International Journal of Emergency Mental Health and Human Resilience,Vol.22, No.3, pp 48-49 © 2020 OMICS International ISSN 1522-4821

Medical Students Attitudes Towards Mental Health Disclosure: A Qualitative Study

Ryan Christy*

Department of Health and Well-Being, College of Medical, Veterinary and Life Sciences, University of Glasgow, Scotland

INTRODUCTION

The aim of this research project was to obtain and explore the perceptions of medical students at the University of Glasgow surrounding mental health and its disclosure. In 2013, the GMC conducted research in order to advise medical schools on how best they can support students with mental health concerns and produced a document outlining how medical schools must play a role in supporting their students and giving advice to symptomatic students (Grant, et. 2013). A common theme running through many of the beliefs held by medical students in previous studies, was the stigma surrounding mental health and help-seeking (as per Erving Goffman 1963) (Tyler, et. 2018; Dahlin, et al. 2005; Afsar, et al. 2015; Billingsley, 2019; Winter, et al. 2017).

OBJECTIVES

There is particular interest in the field of mental health in today's society and the main objective of the research was to see if the idea of stigma still surrounded medical students beliefs on disclosure and if so, what were the barriers to seeking help. The research also wanted to see if any of these beliefs differed from the GMC findings in 2013 (Grant, et. 2013).

METHODS

A questionnaire was formulated and released to all year groups of medical students at the University of Glasgow via medical student online forum. All responses were then analysed by the primary researcher using Mayring's six step approach of systematic, rule guided qualitative text analysis (Mayring, 2000).

STEP 1: Research questions defined: what are the barriers to disclosure faced by medical students and what do they believe are the risks for them developing mental health problems.

STEP 2: Determining category and levels of abstraction. A two column coding matrix was created based on the two research questions. Many subcategories were expected to be found under each category (column). For example, column 1 was the category, 'barriers to disclosure' and reoccurring sub-beliefs were noted, (1A) fear of repercussions, (1B) 'expectations', (1C) judgement and (1D) lack of support.

STEP 3: Developing inductive categories from material. All responses were reread and each sentence coded to a category, for example; "I would be scared the GMC would be contacted if they knew about what I was going through" was given the code (1A). All phrases reinforcing this belief were added as subcategories.

STEP 4: Revising the categories. The primary researcher and supervisor repeated the coding exercise and were able to agree that there was evidence to support four main beliefs in each category. The subcategories reinforcing these beliefs were then grouped together.

STEP 5: Final work through. The responses were grouped into beliefs that occurred most frequently. It is appreciated that this technique can be subjective to those analysing.

STEP 6: Interpreting the results. The coding matrix identified the reoccurring beliefs and quotations within subcategories were used to support each point.

These themes are compared against previous findings made by the GMC to analyse if mental health disclosure amongst medical students is still stigmatised and if so, have the reasons for this changed in recent years.

RESULT

From these responses four main barriers to mental health disclosure were identified; the fear of repercussions (50%) and that a student's fitness to practise would be challenged; the 'expectations' of a medical student (48.6%) that they should not get ill themselves and if they did it displayed weakness; judgement (13.9%) from medical school staff and peers and; the lack of perceived support (9.72%) or at least lack of knowledge of what support systems existed and how they could be accessed. Many of the respondents felt they would be deemed unfit to practise, it would display 'weakness', they might be treated differently or they

*Correspondence regarding this article should be directed to: ryan.christy@gmail.com

believed the support provided was inadequate or not made easily accessible to medical students (especially given their busy timetable and system of placements at sites distant from the main University Campus). From the questionnaire, less than half the respondents felt the medical school made mental health support clearly available and only 11% were even aware of the aforementioned GMC document. As a secondary outcome the questionnaire also gave respondents the opportunity to explain why they felt medical students were more at risk of developing mental health problems compared to other students and the reasons expressed were; the medical school environment (63.9%) including the competitive nature of the course and the high stress environment; the work load (43.1%) being exceptionally high including placement, lack of study leave and shorter holidays; the 'expectations' of a medical student (31.9%) again in that the "typical medical student" will often put a lot of pressure on themselves as well as feeling pressured by family, friends or society; and the course content (25%) which many respondents felt could be distressing as they are surrounded by illness and disease and sometimes death. Respondents felt that the medical school was "a pressure cooker" for mental health problems and yet the University did not do enough to ensure the wellbeing of its students.

CONCLUSION

The study sample was relatively small but did obtain responses from across multiple student year groups. After comparing my results from the questionnaires to that of GMC research, it would appear that there has been little or no change in medical student's attitudes towards mental health and its disclosure despite guidance being issued to universities by the GMC in 2013. The data was only obtained from Glasgow University and so it cannot necessarily be generalised to all universities, however, it has highlighted some key areas that all universities could potentially explore, such as promoting the support services available and acknowledge that not all students can progress through 5 or 6 years of intense work, placement, study and exams without developing mental health problems that need to be addressed without fear, stigmatisation or uncertainty. The services to help students are often there but insufficient is done to make students aware of their existence and create an environment where students feel it is normal and acceptable to seek help when feeling mentally unwell. Thought also needs to be given to alternative means of providing support that allows students working on placements to access services and in a manner and time that minimises disruption of their studies.

DECLARATIONS

The author declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

REFERENCES

Billingsley, M. (2015). More than 80% of medical students with mental health issues feel under-supported, says Student BMJ survey. BMJ, 351.

Dahlin, M., Joneborg, N., & Runeson, B. (2005). Stress and depression among medical students: A cross-sectional study. *Med Edu, 39(6),* 594-604.

Grant, A., Rix, A., Mattick, K., Jones, D., & Winter, P. (2013). Identifying good practice among medical schools in the support of students with mental health concerns. General Medical Council.

Kulsoom, B., & Afsar, N. A. (2015). Stress, anxiety, and depression among medical students in a multiethnic setting. *Neuropsychiatr Dis Treat,* 11, 1713.

Mayring, P. (2000). Qualitative Content Analysis.[online] Qualitative-research. net.

Tyler, I., & Slater, T. (2018). Rethinking the sociology of stigma. *Am Sociol Rev, 66(4),* 721-743.

Winter, P., Rix, A., & Grant, A. (2017). Medical student beliefs about disclosure of mental health issues: a qualitative study. *J Vet Med Educ, 44(1),* 147-156.