for new interventions and was fully willing to accept the possibility that the study might not provide data that goes beyond a generic and linear help-seeking model. In other words, it was important that I ensured that I was honest about my data collection, analysis, findings, and recommendations throughout the entire study and in no way allowed myself to be influenced by what I wanted the results to be.

Credibility and Trustworthiness of the Study

So that the data from this study will be useful in the research environment, I made a consistent effort to ensure that the research design and collection of data was trustworthy (Glesne, 2006). According to Patton (1999), the credibility of qualitative research must include proper methods for the collection of high-quality data along with an analysis of the data that carefully considers the issues of validity, reliability, and triangulation. To this end, I took measures to promote fairness and accuracy when I recorded the views of the study participants and ensured correctness when interpreting information discovered via study results and findings.

Validity. The first step in establishing validity in this study was to be aware of possible researcher bias so that I could take steps to reduce it. The researcher must be aware of his or her own lens when selecting data and avoid acting on any tendency to only choose data that supports the theory and to disregard data that does not (Creswell, 2009). One way that a researcher can influence the data is by asking participants leading questions. I was sure that I monitored my power to influence interviews or to unduly affect emerging themes when analyzing the responses in order to maintain the study's validity. I also monitored my own reactions and feelings throughout each interview in order to focus on the participant's own reactions and feelings. The ability to set aside my reactions allowed me to accept the data presented during the interview rather than what my preconceptions may have led me to find. Yet it is also important to recognize that subjectivity can also be an asset to this study by providing it with depth and understanding (Glesne, 2006). For example, my personal experience with distress was beneficial in creating a safe and trusting environment for interviews to take place and allow me to make more thorough analyses of the data.

Several years of working at DGSOM along with my own experiences as a graduate student have shaped any assumptions I have regarding medical students, distress, and the help-seeking process. After looking at where preconceptions might exist, I made efforts to minimize their impact by keeping a journal to examine my feelings throughout the duration of the study. I also consulted with members of my dissertation committee to make sure that the questions in the interview and the analysis of the results were not biased.

Reliability. Reliability in this study was maintained by incorporating the following methods: accurate selection of participants, adequate depth and length of interviews, faithful use of the interview protocol, precise recording of interview responses, thoroughness of transcriptions, and ability of subsequent research to produce the same results.

Summary

The purpose of this study is to address the gaps in our knowledge about the process that medical students go through while seeking help for their distress. Data regarding the most important factors that students believe have impacted their help-seeking decisions was collected through the use of in-depth, semi-structured interviews and then analyzed. The findings from this study will assist educators and policy makers in medical education by increasing our understanding as to how various individual, interpersonal, sociocultural, and institutional factors have helped these students in distress to seek and utilize help. This new knowledge may be useful in determining how to better help other students in distress to find appropriate assistance earlier on in their medical careers.

In this chapter, the methodological approach for this study was presented along with a rationale for the methods chosen. Considerations regarding the selection of the site and participants, data collection and analysis, and ethical safeguards were included. Lastly, I

discussed issues of trustworthiness in the study and also provided evidence for the study's applicability.

Chapter Four: Findings

The purpose of this study was to describe medical students' experiences and understanding of the help-seeking process. This chapter provides an overview of the findings from this study and classifies them according to the themes and sub-themes that emerged from the students' stories. The sections in this chapter include a description of the study participants, a presentation of the themes and sub-themes found in the research, and an analysis of how the findings answer the original research questions.

Summary of Participants

The results for my phenomenological study developed through data collected from ten face-to-face interviews with students attending DGSOM. Purposeful sampling helped focus the population for my study and enhanced the probability of reaching students who could provide a rich account of the phenomenon of interest. The sample consisted of four men and six women, and included a blend of both demographics and student experience, which provided for diverse perspectives. This section presents a brief account of the types of distress, stressors, and sources of support that the ten participants encountered during their first year of medical school along with their prior help-seeking experiences.

Types of distress. Every participant experienced at least one form of distress (i.e., severe stress, anxiety, burnout, depression, and/or suicidal ideation) during their first year of medical school. All of the participants had severe stress. Three participants described anxiety, with one being diagnosed with general anxiety disorder. Three students experienced burnout. Six students had encountered depression with two being diagnosed as clinically depressed. One student experienced suicidal ideation.

Stressors. Participants identified a variety of sources that contributed to their distress including difficulties in their interpersonal relationships with significant others, family members, and/or classmates; academic struggles such as high workload, test anxiety, and concern for academic performance; and personal factors such as financial pressures, health problems, and lack of recreation. Some students experienced chronic stressors such as having a learning disability, ongoing financial issues, family problems, or depression. Some students described acute stressors such as failing an exam, breaking up with a significant other, or being physically assaulted.

Sources of support. Every participant in this study sought help from an informal source during the first year of instruction. However, the students' personal support networks varied in size and quality. Some students had large networks consisting of friends, family, and classmates while, on the other end of the spectrum, others had only one person they could turn to for help. Similarly, some students felt that their support sources were extremely helpful while others felt they were less so. Most of the participants also sought support from formal sources. Five students visited the UCLA Behavioral Wellness Center (BWC), four utilized a tutoring group specifically set up for medical students, three participated in a Cognitive Behavioral Therapy study, and three talked to psychiatrists they obtained outside of campus resources.

Prior help-seeking experiences. Every participant had at least some prior help-seeking encounters on a formal or informal level before starting medical school. Half of the students had sought assistance from tutors, four students sought help from teachers or school counselors, three students had experience working with mental health professionals, and two students sought support from religious organizations. These experiences were generally perceived as positive with the exception of two students who described some prior negative help-seeking experiences.

List of Themes

Despite the participants varied backgrounds and differences in the types and sources of their distress, five major themes emerged from an analysis of their stories. The first major theme is that help-seeking behavior is influenced by more than deliberate reasoning processes. The second theme reveals that lack of time and lack of confidentiality and/or fear of negative judgment were the most common barriers to seeking help cited by students. The third theme is that a positive help-seeking attitude and prototype were common motivating factors in help-seeking. The fourth theme is that delays can occur at any of the four stages of the help-seeking process. The fifth theme focuses on how a student's definition of his or her distress can impact his or her help-seeking decisions. Quotations have been selected to support and further illustrate the themes, and pseudonyms have been chosen to preserve the anonymity and confidentiality of the participants.

Theme 1: Help-Seeking Behavior may be influenced by more than deliberate reasoning processes

The assumption that decisions to seek help are guided solely by intentional and reasoned thought processes has underpinned the majority of past research conducted about professional psychological help-seeking decisions (Hammer and Vogel, 2013). Yet, many of the decisions are made not only by systematic reasoning, but also involve reactionary processes (Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008). For many decisions, in fact, reactionary processes may exert an even greater influence on the probability of engaging in an action than systematic reasoning. In this study, the students provide many descriptions of a reason-based approach in

their help-seeking behavior. However, in addition to these descriptions, some students also described behavior that developed from a reactionary process and didn't include a prior intention to seek help. The discussion of this theme will begin with examples of reason-based processes as perceived by medical students followed by examples of reactionary-based processes. Within each of these pathways, students described various factors that precipitated the decision-making (e.g., acute or chronic stressors, or an introduction to support opportunities).

Help-seeking behavior from reason-based processes. Most participants made some help-seeking decisions that were based on systematic and reasoned cognitive processes. These students had the intention to seek help, which means that they specifically possessed a conscious plan arrived at via reason-based cost-benefit analyses to exert effort to perform a help-seeking behavior. Among others, these types of reason-based decisions are well-illustrated by study participants Diane, Samantha, and Peter.

Diane experienced emotional distress that was affecting her academic performance. She described herself as “completely not absorbing anything” and “spacing out” when she attempted to study. Thus, she analyzed the costs and benefits of going to various sources of support with which she was familiar; but for each one she came up with reasons that utilizing it would potentially do more harm than good. If she talked to family and friends back at home, it could “hurt the reputation of [her] dad” and it would “make [her] family look broken.” She didn't want to “report bad news to [her] boyfriend either” because she didn't want her problems to cause him distress. She also didn't want to talk to her friends from medical school or anyone from peer counseling services because she didn't want them to “sympathize with [her] in any way” as “it [would] just change the dynamic [of the relationship].” So she finally chose to go visit a BWC counselor because she thought it was better to talk to someone who she didn't “have contact with

in [other aspects of her] life. That way it [would have] no ramifications.” This dialog shows that Diane’s choice of a source of support was clearly the result of a reasoned cognitive process.

In Samantha’s case she also describes a reason-based approach for one of her pre-medical school help-seeking processes, but unlike Diane, she required an additional step of doing research to find the best support source. Initially, Samantha had an emotional support group that she turned to for help; but, after a while, she determined that support source was ineffective for her:

I was more their support system because they thought I had it all put together, and I felt like nobody would have understood it either... even if I were to sit there and explain everything I [felt] like they're not going to offer me much. Even [people] who've been through something similar, I [felt] like I'm just going to be wasting my time talking and there's going to be no solution. I [had] to figure it out myself. (Samantha)

However, Samantha also soon realized that she could not navigate her distress on her own either and thus decided to do some research in an attempt to find the most optimal source of support for her needs:

Well I think I realized that...I wasn't able to control this on my own...[the] insomnia came back really bad... [and the need for] self-medication. And I was afraid the health effects were going to catch up. So [as the therapist] specialized in EMDR [(Eye Movement Desensitization and Reprocessing)], I did a lot of research on that and how it could help with trauma. So I was willing to give it a try. (Samantha)

Peter’s reason-based process differs from Diane’s and Samantha’s in that he did not seek help because he was currently in distress but rather because he wanted to proactively mitigate possible future distress from issues potentially arising due to his learning disability:

I think having or knowing that I had the ADHD diagnosis made me more cautious in the way I approach medical school [and so] I signed up for tutoring. I would always go to my block preview sessions or review sessions for midterms and finals and [in] going to them I [would realize I] actually know all this, but it forced me to stick with it and prepare and be on top of it. You don't want to fall behind. (Peter)

Despite his awareness of the testing accommodations available to him, Peter also decided not to enroll in the Center for Accessible Education (CAE) as it would require him to disclose his ADHD, a risk that he believed outweighed any potential benefit:

I'd try to repeat [any failed exam] and do better and just work harder, and [do] whatever it took to do it exactly like everybody else and without special accommodations...I don't want to be treated differently or taken less seriously or [suffer] whatever [negative consequences that] potentially could come out of it. (Peter)

Peter's proactive approach to tutoring and his decision not to reveal his learning disability to the CAE are both clearly the result of reason-based processes.

Help-seeking behavior from reactionary processes. In contrast to the reason-based processes described above, some participants described instances of help-seeking that were unanticipated and lacked prior intention. These decisions were sometimes the result of a reaction to an acute stressor in which the participants immediately accessed a formal support source after encountering an academic setback (e.g., a poor result on an exam) or emotional crisis (e.g., a breakup with a significant other). Other times the spontaneous decision to get help resulted from an unexpected introduction to an opportunity to get help.

Two students, Sophie and Michael, reported instances in which they each sought help as a reaction to an acute stressor. Sophie's experience occurred after completing a final exam:

I remember coming out of there flat-out thinking I failed like I had bombed it. I [was] literally e-mailing [as I was] walking out of the exam room. [I was] on my phone e-mailing [the director of the Academic Support Office] saying “I need to meet with you”. ... I felt terrible coming out of that exam. And so I went back to [the director] to seek some help there.

She then immediately met with the Academic Support Office director to discuss her academic performance and her mental health. In these meetings, Sophie identified her distress as burnout and affirmed that she needed help with it.

Michael began college with no prior experience of academic or emotional issues. He was surprised when he failed his first two assignments in his pre-med course and remembers “panicking” and feeling “very distressed”. Despite his lack of past struggles and resultant inexperience with seeking help, he still sought assistance immediately:

I went to my advisor pretty early on [and] said I had failed two homework assignments. I just felt like I was very quickly going downhill and so I needed rapid help... I need[ed] something right away before things [got] worse. So instead of trying to figure it out on my own I [thought] “let me go to her and see what she says.”

Michael’s decision to seek help from his advisor was spontaneous and resulted from an acute stressor. Later in his interview, he went on to describe another spontaneous help-seeking decision he made that came about when he was introduced to a new opportunity. Michael was seeing a BWC counselor on a regular basis in order to cope with emotional distress that he was experiencing as a result of a break-up with a significant other. During what turned out to be his last visit to the BWC, he saw a flyer for a study that offered Cognitive Behavioral Therapy (CBT). Prior to this point, he hadn’t been looking for other sources of support and his intention

had been to continue going to the BWC. However, when he came across the flyer, he reflected on his BWC visits and felt that they were “treading the same steps.” He explains, “So I need[ed] to almost change my approach. And I had scheduled [a BWC appointment] but then I signed up for this CBT thing and I ended up canceling my BWC [appointment] and not going back.”

Two other participants, Carol and Sophie, also made spontaneous decisions to join the same CBT study as Michael. By the middle of Carol’s first year of medical school, she had been struggling academically and was experiencing physical symptoms such as headaches, fatigue, and tightness in her shoulders due to the resultant stress. Despite this distress, Carol did not have any intention to seek help until she received an email midway through the year that advertised a study offering Cognitive Behavioral Therapy for distressed students. When she read the email she thought “I realized I probably need to seek more help...I’m totally stressed and I’m totally anxious. I’m going to see if I can do the study.” Carol also said that she probably would have sought help earlier in the year if she had come across an opportunity for therapy sooner: “And I think if it was just like I could press a button in that moment and say okay I'm scheduling an appointment for tomorrow at this time, no questions asked, I'm just going to go there; I would have done it.” She also notes that “timing is important” in regard to when opportunities are presented to students. If the opportunity is only discussed at the beginning of the year, Carol points out “it's not [reminding] us [medical students to] access the resource in the time that I think we need it.”

There is another type of spontaneous help-seeking behavior, as described by Mary, in which an individual who is neither in distress nor intending to seek help does suddenly decide to utilize a source of support when presented with the opportunity. Mary began medical school

“well-prepared academically” and feeling “focused.” In the first week, she was told about the Behavioral Wellness Center (BWC), which she discusses in the following passage:

When they told us about the BWC, I reached out right away. I said I'm just going to go, which for me [it] was very different to be so proactive. I do think that them saying it right up front... [combined with] my history of help-seeking...[led me to think], “Why not go utilize it? Why not be proactive?” So, I did.

Mary describes her help-seeking decision as spontaneous and proactive. Although she was not experiencing distress at that point in medical school, she had prior experience with mental health issues and some positive help-seeking experiences with formal support sources. It was important to Mary to establish a support source that she could talk to right away because she thought that she couldn't “afford to fall behind” if she encountered any issues. She explains, “I didn't know anyone at medical school and it's going to take time to develop those relationships either way. So maybe the Behavior Wellness Center is the way to go.”

Spontaneous help-seeking behavior can also involve support sources outside of the resources provided by the organization and the individual's personal support network. Samantha experienced severe distress in her first year of medical school that included depression and suicidal ideation, and so consequently took a leave of absence. After utilizing both formal and informal support sources and being on leave from school, she described herself as “still extremely mentally sick”. At this point, Samantha “didn't seek traditional emotional support with a therapist [or] with the Behavioral Wellness Center” because she thought that kind of support was “going to bring [her] farther back.” While still on her leave of absence, she came across an opportunity to try something she had never done before, a ten-day Vipassana meditation retreat, and without knowing exactly what it entailed, she decided to do it:

Somebody mentioned meditation [to me] and [I signed up]. It wasn't a preconceived plan. I think for me that's probably what I needed. If you [told] me “I'm going to prepare for this whole ten days of [meditation]”, I don't think I would've done it. When I did that Vipassana [meditation], I literally didn't know what the schedule was like until I was at that retreat center. I looked at the schedule and I [thought] “Oh my god! What the hell did I sign up for?”

Samantha mentioned that she didn't think she would have participated in the meditation workshop if she had known the details ahead of time. Fortunately, her decision yielded positive results:

I started just getting better...much, much better, where I started being really happy and really very accepting of “Okay, if I get to go back [to medical school], that's amazing. If not, that's great too.” There's just so many options and I started looking at everything as a blessing and [it was] just a complete one-eighty.

These stories confirm that spontaneous help-seeking decisions are a significant part of the help-seeking process for many medical students, and thus should be accounted for in help-seeking models.

Theme 2: Lack of time and confidentiality are common barriers to seeking help

In addition to the type of cognitive pathways (reasoned or reactive) that students used in their help-seeking decisions, the participants also discussed any barriers they perceived towards getting help. Analysis of the data revealed that (1) lack of time and (2) lack of confidentiality and/or fear of negative judgment were the most common barriers cited by students.

Lack of time. The lack of time available to seek help was frequently cited as a concern by participants. For example, despite thinking it would have been beneficial for her to do so, Carol did not think that she had time to get help during her entire first year of medical school:

I think that [time] is a barrier...finding the time when you're in that state where you're so tired you [that] don't want to do anything [and] you don't want to talk to anyone. And then you know in the back of your head that you probably could benefit from talking to someone, but the idea of having to set it up and then having to trek somewhere to go and seek that help or you might have to wait two to three weeks, I think that really deterred me from actually seeking those services.

Diane's perception that a lack of time would impact her willingness for therapy increased throughout her first year:

There was a time I felt the need to go to [the] counseling center and at the beginning I [thought] yeah if they want to do some kind of treatment [such as] visit them every week or every two weeks, I would be committed. But then later [I experienced] medical school [as] so busy, I [didn't] really want to spend an hour just to calm myself down.

In addition to being a barrier for getting initial treatment, Sophie points out that considerable time would also be required to establish a bond with the therapist over multiple visits: "You need to build a relationship with that [therapist]. You need to get to know them over time until you feel comfortable talking about some things, especially if [you are a] particularly private [person]." Sophie also anticipates the lack of time being a problem throughout her medical education, including residency.

I know for a fact that if [my distress] ever got that bad I would almost be relegated to pharmaceuticals immediately because I have time to take a pill in the morning but I don't

have time to go to a counseling session for an hour or two every week. So if you could call that a barrier for certain types of therapy, definitely. It would make a very clear-cut choice of which route I was going to take if I was seeking help. (Sophie)

Fear of a lack of confidentiality and/or of incurring negative judgment. For some participants, fear of a lack of confidentiality and/or of incurring negative judgment was a barrier in their help-seeking processes. They worried that a violation of their confidence could have academic consequences, an impact on their interpersonal relationships, and a negative impact on their medical careers, or they feared that those whom they did share their struggles with, even if they were to keep their confidence, would themselves negatively judge them or their loved ones. Diane and Mary both experienced severe distress related to family problems and described their inability to talk to people within their personal support network because they thought doing so would be disloyal to their families, who could incur negative judgment:

I wanted help but I couldn't really necessarily accept it because I felt like I'd be betraying my family in a way if I'm talking about them behind their back[s]. (Mary)

If I talk to anyone it's going to hurt the reputation of my dad. If I tell anyone [it will] make my family look broken. (Diane)

In addition to not wanting to talk to anyone in her personal support network, Diane also did not want to talk to peer counselors because they were people with whom she could potentially interact in social settings: "I don't want people to look at me differently when we are socializing. I have all these friends that I don't want...to sympathize [with] me in any way. It just changes the dynamic." Due to these concerns, Diane was unwilling to talk to friends or peer counselors, and so she decided to see a counselor at the BWC instead. Thus, although Diane feared incurring negative judgment from her personal support network and peers, she did view the BWC as a

nonjudgmental source of support that would protect her confidentiality and therefore as a safe place to go.

Samantha's fear that the knowledge of her going to therapy could have a negative impact on her career prompted her to select a therapist outside of her hospital and school network:

I didn't think it could get out [that I was going to therapy], which was really important [to] me. I didn't want to have a record of this [therapist] in my chart. I definitely didn't want it to impact my future career as a doctor.

Peter had a concern about confidentiality based on a fear of negative academic and career repercussions: "I didn't want to have any paper trail into the university system at that point which maybe is an impractical fear, but I didn't want...my personal issues and personal conflicts at home to be somehow tied to my academic success or academic future." After careful deliberation, Peter ultimately chose to go to the BWC because of the confidentiality of its services: "I know it's confidential and the data and everything is separate from anything else in the hospital in the UCLA system." However, he still had confidentiality concerns when it came to arriving and leaving the BWC office:

I dislike walking to the Behavioral Wellness Center and walking away from it because... [I] always dread I'm going to run into somebody like a research mentor, faculty or staff or anybody...I wouldn't really worry about it if it wasn't an attending or a higher up that would later on be evaluating me, judging me or working with me.

Peter's concern about a potential breach of confidentiality and possible subsequent negative judgment is further demonstrated by his decisions to not switch his medication management to the BWC and not to disclose his ADHD diagnosis to the Center for Accessible Education (CAE).

Although some participants acknowledged the confidentiality provided by the BWC, Mary perceived a conflict of interest that made her uneasy while utilizing the services there:

It did make me slightly uncomfortable to know that there was only one or two counselors and they were seeing all the medical students. ...That kind of bothered me and even now my ex, who I was dating last year, had also seen the same counselor. So when I mentioned who I was dating to the counselor, they knew the person.

Theme 3: Positive help-seeking attitude and prototypes improve willingness to seek help

In addition to identifying some barriers to help-seeking, the participants of this study also described some factors that helped them overcome barriers and/or had a positive impact in their help-seeking process. Findings revealed that a positive help-seeking attitude and prototype were most commonly cited as motivating factors in help-seeking.

Positive help-seeking attitude. Many participants identified having a positive help-seeking attitude as having an impact on their willingness to seek help during medical school. Carol said her positive attitude toward help-seeking developed because of the culture of her high school:

[My high school] normalized [getting help for mental health] and said this is something that's here. So whenever you do need it, not now, maybe not for two years, but when you do, this means you can do it. And I think there really is something that's just ingrained in my head [that says] "When you're struggling, you seek help, because help is there."

Carol's sentiments were echoed by Sophie, who also has a positive help-seeking attitude that began due to her high school culture:

[Help-seeking] was more challenging in [the state I lived in before California] than it was in California because there wasn't a very supportive environment in general, not for science so certainly not for women in science, and mental health wasn't really talked about that much. So it was much easier to talk to my teachers in [California] if I wanted to. They were a little bit more straightforward in saying that they wanted to be there for you as opposed to in [the state I lived in before California]They would publicly state "in case you're ever feeling down or need help, here are your options." I don't think they did that as much in my first high school [in the state I lived in before California]...In California, I just remembered noticing that there's a little bit of a shift in mindset and people just seem to care about mental health more for things like anxiety or school stress. So it seemed like a more forward thinking model of education.

Gary developed a positive help-seeking attitude from his religious community. During high school, premedical school, and medical school, he was willing to get help from his religious mentors with whom he had already established relationships. When asked if he had any hesitation to ask for help from the mentors in his religious community during a time of severe emotional distress, Gary responded,

Not really. Because at that time I had already known [my mentors] for [several] years. I [had] already established relationships with them so it was kind of natural especially because they were the main relationships that I had. And I didn't develop a lot of lasting relationships in high school. So... [they were who] I turned to automatically [for emotional support].

Chris believes that the positive help-seeking experiences in his past have given him the confidence to continue asking for help when he needs it:

If I didn't think that it was possible to have a [supportive] interaction like that with someone [due to my past experiences], I don't think I would have approached them for that issue I was having at that moment.

Moreover, it appears that a positive help-seeking attitude can also be formed solely by having been the provider of help to others in the past despite not yet having been the recipient of it. This situation is illustrated by Michael who experienced significant distress for the first time during his college pre-medical instruction. Although he had never before encountered significant academic struggles and therefore had not been the recipient of any extra assistance, he was quick to seek out help when he began to have difficulty. Michael did, however, have considerable past experience in providing help to others by way of academic tutoring and athletic mentoring during high school which had positively influenced his attitude about getting help for himself when he did finally need it:

I think maybe that [the experience of helping others] just made me more open to one-on-one encounters. It didn't matter which side I was on, if I was the one being helped or the one helping, I've always had a positive association with [both providing and receiving help]. If I'm struggling ...maybe I'll have some benefit if I'm able to talk one-on-one and get some personalized feedback. It's something that has always been an automatic thought for me.

Some participants described how a singular help-seeking event could impact attitude. Stephanie, for example, explained how having one extremely positive therapy session dramatically changed her perspective:

To be completely honest, I'm not very open minded when it comes to psychology or psychiatry in general but I felt that it was really, really helpful and I would do it again. So

I definitely went into it closed minded and I left completely different. I felt like it was helpful just to talk to somebody and have them tell me how to think about things differently or to approach my situation from a different perspective.

Diane's attitude towards therapy also changed after her first session:

I [thought therapists] can't really offer any substantial help...I [thought] it's not super necessary to go there because it's just some kind of intangible help. But when my friend passed away [and I subsequently talked to a therapist], I actually realized that this kind of just talking does help.

Impact of Help-Seeker Prototype. The Prototype Willingness Model (PWM) when related to the help-seeking process of medical students indicates that these students form images or "prototypes" in their minds of a person engaging in an ideal manner in the help-seeking process (the target behavior). If one views the prototype favorably and sees oneself as similar to it, then this individual is more likely to engage in the target behavior if presented with a spontaneous opportunity to do so. The participants' help-seeker prototypes were not only influenced by their experiences prior to medical school, but were also further formed once they were already in medical school by stories they heard from upperclassmen describing their own struggles and help-seeking processes throughout the program. Stephanie's experience, for example, supports this idea that a help-seeker prototype is more valuable when it more closely approximates the subject's own experience:

It's more helpful because [the second-year medical students] know exactly what you're going through because they just went through it. A student from a different school might not be exactly the same because [the] curriculum is different. It's more helpful to talk to somebody here and it's also very helpful to talk to an upperclassman because a fellow

student who's in my grade doesn't know because they haven't done it before. So their advice might be good but I don't really know if it's tried and true...as [would be the advice of] somebody else who's actually went through it.

Through having listened to the experiences of second year medical students at the same school as her, Stephanie's help-seeker prototype became more similar to her as it did not just involve any type of "person" anymore, but it became an actual "medical student" at the same school seeking help. Her prototype also became more favorable as the help-seeking stories she was hearing were from second-year medical students who had already successfully completed their first year of medical school, which was Stephanie's primary goal at the time.

Peter found value in hearing the stories from past DGSOM students during an orientation session at the beginning of the year. He explained, "I liked hearing [those stories]. It kind of does normalize things and it kind of shows that life goes on." He also noted, however, that none of the stories included the particular issue he was dealing with: "I don't really think we had any testimony or discussions about students that had learning disabilities and how they approach medical school." He then reflected on his own reluctance to share his struggles with ADHD within a large setting:

I feel guilty because there's a part of me that wants to be somebody that speaks out or helps somebody else because statistically there has to be at least one other person in the first-year class that might be going through something similar [and] comes from a similar background as myself. But that also means that I have to be very vulnerable and open in front of a lot of people which I historically have not done. There's a little bit of guilt and shame [about] not being able to be there and help somebody else considering the fact that's why I went into medicine - to help somebody else.

Thus, in Peter's case, although the stories had some positive effect on his help-seeker prototype, he didn't relate to them as much as he would have had some of them been about struggles more specifically similar to his own. He also did not view the lack of stories about medical students contending with learning disabilities to be a favorable indicator that it would be safe for him to be more open with his own story.

Gary remembered hearing stories about imposter syndrome during the same orientation session that Peter discussed, but he did not connect with the stories in a meaningful way at that time. It wasn't until later on when one of his tutors shared his own experience with imposter syndrome that Gary felt better about having it himself:

I'd like to think that I'm kind of over [worrying so much about] it at this point or over at least that feeling, even though the imposter syndrome is still there. I was talking to one of my doctoring tutors about it and he was telling me he's been a doctor for 35 years and he still has imposter syndrome. It's good to know that I'm not the only person; it's not just a student thing...I'm starting to look at it in a way of using it to make myself better at things.

Michael also discussed imposter syndrome, a concept that he wasn't familiar with until he met with his DGSOM society dean to discuss his distress about feeling out of place:

[My society dean] reassured me that these were very real feelings I was having and didn't invalidate them...or [make] me feel it was silly to feel this way...[she was] identifying it as imposter syndrome and telling me that a lot of students feel "I'm out of place here" [and that] "everybody else is in on something that I am on the outside of" and [that] just made me feel a lot better. I think that's also why I then took the next step [of] talking to

my friends because I [didn't] want to ruminate on this or have myself feeling down about it. Let me just nip this in the bud and take care of it.

Later in the year, Michael was seeking help to deal with a separate issue that was causing him distress. At this point, he had no prior experience with a therapist and had no intention to talk to one. However, after a friend of his discussed a positive experience at the BWC, he said he started to consider it as an option and eventually decided to go:

It was actually one of my friends who's in my class who had gone to the BWC before who told me that it really helped her...it's a good way to put your mental health first without it being too much of a hassle. So she just kind of [gave] me something to keep in mind, something to consider. And then I started going to the BWC and I would go once every other week or so and just kind of talk through things there.

The story from Michael's friend, who is also a fellow medical student, of engaging in the specific behavior of talking to a therapist and being helped by it both served to contribute positively to and familiarize Michael's own help-seeker prototype. This prototype development enabled him to further engage in his own help-seeking behavior. This experience was echoed by Carol who explains that talking to classmates about therapy inspired her to go:

My friends [motivated me to go to therapy] because they were also going through similar things and would talk about it. [I would say,] "I'm so stressed. What are you doing [about your stress]?" And they [would say] "Oh, I go to psych services and it's really nice to talk something through. They're not just here for academic support but whatever you want to talk about." So the two times I went were definitely times [when] I felt really overwhelmed...and the fact that I know other people who have used it and they've had good results makes me more motivated to seek that resource.

If a prototype for a specific behavior includes the idea of a negative result, then willingness to perform that behavior can be reduced. For example, when Sophie was in college she heard about negative experiences from friends who went to therapy and this made her less inclined to go even when dealing with a less complex issue:

[My friends] weren't helped in the way that they needed it. [The mental health counselors] just didn't know how to approach people with [sexual assault stories]. Essentially, they didn't know how to how to talk to those individuals and, it wasn't something I personally had a problem with, but it is something I knew many friends had experienced and so knowing that they were not helped for that issue, I probably was not inclined to go see them for any other broader mental health related conversation.

Prototypes also influenced participants to exhibit proactive behavior in order to avoid distress. For example, Sophie, Peter, and Stephanie all cited the stories they heard from more senior medical students as motivation for them to seek academic help prior to experiencing distress:

[The second-year medical students] basically told us [to] plan to fall off the face of the earth for Block 3. And that alone scared us all into submission and we were going into Block 3 very worried. ... I felt it was too dangerous to try to just do it on my own and signed up for the tutoring. (Sophie)

I started [going to a tutoring group] initially because you always hear these terrible stories about medical school and I don't want to fall behind. (Peter)

[The second-year medical students] will mention "Oh, you should start [studying] now because we were freaking out and we were really not having a good time with it." So the stories, I know they're there. I think that they're trying to scare us but I think they're also

trying to keep us from being blindsided. So I've heard them enough to be proactive about it. (Stephanie)

The participants' help-seeking stories clearly show the importance of decisions that are not only guided by intentional and reasoned thought processes but also of those that are the result of more reactionary processes that did not include a prior intention to seek help. Findings support that the latter type of decisions are more prevalent when an individual has positive prior help-seeking experiences, relatively few barriers to seeking help, and has developed a positive and familiar help-seeker prototype.

Theme 4: Delays in the Help-Seeking Process Can Occur At Any Stage

All participants discussed delays encountered from internal and/or external factors during their help-seeking processes. The data also show that delays can be encountered at any of the four stages: (1) Problem Recognition, (2) Seeking Help, (3) Support Selection, and (4) Support Utilization.

Delay with problem recognition. Delays can occur during problem recognition, the first stage of help seeking. Some students discussed how failing to recognize their distress impacted their ability to properly manage it. Carol was showing symptoms of depression in the years leading up to medical school and during her first year at DGSOM. She describes getting diagnosed with depression in that first year while participating in a Cognitive Behavioral Therapy study:

If I didn't do that study, I don't think today I would say I have depression. I wouldn't have even known. I [wouldn't] even know how to cope with my feelings if I didn't have a

name to tie to those feelings because I think I've had depression for many years but never [did I think before I heard that diagnosis] that I had depression.

Peter shares a similar sentiment regarding the importance of problem recognition:

I think identifying that you have a problem is the first part of being able to fix it and address it. I was very grateful [for the diagnosis]...I was thankful to have that opportunity to fix [my problems] and hopefully get better.

Embedded within the problem recognition stage lies an emotional reaction component as the problem is defined and then internalized by the individual. A delay can occur when the individual doesn't accept the diagnosis due to a negative association with it. For example, Carol and Peter each received a diagnosis that they viewed as unfavorable from a mental health professional and so they both refused to immediately accept it due to internal (i.e., doubt, disbelief, and fear of imperfection) and external (i.e., public stigma) factors.

I was in denial [of my depression diagnosis] for maybe one to two weeks. My [question] was "How did I miss this in myself?" What I was struggling with was that [my diagnosed depression] wasn't matching in my head [with] what I thought clinical depression was.
(Carol)

I wasn't really thrilled [about the ADHD diagnosis] because I had to acknowledge that or accept that [I'm] not perfect or I'm not ideal [and] I have certain faults. I didn't like that initially, but I liked talking with a psychologist and having those follow-up conversations was really helpful because he did help me come to terms with [the diagnosis]. It took a little bit of time...I didn't like acknowledging the fact that something was wrong even after I was diagnosed...I [didn't] want people to think of me in a different way...I'd rather

have people know me for, or judge me, based on what they see, how I interact with them, or how much or little I know rather than just some arbitrary diagnosis. (Peter)

Delay with seeking help. Following problem recognition is the second stage of the help-seeking process, which involves one making the decision to seek help after evaluating (a) the severity of the problem, (b) the potential effectiveness of using of one's own resources to fix the problem, (c) the efficacy and accessibility of outside help sources, and (d) whether it's publicly and/or personally acceptable to need help for the specific problem at hand. Some participants encountered delay during this stage. Peter, hesitant to seek help for emotional distress due to a breakup with a significant other, tried first to work the problem out on his own:

There was a little bit of a delay [in going to a therapist]...I went during week 3 or 4 [for] the first time. I had the same issues leading up to then, but I was just trying to either address [them] myself or [by] talking to my dad and it just kind of built up to the point that I [thought], "well, I don't really know what I think, [or] how I want to act or behave regarding the relationship" and I had a lot of doubts and concerns.

Similarly, Diane attempts to do things on her own before talking to her main source of support - her parents. She says, "Even now still, I try to solve the problems myself before I absolutely have to talk to [my parents] for one reason or another." Diane explains that as a result of the cultural influence on her upbringing, she was taught to "report the good news but not the bad news to your family when you are apart because they have their own things to worry about." She adds, "If you want to be a good daughter or son, you don't want to trouble your parents with all your [problems]. That's [the] notion in the back of my head." Sophie and Chris, who also come from other cultures, mentioned this particular factor as an influence on their behavior as well. Sophie explains, "It's pretty culturally expected that you figure your stuff out yourself. So I'm sure that

played a huge factor in [my behavior], but I tended to, whatever I was dealing with, [get] through it.” Chris noted, “If you can't solve it yourself, you just have to work harder. Maybe that partially comes from a cultural aspect, maybe that comes from society, you know, family culture which is society’s culture.”

Accessibility and perceived efficacy of help. Some participants expressed concerns regarding the efficacy and/or accessibility of various support sources. Sophie revealed her doubts of finding an effective treatment for her burnout symptoms:

I always feel like I'm proactive about doing all of those things that I'm supposed to be doing, but when they don't help and you are not at the level to qualify for more, like pharmacological or more clinical treatments, you're kind of stuck in this limbo of “If it gets worse you can get help, but if not, just try to make it better on your own.” It's frustrating because you would think that there should be, you want there to be something [to help that isn't pharmacological or clinical treatments], but there's just not [anything] treatment-wise or...really any kind of alleviation.

While Sophie describes the difficulty in finding an effective treatment, Chris discusses the difficulty in finding a person with the ability to provide the specific help he thinks he needs:

[Asking for help] was harder [when I thought my struggle was unique] because that singled you out right away and you don't know if they can help you. You don't know if they know how to help you. You don't know if there's somebody that has been through the same thing and can offer you that advice [and] tell you, “Yes, I've been through the same thing and this is something that can be [taught] and I'm telling you because I'm the living experience of it. This is what I did and this is what worked and [this is] what you should do.”

Accepting and prioritizing help. Some participants considered whether their particular need for help would be acceptable from a public and/or personal standpoint:

Maybe [not asking for help] is something that I wanted to aspire to and challenge myself to do...see what I could do without help. Maybe that would prove to myself how much better I was at doing things. Maybe [getting help] was not showing myself how much I can do. (Chris)

I wanted help but I couldn't really necessarily accept it in a way because I felt like I'd be viewed as weak...and [I felt] like oh what's wrong with me that I need to go seek professional help or why can't I just do this on my own? (Mary)

For other participants, help-seeking opportunities were given lower priority compared to other activities, as in Diane's case, or perceptions that they viewed as incompatible with needing help, as in Samantha's case. Diane contemplated the amount of time that would be required for ongoing therapy sessions and determined that she "would rather spend that time either dancing or doing something else to really take [her] mind off something instead of just talking about it." Samantha's desire to be viewed positively by her colleagues "[held her] back [from seeking help] through [most of her] first year ...because [she] didn't want any damage to [her] reputation."

Delay with support selection. Once the decision to seek help has been made, an individual in the third stage of the help-seeking process identifies and selects a source of support. Some participants described delay during this stage for reasons such as a lack of information about help resources and feeling that a potential source of support was unapproachable.

Insufficient knowledge of available resources. Most of the participants were aware of the services provided by the BWC and half of the study participants had sessions there.

However, two participants were unaware of the features and services provided by the BWC (e.g., convenient location, availability, appointment system, and confidentiality) during their first year:

I think having some type of resource that is easily accessible would be super helpful...I think signing up is the hardest, like figuring out the logistics, finding the website, filling out the form, making an appointment or a call...if you [could send] a doodle for different appointments for counseling and they [would] do it close to campus after our classes, I would definitely do that. (Carol)

The BWC is located near the medical school and so is easily accessible, and making an appointment there only requires a bare minimum of information (i.e., one's name, phone number, and email address) and so is also easy to do. Thus, based on Carol's description, if she had known more about the BWC, she may have gotten the help she needed sooner. Stephanie expressed similar sentiments as Carol and therefore also demonstrated a lack of knowledge about the BWC:

If there was somebody here and they had appointments, I would definitely go to them just because they're so easy and convenient. I would definitely have used it when I had any type of financial issue and for help with performance anxiety in anatomy because that was my biggest [issue]. I was really afraid that I was going to freeze up or not remember [the material] just because [of the] pressure to answer the question in one minute. And so I had a lot of anxiety about that and really worked myself up for no reason.

Then after I told Stephanie about the BWC, she explained why she did not remember the details about it: "I honestly cannot remember [what was said about the BWC] because it was so long ago and [the orientation] was so long , [it was] like an eight hour lecture every day, and I remember they covered a lot of topics like this."

Stephanie communicated further concern about possible delays she could experience in her help-seeking process in the future due to not knowing the resources available for academic assistance in the later years of her medical education:

I actually am very concerned about [the end of the second year] because I really don't know what resources you're supposed to utilize at that point. As far as third and fourth year[s] go [i.e., the clinical years], I don't really know what to expect for that at all.

Sophie was also worried about possible delays in seeking any necessary help in the latter years of medical school:

If it got [to the] third year or even when dedicated period [to study] for Step starts and [if my burnout was] way worse than what I was feeling in year one, I don't think there would be time to go see a therapist on a regular basis and, quite frankly, I would be very worried if that was covered under [the student health insurance plan] on a regular basis. I know CAPS has some free counseling here and there but I can't [go there because] it's not independent.

Hence, time becoming even more limited as medical school progresses, potential lack of insurance coverage, and unwillingness to utilize psychological resources that are affiliated with her school (i.e., “not independent”) due to concerns about possible damage to her reputation are all factors that could cause delays in Sophie’s help-seeking process in the future.

Delay can also occur when one is no longer deriving significant benefit from one’s current source of support but is unsure of how to change to a new source of support. For example, Mary was already talking to a counselor but began to feel that she was no longer benefiting from that counselor’s perspective. She wished to switch to a new counselor but didn’t

know how to go about it and, as a result, she stopped seeing the counselor altogether and so her progress was delayed:

That's another thing that's delaying me from doing anything even though recently I've been wanting to have someone to talk to. I got some useful perspective from this psychologist [at the BWC] but I would appreciate a different perspective at this point and I don't know how they approach that. I don't know if I would have to just tell the person directly. Is it possible to see someone else [at the BWC] or do they refer outside?

Importance of approachability of support source. Participants described how they considered approachability of potential support sources when it came to identifying, selecting, and contacting them. Approachability is such an important characteristic, in fact, that if a potential support source lacks it, then students can experience delay in accessing help because they are unwilling to contact that source. Chris, for example, maintains that a potential support provider exhibiting approachability is essential for student utilization:

Every time that I feel comfortable with someone it's because of the way they approached you before...even before you had the chance to assess them as a person. If they come out and the very first day of class they seem very welcoming and they approach you with a very open arm type of framework or idea, you're a lot more willing to ask them for help, to use them as a resource...That's just so essential...When you feel distant and you feel like the teacher is going to snap back at you, you're not going to ask for help.

Thus, in the same way that an approachable support source can facilitate the help-seeking process, a distant support source can delay it. When Diane realized that she wanted to discuss her distress with a formal source of support, she saw her professor as an option:

She always made herself approachable [not only] as a psychology professor but also as a person who really cares about her students. Since day one, since the first time taking [a] class with her, she talked about being aware of mental health, being aware that everyone goes through difficult times and it's not shameful ...[and] you should reach out for help when you need to. That kind of advertising also helped in making me think that [my distress] was something I shouldn't be embarrassed about.

Hence, Diane's psychology professor's approachability both encouraged Diane to reach out and at the same time mitigated any feelings of embarrassment that Diane may have had about needing help. If Diane had continued to feel embarrassed about needing assistance and had not felt encouraged by her professor, then she could have had significant delay in her help-seeking process. In general, the consensus among participants was that the more approachable a source of support tended to be, the more likely they were to utilize that source.

Delay with support utilization. Some students described delay during the fourth stage of the help-seeking process which involves the utilization of support. In this stage students approach and evaluate the treatment and advice they were given. Some participants described experiencing delays at this stage due to either their own lack of commitment or the ineffectiveness of the support source.

Lack of commitment. Some students described how a lack of commitment to a treatment may have had an impact on the effectiveness of the treatment. Carol describes her experience trying out CBT (Cognitive Behavioral Therapy):

I tried [CBT] out. I don't find it to be super helpful, but I may not just have given it enough time because I tend to use those skills only when I'm feeling really bad not just in my everyday life and I think that's what they expect through the program. I also didn't

have a lot of time...I didn't give my hundred percent to this program I have to say. CBT in a different setting might work.

In addition to the lack of time that Carol cited as impacting her effort towards CBT, she also described having an aversion to some of the methods involved:

They taught us the skills... but when you're feeling shitty, like even though in my head I know I don't actually think this, but I also don't care to argue with myself. It's like you're [already] feeling bad. Why am I having this internal dialogue too?

Similarly, Mary felt that she may have benefitted from a particular treatment involving medication if she had given it a proper chance:

I took that [antidepressant] for probably a couple of months, [but] I didn't really feel any different. Maybe, as I've learned from medical school, it's not necessarily a long enough time, a couple months, to see anything, and people need to try many different ones. I think [I didn't like] the process of 'okay, well I'm going have to go back to see this doctor and we're going to try this again,' and I was worried it would cause me to gain weight or would have other side effects. The perceived kind of stress of going through that process kind of deterred me enough to stop taking it, which probably [wasn't the] most beneficial [thing to do] for myself.

Samantha, who shared Mary's concern for side effects, said the following about the anti-anxiety medicine she was prescribed:

I was still trying to do well academically and if I would have taken Xanax I would [have been] useless. So I tried not to take those but when the panic attacks became so severe I forced myself to take one.

Even when the medication is perceived as effective, other factors related to the use of the medication could potentially cause delay. Peter acknowledged his initial hesitation to ADHD medication because of the stigma associated with it:

I didn't like the idea of [the medication]...I know there's the stigma of college students trying to misuse certain medication for performance enhancement...and I didn't like the idea of being associated with that either because I was able to do well in school without anything else. I was just trying to have a better relationship with my dad and solve certain problems, but that kind of came out of it.

When Peter started medical school he wanted to keep his ADHD medication private but felt he had to disclose it on some medical forms in case of a health emergency. Peter also declined an offer of help from his BWC counselor to transfer his medication management to UCLA to make it more convenient and affordable:

I told her [that] I want to keep those things separate if possible. I feel there's still some sort of stigma attached to it and I don't want the attendings to treat me differently or give me special treatment or think that, or even [anyone at] the school [to think that I] need extra time for tests or anything like that. I've gotten this far without any extra help and I didn't want to start now.

Ineffectiveness of support. Some participants felt that the support they used was ineffective due to not being a good match for them. Sophie evaluated her experience with CBT, “I partially did [CBT] hoping to learn something new or see if there was a way of alleviating that middle ground [of needing help but not quite to the point of needing pharmaceutical drugs], but I just didn't take to it.” Similarly, Michael thought that talking to a BWC counselor wasn't a good fit for his circumstances:

The therapy that I was getting at the BWC was talk-based...but I felt like I was doing a lot of talking already with my friends...The last appointment I went to it just kind of felt like we would be treading the same steps and I [thought] “When does this end? Why am I still coming here?”

Although Michael didn’t think talk therapy was the right approach for himself, he still held that it “had its merits” and “would be most beneficial to somebody who maybe felt they didn't have a support system to really open up to because it was nice to...be able to be totally open with a professional and say what was on [your] mind.” This concept of patient-treatment matching based on the unique needs and characteristics of each individual is reiterated by Sophie:

Everyone handles things so differently and I just think people have such varying thresholds for burnout or for recovery of burnout and so everyone's needs are so different...and given how different people function, I know of so many times where people offered me advice and [I thought] "No, it's not gonna work for me but I'm glad that it works for you.”

Mary understands the importance of matching the appropriate treatment with the patient as well but also pointed out the potential negative consequence of overwhelming someone by providing too many different resources:

[I suggest] taking everyone's advice with a grain of salt because everyone approaches things differently. In medical school you get so much advice, you're thrown so many different [resources] and it's just easy to get too overwhelmed or overcommit. There's something to be said about just sticking to one piece of advice or following one kind of trajectory, not spreading yourself too thin.

Thus, to minimize delays at this stage of the help-seeking process, the findings support that it is useful to properly match the treatment to the patient but also caution the help-seeker to try not to become too overwhelmed by an excess of information in the form of differing advice and a multiplicity of resources.

Nonlinear progression through stages. The findings support a holistic/nonlinear model of help-seeking as opposed to the traditional linear model as some participants went through the stages in a non-linear progression. As suggested by the previous theme, any participant who followed a reactionary process, as opposed to a reason-based process, of help-seeking did not progress through the four stages of help seeking [i.e., (1) Problem Recognition, (2) Seeking Help, (3) Support Selection, and (4) Support Utilization] in a linear fashion but rather were able to start utilizing a source of support without a prior intention to seek help. Thus, in this case, students in Stage 1 (Problem recognition) went straight to contacting a source of support (Stage 3).

Ongoing Process. Some students experienced the help-seeking process as an ongoing process throughout the year as a result of having chronic distress or from dealing with multiple stressors. Additionally, some participants, expecting the process to continue to be ongoing, discussed how they envisioned themselves going through the help-seeking process in the future. Gary, for example, doesn't expect his impostor syndrome to go away and instead has learned to disempower it through accepting it and has even moved onto starting to "look at it in a way of using it to make [himself] better at things." Similarly, Carol doesn't see her depression as ever going away completely either and is continually in a process of detecting and interpreting her symptoms and level of distress:

I don't think there's anything that's going to make me one day wake up and not have those feelings [of depression]. What's reasonable to expect is that some days I'm going to feel good and sometimes I'm going to feel bad, but what can I do in those moments where I feel bad? What can I do to help myself get over it, to let it ride out? ...Because, at least for me, it comes in waves a lot of [the] time and it correlates with my stress.

The findings showing that help-seeking can be both a non-linear and ongoing process supports a revised model help-seeking that includes these ways of experiencing it, and therefore provides a more accurate account of the overall phenomenon.

Theme 5: Help-Seeking Decisions are Affected by how the Student Defines His/Her Distress

While the severity and type of distress can be viewed as a continuum of experience, participants defined their distress sometimes in distinct categories. These definitions affected the help-seeking decisions the students would make. One of the major categories discussed by students was the idea of 'normal' distress as opposed to a higher level of distress considered 'abnormal', 'severe', or 'real'.

Normal vs Abnormal Distress. The first stage of the help-seeking process (problem recognition) includes a moment when an individual defines the problem. One of the most common ways participants defined their distress was to think of it in terms of being at a normal or abnormal level. This definition could be arrived at after viewing their distress in different contexts. For example, a level of distress could be considered abnormal, and severe at a personal level for the student, but considered 'normal' for a medical student at a particularly challenging point in the first year curriculum.

Abnormal (personal context). Some participants were motivated to seek help when what they were feeling was not considered normal and they wanted to return to a normal state of well-being:

I just knew that I wanted to get back to being just happy and nice like my old self...like messing goofing around, telling jokes, and going out with people, and playing sports with other people, than just doing things by myself. And I guess it was kind of the tipping point. And the [BWC] counselor asked me on the first day “Oh, what's your goal from coming here?” I just want to be happy and back to how I used to be regardless of what comes out of it. I just want to get to that stage. (Peter)

Diane recognized that her distress was having an effect on her relationships and herself: “I don’t want to go back home to [my boyfriend] and be frowning all day long.” And she recognized that it was important that she find a way to alleviate it: “How do I cope with my own problem and bring the sunshine to the people I care about?...I’ve got to figure my stuff out.”

Normal (academic context). While the sources of distress for Peter and Diane were factors outside of medical school, other students experienced the source of their distress to be primarily related to their academic workload and, as a result, they often viewed it as a normal and acceptable part of medical education. Thus, instead of getting help, they were often willing to “wait it out” until they could have small or large breaks from their academic workload. Sophie explains coping with her distress in such a manner:

Realistically I don't think it's gonna get that much better for a while so I've kind of just accepted that this is the reality of the situation and you just kind of mediate it...Through the times of exam times and crunch times it's almost like a sacrificial ‘Okay, I'm not going to be happy for a week; but I'm going to study and then I'm going to pass and then

once I'm passing, I'll be happy.' And that just repeats itself...this really nice long

[summer] break coming up made it easier to just push through that burnout at that point.

Carol also managed to persevere despite her distress because she knew that summer break was approaching:

I couldn't keep doing this if I had to just continue on without a summer...I knew I was almost done [with the first year]. I just need to get through a few more weeks and then I have summer...I knew it's temporary.

Chris provided a detailed experience of the burnout he experienced towards the end of his first year and how summer break helped him recover from it:

You feel like you don't have the time anymore. It really impacts [you] because all you find yourself doing is working. And when you find yourself working all the time, you kind of get tired of working. And that's how I felt for Block 4 and 5. I felt like I wanted to keep working but I didn't have the same passion that I had in the first three blocks because Block 3 was such a tremendous hammer. And the summer really helped me get myself back together, I think mentally and rediscovering the drive.

These examples support the idea that when students define their distress as abnormal, they are more inclined to seek help for it; whereas when students define their distress as "normal," they have a greater tendency to "wait it out" until they reach a time period, such as a break from school, that they can use to recover.

Redefining Distress and Readjusting Priorities. Some students described how redefining their distress led them to see it as a consequence of a lack of balance between work and recreation/relaxation in their lives. This often led students, such as Carol, to manage their

distress by setting aside some time to focus on other activities besides those exclusively related to medical school:

[My depression] definitely made me feel like I had more on my plate [than other students] and also [made me] think about how to balance my well-being with how I do academically ... you can continue to push yourself really hard or you can take that time to do things that are for your own self-care, and I tend to do a little bit more [self-care].

Once I realized I was depressed, I put a little more time into doing things that gives me pleasure like watching TV, like treat[ing] myself to a nice meal or hang[ing] out with friends rather than holing up and just feeling really bad about myself.

Sophie describes this realization about the importance of living a more balanced life even as a medical student in a positive manner:

I definitely did not realize how important work-life balance was to me because I spent most of my childhood [elsewhere] and [the focus] was about going into medicine and putting your career first ... This is the only thing that matters in my life. And turns out it's not, which is a good thing to figure out. So it's really eye opening. If you had to paint a silver lining to stress.

Mary noticed how finding more balance between her academic and personal life by deciding to spend more time on leisure activities (e.g., television, cooking, trail running) had such an overall positive affect that her academics were not adversely affected despite her spending less time on them:

I wasn't studying as much as normal but I wasn't doing any worse. I wasn't any further behind [and] it made me realize it's okay. You can actually have somewhat of a

balance...and even taking a break can make you come back and be more focused and refreshed.

Stephanie saw improvements in her stress levels when she studied less and focused on self-care:

I take Fridays off every single week because if I don't, I feel like I don't study as well during the weekend or during the rest of the week [and] I get just overwhelmed. So I run and I watch a lot of TV...Before an exam, I actually study less the preceding week so that I have energy to go hard for four or five days because if I don't do that then I'm actually more stressed because I'm just tired.

Diane discussed how she is willing to accept poor academic performance in the short term in order to pursue other passions:

Recently I'm having academic problems, but I don't think that's a real problem. It's not causing me any mental distress at all. I'm committing myself to a bunch of [extracurricular activities] because I never got a chance to do that in college. Now I'm just completely going out and enjoying them, and I think with my academic ability I can catch up in time before the final exam happens. I'm actually really happy even though I failed my midterm.

All of these examples highlight how one chooses to define one's distress impacts one's subsequent help-seeking decisions and life-style choices. If the distress is viewed as "abnormal", then one is more likely to seek professional help to manage it, whereas if the distress is seen as a "normal" part of medical school, then one may be more likely to try to cope with it on one's own and wait for a break from academic work to recover. The act of defining one's stress has also led several participants to strive towards leading lives with a better balance between work and leisure activities, which also seems to typically be a healthy coping mechanism overall.

Conclusion

Findings discussed in this chapter reveal insights into the help-seeking process as experienced by medical students. This study provided evidence that help-seeking behavior in the setting of medical education involves reactionary processes along with reasoning processes. The findings also reveal that the four stages of the help-seeking process can be experienced in a non-linear fashion and are susceptible to delay at any stage. Participants identified significant factors that influenced their help-seeking experiences such as existing student prototypes, past help-seeking experience, and the meaning attached to the distress. In Chapter Five, I discuss these findings in the context of the Prototype Willingness Model and the Conceptual Model developed for this study. I also suggest possible directions for future research, and consider the implications and limitations of this study's findings.

Chapter Five: Discussion

Introduction

The purpose of this qualitative phenomenological study was to examine the phenomenon of help-seeking as perceived by medical students in distress, leading to an improved model of help-seeking behavior. This chapter includes a discussion of major findings as related to the existing literature on medical student distress and help-seeking theories, and what implications may be valuable for policy, practice, theory, and research. The chapter concludes with a discussion of the limitations of the study, suggestions for future research, and a brief summary.

This chapter contains discussion and future research possibilities to help answer the research questions:

1. How do medical students perceive the experience of seeking help for distress?
 - a. What precipitates the students considering seeking help for their distress?
 - b. What obstacles to getting care are perceived by the students?
 - c. What helps students to decide to seek help, if they do, despite the perceived obstacles?
2. How do students experience and understand the stages of delay in the help-seeking process?
 - a. Are there particular stages in the process where significant delay is encountered (e.g., from recognition of symptoms to making a decision to seek help)?
 - b. Does the delay, if any, come from external factors (e.g., slow response from potential helpers) or from personal ones?
 - c. Are there any stages in the process that students go through repeatedly before accessing help?
3. How does the meaning that a student attaches to his or her experiences influence his or her process of help-seeking?
 - a. How does a student define their distress and does this definition change throughout the help-seeking process?
 - b. What is the relationship, if any, between the way a student defines his or her distress and the decisions he or she makes?

To examine these different concepts, this study relies on a phenomenological design, detailed in Chapter Three, to collect and analyze responses from ten in-depth interviews with

medical students. The key findings indicate: (1) help-seeking behavior is a result of dual pathways, (2) positive help-seeking attitude and prototypes increase willingness, (3) personal meaning has an impact on help-seeking behavior, (4) help-seeking can be a continual and non-linear process, (5) internal and external factors cause delays at each stage of the help-seeking process, and (6) the Integrated Model of Help-Seeking Behavior is a useful framework for studying the help-seeking process. In the following sections I will provide a discussion of the significance and implications of each of these key findings.

Discussion Part I: Help-seeking behavior is a dual pathway process

The help-seeking behaviors described by the participants of this study were a result of not only deliberate, reasoned decision-making but also of spontaneous, reactive decision-making. This finding aligns with existing research that proposes that help-seeking behavior for health-related issues is more accurately accounted for using a dual-process model (Gerrard et al., 2006; Gibbons et al., 2004). Students who followed a reactive pathway, as opposed to a reasoned one, described seeking help when encountering acute distress or when coming across a help-seeking opportunity. This finding shows that in some circumstances medical students are willing to use support services even when there was no plan to do so beforehand. Given this data, service usage may improve if both the reasoned and reactionary processes are considered during the development of interventions.

Participants who adopted reaction-based help-seeking behavior cited either an external and/or internal factor as the source of distress; although high-stakes assessment was the most frequently identified stressor. In fact, regardless of the cognitive pathway, student assessment (i.e., preparation for and performance on high-stakes exams) was frequently mentioned as a

factor for different types of distress (e.g., severe stress, burnout, and anxiety). The findings in this study that suggest students may give precedence to exam performance over their own mental health is in alignment with the results found by Winter, Patel, and Norman (2017).

In terms of barriers towards help-seeking, participants in this study cited factors such as lack of time, lack of confidentiality, and fear of negative impact on their careers as a medical professional. This finding supports the barriers to treatment identified by medical students in the research of Givens and Tija (2002). These barriers may decrease the likelihood of service usage among distressed students whose help-seeking behavior is more spontaneously motivated and responsive to opportunities for immediate service. Thus, it may be beneficial to develop strategies to provide immediate care and promote awareness of such services in order to maximize service usage by the portion of students who do not have a prior intention to seek help but are willing to receive help when the circumstances are conducive. The use of online intervention applications could be a promising area for research as web-based applications have particular advantages in the delivery of immediate support.

Discussion Part II: Positive help-seeking attitudes and prototypes increase willingness to seek help

Participants in this study attributed their willingness to seek help to positive help-seeking attitudes and positive prototypes of a help-seeker. This aligns with Hammer and Vogel's (2013) findings that suggest prototypes and willingness are key elements to understanding and predicting help-seeking behavior. Results from this study show that a positive attitude toward help-seeking developed anytime from early childhood to high school can still be valuable later in a student's educational career especially as the level of academic work and rigor increases.

Positive help-seeking attitudes can also come from religious communities or personal experiences. The descriptions from participants of how a singular positive help-seeking experience could significantly improve one's attitude toward the related help-seeking behavior are in line with the findings from Wade et al. (2011). This study also expands on existing research by demonstrating that a positive help-seeking attitude can also be formed by the experience of providing help to others even when not having yet had the experience of receiving help oneself. One possible area of inquiry would be to examine how an individual's prior experience from either the giving or the receiving end of a help-seeking modality can impact that person's attitude towards the same modality as approached from the opposite end. The influence of prior help-seeking experiences on behavior as shown in this study substantiates Ishikawa et al.'s (2010) suggestion that inquiry into a patient's past help-seeking experiences can result in a better understanding of that individual's attitudes and ultimately lead to more appropriate care. Taking this a step further, this type of information could be used in screening purposes and help identify students in distress earlier.

The presence of a favorable help-seeker prototype was cited by participants as another factor that could increase willingness to seek help. The findings showed that a useful help-seeker prototype can develop from interventions (e.g., a presentation by prior students discussing help-seeking with beginning students) or from interactions with upperclassmen and faculty. The closer a prototype approximates the subject's own experience, the more valuable the prototype can be in improving the attitude towards help-seeking behavior. However, students with more unique or specific issues (e.g., learning disabilities, imposter syndrome) may not have a clear prototype to help them feel better about a particular type of help-seeking behavior. Thus, interventions designed to improve prototype favorability should consider the wide range of

student experiences related to distress and help-seeking in order to avoid overlooking any particular prototypes that may be useful to a portion of the student body. Also, future research should assess the value of prototype-related interventions by comparing the effect of different formats such as large group presentations, one-on-one interactions, and multimedia (e.g., student stories presented in text or video). As shown by Stock et al. (2009), interventions that improve prototype favorability can increase probability of the associated help-seeking behavior.

Discussion Part III: Personal meaning has an impact on help-seeking behavior

Another focus of this study was to explore how a medical student defines his or her distress and how that that personal meaning or conceptualization attached to the distress might impact their help-seeking actions. Some participants defined their distress as a problem of improperly balancing life and work and, thus, they adopted strategies outside of professional mental health care (e.g., hobbies, exercise, socializing with friends, and religion) in order to reduce emotional distress. Given that utilization of professional help may not be sufficient by itself in addressing all of an individual's needs, it might be helpful if future research were to examine the impact of positive coping strategies on a student's help-seeking process and well-being with particular attention on the changes, if any, in individual behavior throughout the different years of instruction.

The findings of this study also align with research indicating that insufficient recognition of an individual's own mental health issues can result in significant delay in the help-seeking process even when support services are available (Winter, 2017). Given the significance of personal factors (e.g., self-awareness, coping methods) to the help seeking process, it is important that future research look further into the use of strategies that help individuals develop

their own ability to recognize symptoms of poor mental health, assess well-being, and regulate behavior. Data from such research could inform the development of interventions that allow educators to play more of a role in helping students develop the skills necessary for optimizing self-care, finding work-life balance, and making the most appropriate help-seeking decisions.

Discussion Part IV: Help-seeking can be a continual and non-linear process

The conceptual framework used in this study draws from the Veroff, Kulka, and Donovan (1981) model which divides the help-seeking process into the following four stages: (1) Problem Recognition, (2) Seeking Help, (3) Support Selection, and (4) Support Utilization. The results of this study confirmed the utility of the four distinct stages for analyzing the help-seeking process. However, the initial versions of this 4-stage model create the impression that the process occurs in a linear fashion with the stages experienced successively. Yet, the findings of this study show that help-seeking can be experienced as a continual or non-linear process. Discussion from earlier in this chapter showed that reaction-based help-seeking can occur without the intention to seek help thus bypassing the second stage. In addition to experiencing the stages of help-seeking out of sequence, some participants described help-seeking as a continual process. An ongoing cycle of help-seeking could result from (1) having a complex issue that required numerous cycles of help-seeking in order to try different methods or (2) having a lifelong issue that would always have to be managed (e.g., clinical depression or ADHD). Participants who utilized a source of mental health care described how they continued to assess their experiences and evaluate the usefulness of the particular methods or individuals involved in their support. Also, some participants noted that the efficacy of certain treatments will vary by individual because of everyone's unique individual needs and characteristics.

If the help-seeking process is an ongoing process, as the findings suggest, then the support for that individual should also be ongoing. Establishing a continuity of care, through the support provided by the medical school, can be beneficial to students (Greenhill et al., 2015). However, the unique curricular design of medical school may create challenges in providing consistent and continual care to students who have to train at different sites and interact with different individuals throughout their medical education (Winter et al., 2017). Further research could look at the type of support experienced by students at different stages of their medical education and career with close attention paid to those who identify themselves as needing continuous help-seeking. Another future line of inquiry could involve looking at how long it takes a patient to establish a bond with a professional psychological support source and what factors determine the continued use of that same support source throughout a student's academic and professional career. Interventions should look to address every stage of the process, from problem recognition to support utilization.

Discussion Part V: Internal and external factors cause delays at each stage of the help-seeking process

The findings of this study showed that individual, interpersonal, sociocultural, and institutional factors all play a role in impacting the help-seeking process for medical students. This supports a major theme of Anderson's model which proposes that health service use is a result of the interaction of individual and external factors. Participants in this study discussed ways in which different circumstances, various systems (e.g., cultural, value, institutional), and personal meaning caused appropriate care for their distress to be delayed. Some of these findings align with prior research and suggest that help-seeking is not simply an individual activity, but a

social action that involves the interplay between the individual and the members of their personal support network (Shapiro et al., 1984; Okello & Neema, 2007) or their surrounding culture (Ishikawa et al., 2010).

This study contributes to current research by demonstrating that at each stage of the help-seeking process there is potential to encounter delays stemming from an internal or external factor or any combination thereof. These findings illustrate the complex and dynamic nature of the help-seeking process that can help account for the wide range of individual help-seeking experiences that were described by the participants. The implications of these findings is that the needs of a distressed student can be addressed more appropriately if the people involved in that student's care are more aware of how to recognize problems at different stages of the help-seeking process. Thus, a conceptual model that illustrates the help-seeking process in a more comprehensive and holistic manner than the preceding models would be helpful in determining how, where, and when medical students seek help for mental health problems.

Discussion Part VI: The Integrated Model of Help-Seeking Behavior is a useful framework for studying the help-seeking process

The Integrated Model of Help-Seeking Behavior (IMHSB) combines existing models of help-seeking into one singular conceptual model to provide a more holistic framework in which to examine the intricacies of the help-seeking process. Throughout the previous discussion sections in this chapter I highlighted the key findings of this study which align with the work from other researchers. The most significant and novel contribution of this study to existing and future research is the framework provided by the IMHSB. In particular, the findings support the model's depiction of help-seeking as a process that involves an intersecting array of various

systems (individual, interpersonal, socio-cultural, and institutional) that can impact delay and advancement in the help-seeking process throughout any stage. The findings of this study also support the IMHSB's depiction of help-seeking as a process that can be experienced continually or in a non-linear fashion.

The results of this study indicate the necessity of an integrated approach towards help-seeking research in the context of medical education. The planning and evaluation of strategies to support medical students can be aided by the IMHSB's visual representation of the help-seeking process which allows researchers and educators to analyze all the potential barriers and motivating factors that impact help-seeking behavior.

Limitations of the Study

The results of this study should be considered in light of its limitations. First, by using a limited sample size in this study the findings cannot be generalized to the larger population of medical students. All of my participants were able to complete their first year of medical school, and their perspectives on help-seeking may not be representative of the whole range of students who experience distress. An important next step in this inquiry is to incorporate the perspectives of students who didn't get the help they needed. Research might also include students from a broader range of class years to explore the differences in how the help-seeking process is perceived at different stages throughout undergraduate medical education. When reviewing the results, it is also worth considering that the students self-selected to participate in the study and makes it possible that they share some key characteristics that may have limited the range of responses.

Conclusion

My interest in the mental health of graduate students, especially those in rigorous and demanding programs such as medical education, guided the focus of my study toward examining the help-seeking process of medical students in distress. By placing the voices of students at the center of my research, this study revealed insight into the process of help-seeking as experienced by medical students, focusing on how medical students conceptualize their mental health and what they perceive as barriers to mental health services. The interview data and subsequent analysis provides the following key findings: (1) help-seeking behavior is a result of not only deliberate, reasoned decision-making but also of spontaneous, reactive decision-making, (2) a positive help-seeking attitude and prototype increase willingness to get help, (3) the stages of the help-seeking process can be experienced non-linearly, (4) external and internal factors can cause delays at any stage of the help-seeking process, and (5) the way in which each student defines his or her own distress impacts his or her help-seeking behavior.

The main contribution of this study to future research and practice is the introduction of the Integrated Model of Help-Seeking Behavior (IMHSB), which combines existing models to provide a more comprehensive framework in which to examine the intricacies of the help-seeking process. Help-seeking, as depicted in this model, is an intersecting array of circumstances, various systems, and personal and social meaning, all of which interact within the four distinct stages of help seeking - viz., (1) recognizing the problem, (2) deciding to seek help, (3) selecting a support source, and (4) utilizing the support. The findings support this revised model as a suitable framework for viewing help-seeking behavior and also as a flexible model for future research. The IMHSB provides an integrated approach which can assist educators and policy-

makers in considering all the possible barriers and drivers that influence students' help-seeking behavior when planning strategies for supporting the mental health of medical students. This new knowledge may be useful in determining how to better help medical students in distress to find appropriate assistance earlier on in their careers. Helping these students to effectively manage their distress not only benefits the students themselves, but also facilitates them in developing into emotionally healthy doctors that will therefore be better able to provide quality patient care than they would have otherwise, thus raising the quality of healthcare overall.

Appendix

Interview Protocol

Oral Consent

Hello (*name of participant*). Thank you for taking the time to talk with me today. My name is Jason Rock. I'm a graduate student from the UCLA School of Education. I'm here to learn about the help seeking process as experienced by medical students. If it's okay with you, I will be digitally recording our conversation since it will be hard for me to write down everything while also carrying on a conversation with you. Everything you say will remain confidential, and I will protect your privacy to the best of my ability. You may decline to answer any question you don't wish to answer. You may also request to continue off the record. If at any time you want to withdraw from this study, please tell me and I will erase the audio file of our conversation. Do you agree to participate?

Introduction

Thank you for agreeing to participate. The purpose of this interview is to learn about the help-seeking process and to discuss your experiences and perceptions on this topic. There are no right or wrong answers, or desirable or undesirable answers. I would like you to feel comfortable saying what you really think and how you really feel. I have a list of questions to guide the interview that I will look to if necessary. I've organized my questions into three main parts. The first part of this interview is about getting to know you and to understand your experiences and attitudes toward distress and help-seeking before you came to medical school. The second part of this interview, and probably the most extensive part, will focus on your experience of help-seeking during medical school. The third and final part of this interview focuses on the "meaning" of your experience.
So let's start at the beginning...

Part 1: Providing Context

Objectives:

- **build rapport and trust by starting off with basic questions to warm up participant and collect important background data**
- **provide a context for the student's experiences during medical school by asking them to describe their experiences and attitudes towards help-seeking prior to medical school**

1. Where did you grow up?
 - a. What was that like?
 - b. When you were younger, what did you think about people who suffered from distress?

- i. Why do you think you thought this way?
 - c. What was your attitude toward help-seeking, in general and for distress?
 - i. Why do you think you felt this way?
- 2. Could you describe an instance before medical school when you were experiencing emotional distress and what you did or didn't do to seek help for your distress?
- 3. Can you describe a time before medical school when asking for help was a negative or positive experience?

Part 2: Recounting the Experience

Objectives:

- **Collect detailed accounts of the student's help-seeking experience during medical school**
- **Align interview questions with Research Questions 1 and 2 (see below)**

RQ #1 How do medical students perceive the experience of seeking help for distress?

- a. *What precipitates the students considering seeking help for their distress?*
- b. *What obstacles to getting care are perceived by the students?*
- c. *What helps students to decide to seek help, if they do, despite the perceived obstacles?*

RQ #2 How do students experience and understand the stages of delay in the help-seeking process?

- a. *Are there particular stages in the process where significant delay is encountered (e.g., from recognition of symptoms to making a decision to seek help)?*
- b. *Does the delay, if any, come from external factors (e.g., slow response from potential helpers) or from personal ones?*
- c. *Are there any stages in the process that students go through repeatedly before accessing help?*

Problem Recognition and Seeking Help

1. Please describe your experience at the medical school when you were considering seeking help for distress.
 - a. Tell me about how you began to recognize a potential problem with distress.
 - i. Detection of symptoms (physical/emotional/academic)
 - ii. Defining/Redefining of problem (internal vs external; physical, mental, spiritual)
 - iii. How long did you experience distress before deciding to seek help?
 - b. Can you describe the process of coming to the decision that you wanted to seek some kind of help (informal or formal)?
 - i. Did you begin to see the problem as undesirable and something that you could not fix on your own? Please describe.
 - ii. What was your attitude towards asking for help (informal and formal)?
 - iii. How long did it take you to identify a source of support once you decided to seek help?

Support Selection and Support Utilization

2. Please describe any experiences you had at medical school in selecting your sources of support.
 - a. How did you identify potential sources of support?
 - b. How did you decide on the sources you selected?
 - c. How did you go about contacting your support sources?
 - d. How long did it take you to contact a support source once you decided to seek help?
3. Please describe any experiences you had at medical school of utilizing support.
 - a. Tell me about what the support consisted of (treatment, advice, medication, referral).
 - b. What was your evaluation of the support?
 - i. Did you experience improvement?
 - c. How long did it take you to evaluate a source of support once you started utilizing that source?

Obstacles and Channels to Support

4. Could you give me an example of something you perceived as an obstacle at any point during your help-seeking process?
5. Could you give me an example of something that you found helpful during your help-seeking experience?

Part 3: Reflecting on the Meaning

RQ #3 How does the meaning that a student attaches to his or her experiences influence his or her process of help-seeking?

- a. How does a student define their distress and does this definition change throughout the help-seeking process?*
- b. What is the relationship, if any, between the way a student defines his or her distress and the decisions he or she makes?*

1. How did you define your distress?
2. Did your definition of distress change over time?
3. Do you think the way you defined your own experiences of distress had an effect on the help-seeking decisions you made?
4. In what ways, if any, has the experience of help-seeking impacted the way you see yourself or the world around you?

Wrap-Up

1. Do you have anything you would like to add?
2. Do you have colleagues in the field who you think might be interested in participating in my study?
3. Do you have any questions for me?
4. Do you have any suggestions for the medical school to support students throughout the help-seeking process?

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