



## DOCTORAL THESIS

### Psychosocial barriers to accessing psychological services for junior doctors (JDs) A grounded theory study

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*Award date:*  
2013

*Awarding institution:*  
University of Roehampton

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# Psychosocial barriers to accessing psychological services for junior doctors (JDs):

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A grounded theory study

By

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A thesis submitted in partial fulfillment of the requirements  
for the degree of  
PsychD Counselling Psychology  
School of Psychology  
University of Roehampton  
2013

## Preface

The research initially set out to study the general UK junior doctor population who would not or will not avail themselves of psychological services. Mostly junior doctors from Asian populations volunteered to participate. This led to including cultural issues in the analysis which was not originally intended. It would have been preferable to recruit more Caucasian participants to clarify and ground the results more firmly however, this was not possible as the direction of the study was not anticipated.

For clarity and ease of interpretation of the grounded theory, the literature review has been structured according to the results. Therefore, each core category forms a new section in the review and each section contains empirical research on each concept followed by theories which were felt to enhance the understanding of each category. The method of this study corresponds with Charmaz's (2006) version of grounded theory where she states:

*"Draft your literature review and theoretical framework in relation to your grounded theory"...The constant comparison method in GT does not end with completion of your data analysis... Through comparing other scholars' evidence and ideas with your GT, you may show where and how their ideas illuminate your theoretical categories and how your theory extends, transcends, or challenges dominant ideas in your field (p164).*

Finally, multiple usages of particular quotes have been presented in the results section. This is in line with grounded theory. This is because even a short statement or excerpt may address several points and illustrate several different categories (Charmaz, 2006).

## **Abstract**

While there is extensive research on medical doctors and their mental health, little is known about the specific barriers which prevent them from accessing psychological services. Numerous studies have shown that rather than asking for help from other professionals such as counselling psychologists and therapists, doctors would rather turn to drugs and alcohol to cope with their psychological distress. Junior Doctors (JDs) specifically are at particular risk of mental ill-health but feel prevented by their profession from seeking psychological treatment. Little research has been conducted on this particular subject area focusing specifically on JDs. This study readdresses the empirical evidence available for the issue and informs more clearly how counselling psychology and related professions can provide a more effective service to this client group. A constructivist grounded theory approach using eight participants allowed for a detailed examination of the participants' subjective experiences of the research phenomenon and the generation of new theory on the barriers which prevent JDs from accessing psychological help. Of the eight participants, seven were from an Asian background and one was of Caucasian origin. Further, seven were male with the remaining one participant being female. A core category was uncovered from the analysis of the data which apply to the research participants: psychosocial barriers to accessing psychological services by JDs. This core category was informed by three main themes: 1) medical identity 2) the development of coping strategies in the British medical culture, and 3) the unacceptability of difference. This core category and its themes make up the grounded theory of the research. In light of the findings it may be suitable to adapt the usual process of therapy and negotiate a more appropriate method of delivering psychological support to reduce barriers and to promote credibility and effectiveness of counselling psychology among this client group.

For Libby.

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# Chapter One

## INTRODUCTION

### 1.0. Overview

Section one of this chapter provides a brief overview of the background to the research project and a rationale for the study and research question. Section two contains the aims and objectives of the project and within section three, definitions of some of the key terms and concepts are presented. Finally, within section four, a summary of the structure of the remainder of the report is provided.

### 1.1 Section One

#### 1.1.1 Background

Many studies have shown that when doctors experience ill health, they disregard the advice they give to their own patients, especially if the problem is psychological in nature (Davidson & Schattner, 2003; Chambers, 1993; Rennert, Hagoel, Epstein, & Shifroni, 1990). The medical community has developed a culture in which working despite illness and self-treatment is the norm (Davidson & Schattner, 2003). Self-treatment for doctors includes diagnosing and treating their own illness and prescribing for themselves. It also includes undertaking informal, or 'corridor', consultations and self-referring to a specialist. Self-treatment is inappropriate because of its lack of objectivity (Richards, 1999).

Numerous studies have shown that rather than asking for help from other professionals such as counselling psychologists and therapists, doctors would rather turn to drugs and alcohol to cope with their psychological distress (Taylor, Graham, Potts, Richards, & Ramirez, 2005; Davidson & Schattner, 2003; Adshead, 2005; Adams, Lee, Pritchard, & White, 2009; Tattersall, Bennett & Pugh, 1999).

Current estimates suggest that almost one-third of doctors practicing in the NHS are from overseas and that the vast majority of these overseas doctors are from the Indian subcontinent (Esmail, 2007). This of course is a surprising statistic because within the general population ethnic minorities represent only about 8% of the population of the UK (Esmail, 2007).

Where it has been well documented that the mental health of UK junior doctors is deteriorating due to various reasons such as workplace culture, stress and demands (Baldwin, Dodd, & Wrate, 1997a and 1997b; Curran, 2008; Lloyd, 2002; Mukherjee, Fialho, & Wijetunge, 2002), the research fails to address cultural factors which may play a role in this phenomenon.

Previous research indicates a variety of reasons for junior doctors' reluctance to seek help from Counselling Psychologists and mental health professionals. Severity of symptoms, lack of knowledge of the effectiveness of therapy on mental ill-health, and fear of social stigma, for instance, are all reported to be significant barriers which may lead to the underutilisation of mental health services (Meltzer, Bebbington, Brugha, Farrell, Jenkins, & Lewis, 2003; Thompson, Hunt, & Issakidis, 2004). Another factor includes one's attitude toward such services and toward help-seeking in general, with attitude being conceptualised as a function of specific beliefs regarding the consequences of a behaviour and an evaluation of these consequences (Halgin, Weaver, Edell, & Spencer, 1987; Cramer, 1999).

Although no studies were found in the literature search conducted using UK samples, there is some research evidence from outside the UK which provides evidence for the effectiveness of psychological interventions for junior doctors when they decide to utilise these services. For example, Isaksson Ro, Gude, Tyssen and Aasland (2008) looked at the effectiveness of counselling for burnout in Norwegian doctors using a cohort study, followed by self-reported assessments after one year. This piece of research looked at counselling interventions that were aimed at motivating reflection on and acknowledgment of the doctors' situation and personal needs. The main finding was that short term counselling interventions contributed towards a reduction in emotional

exhaustion in doctors. The effects were also found to be largely maintained in a three-year follow-up study using self-report measures (Isaksson Ro et al., 2010).

Similarly, Cunningham and Cookson (2009) looked at experiences of doctors in New Zealand, by using a questionnaire survey design to measure the effectiveness of receiving counselling for stress-related impairment. This study covered forty-one psychological providers (fifty-five individual doctor clients in total). This study's main finding was that most doctors in their sample believed the psychological intervention which they received contributed to them remaining in, or returning to work, due to improved stress management and appropriate recognition of their stress or distress.

These studies were conducted using non-UK samples and therefore may have limited relevance to the current study, which is based in the UK. However, taking these studies together, the evidence suggests that, when utilised, psychological interventions can be effective for junior doctors.

### **1.1.2. Rationale and research question**

While working at the Royal College of Physicians (RCP), the author experienced a growing awareness on the issues of doctors' mental health. With a background in psychology and mental healthcare, an interest in the issue was developed. This was also fuelled by the growing amount of media coverage, especially during the period when Modernising Medical Careers (MMC) and the Medical Training Application Service (MTAS) were introduced. This system was reported to leave many doctors unable to proceed with their careers due to the numerous problems associated with it (E-Health Insider Primary Care, 2008). Problems which included lost forms in the on-line system, and applications being marked by non-medical staff who may not have been appropriately trained for such a responsibility, leaving some applicants disadvantaged in their applications (E-Health Insider Primary Care, 2008; The Central London School of Anaesthesia, 2010). It was precisely during this "disastrous period" a particular interest in JDs and their mental health was developed. It was interpreted that, apart from MTAS, they had the added stresses and strains of starting and



maintaining a new and highly demanding career. Therefore, it was out of interest in the mental health of doctors, and then a growing interest in JDs, in particular, that the research question was developed: “What are the views and attitudes of JDs towards accessing psychological services, such as counselling psychology, for themselves?” This was later refined to “Psychosocial barriers to accessing psychological services for junior doctors (JDs): A grounded theory study”.

This is a particularly relevant issue to explore, as it appears to be extremely prevalent in the medical culture. While it is well documented that medical doctors face deteriorating mental health (Baldwin, Dodd, & Wrate, 1997a and 1997b; Lloyd, 2002; Mukherjee, et al., 2002; Curran, 2008), barriers such as the stigma and confidentiality issues associated with getting psychological help, are reported to hinder them from utilising the services. However, how have these barriers been constructed in relation to this issue? Further, what purpose do these barriers serve and are psychological services able to work with these issues? These are the questions that this research project examines.

## **1.2 Section Two**

### **1.2.1 Research aims and objectives**

This research study aims to explore the psychosocial barriers to accessing psychological services for junior doctors, and thereby to inform more clearly how counselling psychology and related professions can provide a more effective service to this client group, and reduce the barriers to access.

The principal aims and objectives of this study are to:

- Conduct an investigation into the psychosocial barriers which junior doctors perceive to be preventing them from accessing psychological services;

- Use a Constructivist Grounded Theory approach to analyse the participants' reports of the research phenomenon;
- Present the results of this process identifying the main factors which are reported to contribute towards the psychosocial barriers to accessing Counselling psychology and related professional services;
- Relate the findings to existing theory and practice and make recommendations for a more effective counselling psychology service to junior doctors.

## **1.3 Section Three**

### **1.3.1. Definition and concepts**

*Counselling Psychologist* is defined as “a relatively new breed of professional applied psychologists concerned with the integration of psychological theory and research with therapeutic practice” (The British Psychological Society, 2008).

Due to the similar nature of the work with other therapeutic professions such as psychotherapy and counselling, studies conducted within these professions that relate to the issue being researched were included in the literature review.

The above mentioned terms (counselling psychology, psychotherapy, counselling) will also be used interchangeably in this study to reflect the inclusion of the type of literature and studies used and looked at.

*Junior doctors (JDs)* are all doctors below consultancy level. They are doctors in training, usually in hospital or in general practice. They will have completed medical school and obtained registration with the General Medical Council (GMC), but will not yet be trained to a level which allows them to work as a consultant, GP or staff and associate specialist. As they progress through training and gain experience, their responsibilities increase but are always under the supervision of a

senior doctor, though not necessarily directly. On completion of training they gain a certificate of completion and appear on the GMC's specialist register for those completing specialist training, or the GP register for those completing as a GP.

*British-Asian junior doctors* are junior doctors (see above definition) who are from an Asian background and living and working as a British citizen.

*Barriers* are phenomena which the participants perceive to prevent them from accessing professional psychological services.

## **1.4 Section Four**

### **1.4.1. Structure of the report**

#### **Chapter Two**

Chapter Two provides a literature review of the theory and research into this area.

#### **Chapter Three**

Chapter Three gives details of the methodology with a rationale provided for using a Constructivist Grounded Theory method.

#### **Chapter Four**

Chapter Four describes the method used for the study.

#### **Chapter Five**

The results are summarised in chapter five of the study. A constructivist grounded theory approach allowed for a detailed examination of the participants' subjective experiences of the research phenomenon and the generation of new theory.

#### **Chapter Six**

A discussion is provided illustrating how issues from the literature review and key findings from the results may fit together, with recommendations for their application. A description of the strengths and limitations of the study is also provided with suggested directions for further research into this area.

# **Chapter Two**

## **LITERATURE REVIEW**

### **2.0. Overview**

Current theories and practice regarding attitudes and prejudices that may impact on whether or not JDs would choose to access psychological therapies are outlined in this chapter.

The chapter is divided into four sections. The first three sections detail a literature review on the factors involved in influencing JDs' attitudes and behaviours towards accessing professional mental healthcare for themselves. It begins with a review of the empirical literature on medical identity as a JD and the constructs which contribute towards this identity in section one. This is then followed by a review of the literature on the development of coping strategies within the British medical culture in section two. Literature on the unacceptability of difference (i.e., stepping away from perceived norms of being a British JD) among doctors and the British medical culture is then reviewed in section three. Following a review of each phenomenon, theoretical suggestions are offered to enrich the understanding of each notion. Section four gives a chapter summary which details the key issues which have been raised in the literature review, criticisms of the literature are explored, and the aims and objectives of this research are stated.

PsychLit and Google Scholar were used in the search for relevant literature throughout the duration of the data analysis. The headings and sub-headings used in each section of this chapter were used as the main search terms plus the additional Boolean "AND" with the key words "junior doctors" AND/OR "mental health" AND/OR "psychological services". Additionally, relevant books were consulted and loaned from Roehampton University library.

### *Inclusion Criteria*

The aim of this review was to look at empirical and theoretical data and literature which could help identify psychosocial factors that may contribute to JDs experiencing barriers to accessing psychological help. To ensure the most relevant and up-to-date literature was used, the following inclusion criteria was used:

- Doctors' mental health.
- Junior Doctors' mental health seeking behaviour.
- Research conducted in Western countries due to the current study being in the UK.
- English language papers.

### *Exclusion Criteria*

For the same reason as above, the following exclusion criteria was used:

- Research on non-medical professions.
- Studies from non-Western countries.
- Severe and enduring complex disorders in medical professions. The current study looks at common mental health difficulties such as depression, anxiety and burnout.

## **2.1. Section One**

### **2.1.1. Medical Identity**

Professional identity is formed during professional training through a process of socialisation (Hudson, 2002). Interaction with, and feedback from supervisors, mentors and peers encourages a continued development of professional identity throughout one's career (Hudson, 2002). Hornby and Atkins (2000) suggest that a positive professional identity stems from a clear understanding of the profession and a sense of competence within that. However, given the prominence of the medical professions in society, the literature suggests that the identity of a JD may go beyond this, and that it is the combination of factors which form the identity of a JD within this population which

may influence their attitude toward seeking psychological help for themselves. Indeed, Cohen, Kay, Youakim and Balaicuis (2009) suggested that in addition to the accrual of the core knowledge base necessary to function as a doctor and the clinical competencies necessary to deliver responsible care, medical students and JDs must gradually become internally comfortable with the social role of physician-healer. Madill and Latchford (2005) put forward that uncertainties about core professional identity develop as early as the first medical school year.

The factors which the literature suggests contribute towards the medical identity of British-Asian JDs include: renegotiating own cultural identity, norms of acceptable behaviour, cultural conceptions of being a doctor, and position in medical family. The literature detailing these factors are detailed and cited below.

### **2.1.2. Renegotiating own cultural identity**

Chung (2007) and Sue and Sue (1990), writers in the area of culture and therapy, explain that there has been suggestions in the literature of a tension between the cultural values of certain ethnic groups and those of the western mental health services. Therapy may involve an emphasis on verbal communication of distress and a focus on the individual's personal needs. However, for Asian populations it is widely believed that individual needs should be subordinate to the needs of the family and collective as a whole, as suggested by key writers in the field (Kramer, Kwong, Lee, & Chung, 2002). This suggestion was also found in a study by Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger (2011) which looked at factors influencing negative attitudes towards accessing mental health services by using a questionnaire-survey design in a general Japanese population.

As second and third generation Asian populations join the British medical workforce, they may struggle to adopt a bi-cultural identity which serves them in the best light to be accepted and recognised as a desired JD. Within this struggle, attaching themselves to the psychological

profession whose professional values and ethos is incongruent with their desired medical identity may not prove to be within access.

In addition to developing a core sense of professional self, JDs must integrate a new and complex group identity. Cohen, Kay, Youakim and Balaicuis (2009) suggested that group membership in the guild of physicians is an old and strong component of a physician's identity. The researchers explained that medicine is its own culture, with its own power hierarchy, its own language, and its own inside jokes. This may have been constructed not only within the medical culture itself, but complemented by non-medical populations where the desire is for doctors to display strength and coping. With this thought in mind, the maintenance of their professional identities both psychologically and externally causes a barrier to even reach the stage of contemplating psychological services.

### ***2.1.3. Medical Prestige***

Despite the common assumption and observation that Asian populations regard medical practice as prestigious, no literature could be found to support this claim. However, a study conducted by Kramer, Kwong, Lee and Chung (2002) found that Asians' strong deference towards authority figures has resulted in placing this at greater importance than their individual choice of career. That is, the choice of career that is different from that chosen by parents can result in loss of emotional and financial support (Kramer, Kwong, Lee, and Chung, 2002). It is therefore possible that British-Asian JDs are following the career choice of medicine as suggested by their seniors due to its perceived prestigious status. Should a prestige be attached to the medical profession, it can be argued that association with and utilisation of 'lesser' services may have a reflection on their identities as a doctor, fearing its perceived consequences.

#### **2.1.4. Norms of Acceptable Behaviour**

Within the literature search, several constructs were suggested to operate in the medical culture which are perceived to be the implicit norms of acceptable behaviour as a JD. These constructs are thought to contribute to an accepted identity as a British JD. These are: just deal with it, and conformity. These are detailed and discussed in turn below.

#### **2.1.5. *Just deal with it***

In their study, Cooke, Halford, and Leonard (2006) found that doctors in training are reluctant to complain because they expect they will be met with the attitude that any problems encountered are due to deficiencies in the candidate. The researchers suggested from their findings that there appears to be a code which exists within the profession that doctors in training do not complain, and that doctors who do speak up risk jeopardising their future careers. Presumably admitting to psychological distress is perceived as complaining which therefore prevents them from contemplating professional psychological help.

Studies have shown that when doctors experience ill health, they disregard the advice they give to their own patients, especially if the problem is psychological in nature. For example, key researchers in this subject area (Davidson & Schattner, 2003; Rennert, Hagoel, Epstein, & Shifroni, 1990) used questionnaire-survey designs to verify this finding. The medical community appears to have developed a culture in which working despite illness, and self-treatment is the norm. Self-treatment for doctors includes diagnosing and treating their own illness and prescribing for themselves. It also includes undertaking informal, or 'corridor', consultations and self-referring to a specialist. Self-treatment is inappropriate because of its lack of objectivity (Richards, 1999). More than this, to be a patient appears to imply the assumption of a status that is inimical to the doctor's own professional status and identity. Doctors, therefore, learn to resist illness and may prefer to deal with any health problem themselves (Mckevitt & Morgan, 1997). Limitations of these studies in relation to the



present research include the positivist philosophical basis and epistemology. Whilst this gave some useful insight which contributed to the knowledge base, research from a qualitative paradigm may complement and add to this knowledge. As it stands, limited expansion of certain issues was not possible by participants. Further, it is unclear in which grades the doctors who participated in the studies worked, i.e., whether they were senior doctors or JDs. The findings also do not account for cross-cultural factors.

### ***2.1.6. Conformity***

Despite the different suggested concepts of acceptable behaviours in the medical workplace, no empirical research could be found in the literature search on the notion of conformity to implicit rules among doctors.

A theoretical explanation offered by Scheff (1988) suggested that conformity is encouraged by a system of sanctions: we usually conform because we expect to be rewarded when we do and punished when we do not. With the punishment, embarrassment and shame may be present.

Goffman (1967) notes that the emotion of embarrassment or anticipation of embarrassment plays a prominent role in every social encounter. In presenting ourselves to others, we risk rejection.

Depending on its intensity and obviousness, rejection usually leads inevitably to the painful emotions of embarrassment, shame, or humiliation; seeking psychological help as a British-Asian JD in this instance would fall into this concept.

More recent research has attempted to address conformity in the general public. For example, Kuntz and Gunderson (2002) looked at differences in levels of conformity in rural areas compared to urban areas. Additionally, Kondo, Saito, Deguchi, Hirayama and Acar (2010) looked at conformity in Japan. Coleman (2007) suggested that conformity makes daily life predictable and holds society together, shaping habits, customs, opinions, fads and fashion.

Although these findings are of some relevance to the present study, clearly there is a lack in the literature which addresses conformity within the medical workplace with particular focus on British-Asian doctors. The empirical evidence which is available focuses on the general public and/or is not recent.

### **2.1.7. Conceptions of Being a Doctor**

Within the literature for JDs' conceptions of being a doctor, four main constructs were found to exist and which may contribute to the construction of perceived barriers to psychological healthcare: power and authority, strength and coping, invincibility and omnipotence, and separation from patients. These are detailed and discussed in turn below.

#### ***2.1.8. Power and authority***

According to Parsons (1987), when doctors diagnose and treat disease, they are using professional knowledge and authority to legitimise illness in others. Thereby, they sanction an individual's assumption of the 'sick role', transforming that individual into a patient. Medical power, therefore, can be described as the necessary authority to define and identify illness and to create the patient. Yet doctors' power to identify illness and to create patients seems diminished when members of the profession are themselves unwell. Doctors who are unwell may refuse and be denied the benefits of patient-hood because of the notion that illness does not belong to them and their identity.

Tate (2010) explained that there are three types of doctor power:

- 1) Sapient power – The power which the doctor has because of their medical expertise.
- 2) Social power , or moral power – This is the result of the doctor belonging to the elite medical profession and where modern society has handed over the social role of the healer to the doctor; when the patient adopts the sick role, they hand over some of their autonomy to the doctor.

- 3) Charisma, or the personal power of the doctor – This is an intangible, which varies considerably from doctor to doctor.

However, this model does not capture the difficulties that British-Asian doctors face in terms of accessing power due to the conflict of their cultural background in the medical environment (Esmail, 2007), and consequently using patients to possibly regain their sense of authority in society.

Indeed, Esmail (2007) suggested that Asian doctors tend to occupy the lower-grade positions in the most unpopular specialties with high propensity for long hours and shift work, from which promotion is restricted and pay and conditions are similarly affected. Esmail (2007) went on to explain that while Asian doctors possess the skills relevant to the British economy and the NHS, their status as “pariahs” determined their lived experience. This suggests a loss of social power within the British medical culture which is sustained by medical personnel as well as patients. Miller, Kinya, Booker, Kizito, & wa Nqula (2011) found in their research that patients that indicated a preference for doctor ethnicity were more likely to prefer European doctors for major surgery, cancer and heart problems and Asian doctors for less severe medical issues. Given this evidence, it may be that British-Asian JDs feel their struggle for power and recognition within the medical system and by society as a whole has placed them in a position of avoiding services which may compromise their toil for acceptance.

### ***2.1.9. Strength and coping***

The perception that doctors are more likely than other professionals to work despite being ill may be symptomatic of a culture in which an image of invincibility is encouraged and vulnerability is denied (Davidson & Schattner, 2003). The direct result of this phenomenon is likely to be delayed presentations, that is, delaying admitting to needing help and/or actively hiding symptoms, even for more serious conditions (Davidson & Schattner, 2003). The perceived caricature persists as suggested by the Department of Health (2008) that good doctors do not make mistakes and that

illness, particularly mental ill health, is a weakness. Taking time off work is frowned upon as letting down colleagues and patients. Furthermore, showing vulnerability may lose the respect of others, a particular concern for doctors as suggested by Watts (2005), a science editor, which suggests that counselling and psychology would fuel this thought. The disclosure of mental illness, alcohol or drug use, or the admission of error can be seen as inviting disciplinary action or GMC involvement and, therefore, as a threat to career and livelihood. It is perhaps understandable, but clearly undesirable in terms of patient safety and person well-being, that doctors tend to be secretive about their problems—and that colleagues collude in ignoring medical problems, including substance abuse (Watts, 2005). Indeed, Taub, Morin, and Goldrich (2006), researchers in physician health and wellness, explained that the medical profession has a duty to promote good health.

Further, Mckevitt and Morgan's (1997) informants spoke of the pressures on them to resist illness as part of 'our culture'. They report this begins for students and JDs who must complete years of demanding training by which they also demonstrate their ability to 'cope' and, therefore, their suitability for the profession. The research evidences that the organisation of medical labour also discourages doctors from giving into illness and imposing the burden of extra work on to their colleagues.

Fisher, Nadler, & Whitcher-Alagna (1982) suggested that seeking help from another entails an implicit analysis of the costs and benefits to one's self-esteem. Seeking help from another to some degree means admitting that one cannot deal with the problem on one's own and, as such, can be an admission of inadequacy.

### ***2.1.9.1. Invincibility and omnipotence***

In a review of physicians' ethical dilemmas in the care of sick doctors, Adshead (2005) found that doctors viewed ill health, especially if it is psychological in nature, essentially as something that happened to other people and not to the doctors themselves. Clark (1995), a psychoanalyst

suggests that the creation of such an omnipotent self is a defence against feeling overwhelmed by distress or need of care; the choice of medicine as a profession is then a mental “insurance policy against catastrophe” (Clark, 1995).

Thompson, Cupplen and Sibbett (2001) explained that the culture of medicine encourages an image of invincibility and denial of vulnerability. This view is in line with other research in the same area (e.g., White, Shiralkar, Hassan, Galbraith, & Callaghan, 2006; Davidson & Schattner, 2003).

A limitation of these studies in relation to this research is that they used questionnaire surveys employing the use of rating scales and quantitative measures. Where these methods are useful and powerful in generating data to suggest generalisability, it does not however account for any further views which may also contribute to the research issue. Further, it is unclear whether the results are relevant across cultures.

### **2.1.9.2. Position in Medical hierarchy**

According to Cohen, Kay, Youakim, & Balaicuis (2009) the Hippocratic tradition emphasised the importance of group loyalty and identity, construing the profession of medicine as a “second family”. The Oath of Hippocrates goes as far as to suggest that teachers of medicine should be regarded by their medical students and juniors as new sets of parents (Cohen, Kay, Youakim, & Balaicuis, 2009).

Writers in the area (McKegney, 1989; Novack, Epstein, & Paulsen, 1999) claim that there is some evidence to suggest that the medical family alluded to in the Hippocratic Oath turns out to be in various ways like doctors’ true families. That is, senior doctors and peers may represent figures in JDs’ own families. Indeed, Niemi (1997) found in her qualitative study of medical students’ formation of professional identities, that as students and JDs encounter senior figures in their medical family, they experience some identity diffusion as they work to sort out not just who they enjoy and feel affection for in this new family, but also who they want to be like. In support of this,

Cohen, Kay, Youakim and Balaicuis (2009) found in their review of the literature, that JDs must learn to develop relationships with the better integrated, higher-functioning peers, senior doctors and other members of the team if they are to succeed. They go on to suggest that these relationships support the development of professional identity and provide a template for future practice. The following sections will describe the concepts found in the literature search which fall under this category of the position in the medical family and how this may contribute to the barriers in accessing counselling and psychological services. These concepts are: JDs versus senior doctors, male junior doctors versus female junior doctors, peers versus peers, and medical profession versus non-medical profession. These are detailed and discussed in turn below.

### ***2.1.9.3. Junior Doctors Vs Senior Doctors***

According to Kramer, Kwong, Lee, and Chung (2002), Asian populations have specific expectations of each age group that differ greatly with the western society. They suggested that because of this difference, all age groups are exposed to conflicts or clashes that may increase the risk for development of mental illness and distress. For example, junior generations are taught to show deferential treatment towards their seniors, and conformity to expectations is emphasised (Kramer, Kwong, Lee, & Chung, 2002; Sue & Sue, 1990; Chung, 2007). However, no research was found to suggest that senior generations respecting the decisions of the younger generation were found. These studies were conducted using participants from the general Asian population therefore there is limited relevance to British-Asian JDs. However, it can be reasonable to assume that this quality also exists in the medical culture among Asian JDs, although it is unclear to what extent. Given this assumption, it could be possible that British-Asian JDs are conforming to what they perceive to be acceptable or not acceptable by their seniors, in managing their mental health.

Research shows that senior physicians in charge of training house officers tend to underestimate the emotional distress in JDs (Purdy, Lemkau, Rafferty and Rudiskill 1987; Urbach, Levenson and

Harbison, 1989). In a study carried out by Redinbaugh et al. (2003), 46% of the JDs who participated found that in times of needed emotional support, they could not find anybody who was helpful. Similarly, in Godlee's (1990) research, JDs found that their seniors gave them inadequate support for their emotional distress.

These research findings may have major implications on JDs' help seeking behaviours as they rely heavily on their seniors to be accepted within their medical community (Murray, 2008). Murray (2008) found that JDs take their lead strongly from their supervising consultant. Although Murray's work was on infection control and prevention behaviours, the results can also be transferred and support the current study as it demonstrates the potency of supervising consultants' attitudes and behaviours on their JDs.

#### ***2.1.9.4. Male Junior Doctors Vs Female Junior Doctors***

Help seeking attitudes and behaviour have been found to be different across gender, where males tend to report a higher reluctance to seek help from a professional than do women (for example, Ang, Lim, Tan, & Yau, 2004; Vogel & Wester, 2003; Cusack, Deane, Wilson, & Ciarrochi, 2004; Yamawaki et al., 2011; Judd, Komiti, and Jackson, 2008; Mackenzie, Gekoski and Knox, 2006). One reason may be that we live in a society where men are expected to be stoic, controlled and self-sufficient. Addis & Mahalik's (2003), writers in this topic area, explain that this expectation may lead to men's increased concerns about disclosure and asking for support because to do so may mean admitting to the inability to handle things on their own, therefore creating a culture where men tend to avoid psychological services and conceal mental ill health. In Cramer's (1999) study, a person's attitudes toward seeking help and level of psychological distress predicted her or his willingness to seek help from a psychological professional. Consistent with these findings, Wallace and Constantine (2005) found that the relationship between self-concealment and help-seeking was significant for men but not for women.

The research findings in the literature search were largely conducted using non-medical participants and therefore there is limited relevance to the medical profession. No literature could be found that directly addressed gender differences in seeking psychological help for JDs, in particular those from British-Asian populations. However, despite this, doctors are still members of society and therefore it would be reasonable to assume that these difficulties that affect the lay person may also be applied to some degree to doctors. Indeed, Afifi (2007) explained that gender does not operate in isolation. It interacts in an additive or multiplicative way with other social markers like class and race. Mackenzie, Gekoski and Knox (2006) found that men's attitudes towards accessing psychological help was positively influenced by higher levels of education. That is, the higher educated they were, the less likely they were to access professional psychological services.

#### ***2.1.9.5. Peers Vs Peers***

In a review of the research evidence on help-seeking behaviours, Vogel, Wester, and Larson (2007) found that a potential influencing construct is the extent to which seeking help (or not) is the social norm. That is, the implicit standard of those close to the individual. Although social norms have not been directly reported as an influencing factor towards seeking professional psychological help, attitudes transmitted by significant others have been suggested to play a powerful role in how an individual defines and acts upon distressing symptoms (Vogel, Wester, & Larson, 2007). Rickwood & Braithwaite (1994) for example, pointed out that having a social network that accepts and encourages help seeking for a problem is necessary for the person to seek help. If therefore, important people in a person's life see counselling as a negative event, then he or she may be less likely to seek help for fear of exposure and loss of social standing. Therefore, if JDs observe that their peers do not engage in such help seeking activities, then it can be argued that they will also be less likely to do so themselves. Indeed, Bayer & Peay (1997) and Vogel, Wester, Wei, & Boyson (2005) found that people reported greater intent to seek professional help when they believed that important people in their lives would approve such an action.



### ***2.1.9.6. Medical profession Vs Counselling Psychology***

Kenny's (2004) a writer on medical influence and power explained that in non-medical cultures, psychiatry is suggested to be perceived as more powerful than psychology, due to the medical background and the prestigious status of the profession. However, it seems to be of the opposite opinion *within* the medical culture. That is, the literature suggests that psychiatry is considered to be at the bottom of the hierarchy within the medical culture (Esmail, 2007; Wigney and Parker, 2007, 2008) and therefore contributing to the barriers of accessing mental healthcare services for themselves.

### **2.1.9.7. Theoretical suggestions to understand the medical identity as a junior doctor.**

#### **2.1.9.8. Emotional Labour**

Larson and Yao (2005) took a psychological approach and defined emotional labour as the process of regulating experienced and displayed emotions to present a professionally desired image during interpersonal transactions at work. The term was originally coined by Hochschild (1983), detailing the organisational control over service workers' emotional life at work. Indeed, Armstrong (2003) asserted that when an individual is faced with any situation, such as carrying out a job, that individual has to enact a role in order to manage that situation. Furthermore, Chell (1987) explained that individuals must act within situations: situations are rule-governed and how a person behaves is often prescribed by these socially constructed rules.

It therefore seems that the emotional risks pertaining to emotional labour stem from a fundamental dependency on the work identity. The greater the proportion of one's self-conception that is invested in a single identity, the more emotionally susceptible one is to the ups and downs of the role or group in question (Ashford & Humphrey, 1993). Thus, the more central the role is in one's identity, the greater the vulnerability is to emotional costs.

Given this theory, it can therefore be considered that the more an individual JD places importance on his or her work identity, the more likely they are to conform to group norms and implicit rules; rules which may include the rejection of mental health services for themselves.

### **2.1.9.9. Social Identity Theory**

Social Identity Theory, developed by Tajfel and Turner in 1979, stems from a psychological process of identification which emphasises group processes and intergroup relations (Tajfel & Turner, 1986). It assumes that people strive towards a positive self-esteem, to which one's affiliation to their in-group is an important regulator (Cameron, Duck, Terry, & Lalonde, 2005). In this way, social identity theory suggests that the groups to which a person belongs (e.g ethnic and profession) can provide a definition of who they are (Stets & Burke, 2000).

Indeed, Ashford and Humphrey (1993) stated that identification with a role may exacerbate the psychological impact of job stressors and performance failures. The more the individuals define themselves in terms of their organisational roles, the greater the internalisation of their role obligations and the more likely that they will feel anxious if they are unable to fulfil those obligations. In Burke's (1991) terms, this failure 'interrupts' the continuous verification of one's social identity and thus triggers distress.

This socially constructed 'self-stereotyping' amounts to the depersonalisation of the self to the point that individuals come to see themselves more or less as exemplifying the group (Turner & Oakes, 1989). Individuals develop a sense of who they are, what their values, goals, and beliefs are, and what they ought to do in accordance to their group identity (Ashford & Humphrey, 1993).

Thus, identification can be emotionally debilitating if one is forcibly separated from the group in question. If a JD were to seek psychological services, this could be seen as separating himself or herself from the group in which he or she belongs due to not conforming to his or her social identity as a British doctor.

### **2.1.9.9.1. Gender Role Socialisation**

Researchers have taken different standpoints when explaining gender differences in help seeking attitudes. One explanation suggests that men's help seeking behaviours are a result of gender role socialisation (Addis & Mahalik, 2003). These role socialisation models explain behaviours and attitudes in men and women as a by-product of norms, cultural values, and belief systems. These cultural components teach individuals about appropriate gender roles. For example, men tend to be socialised to be self-reliant, have emotional control and physical toughness, whereas women are generally expected to be dependent, emotionally expressive, affectionate, and passive (Addis & Mahalik, 2003). All of these components may create a barrier for male British-Asian JDs to seek professional help of any kind when needed.

### **2.1.9.9.2. Collectivism and Individualism**

The concept of individualism-collectivism has been discussed in the literature across the social sciences for decades. In recent years empirical methods have been employed to obtain a superior understanding of these constructs. In-groups and out-groups in collectivist and individualistic cultures are perceived differently. In-groups in collectivist cultures are perceived as homogeneous whereas in-groups in individualistic cultures are seen as more heterogeneous than out-groups (Goncalo & Staw, 2005). Also, collectivistic and individualistic cultures hold different premises. Collectivistic cultures highlight the importance of supporting the wellbeing of the in-group more than individualistic cultures (Triandis, McCusker, & Hui, 1990). Moreover, hierarchy and harmony between the individuals are attributes that collectivistic cultures value and use to define themselves. In contrast, individualistic cultures value personal fate and achievement, independence and self-reliance (Triandis, McCusker, & Hui, 1990).

Collectivism and individualism affect help seeking behaviour in various ways. According to Triandis (1989), attitudes and values endorsed by a certain culture will affect the way an individual will seek

help. Triandis's study (1989) proposed three aspects of the self which affect the way individuals process and assess self-relevant information around them. The three aspects are: private, public and collective. Triandis reported that collectivist cultures focus more on the collective self more than the individualistic cultures whereas individualistic cultures pay more attention to the private self than the collective self.

It has been argued that collectivistic values that are traditionally held by Asian cultures oppose the values associated with Western psychology (Leong, Wagner, & Kim, 1995). Many traditional psychological orientations place high value on open verbal communication, exploration of intrapsychic conflicts, and a focus on the individual. Sue and Sue (1990) maintain that these processes encourage the client to put their own individual goals before those of the collective. This priority runs in direct conflict with allocentric values held by Asian populations, which involve the subordination of individual goals to the goals of the collective.

Given that the medical environment has parallels with collectivist values (Cohen, Kay, Youakim, & Balaicuis, 2009; Niemi, 1997), the experience of JDs from an individualistic background may differ to those from a collectivist background. Given this, no research studies could be found to explain the difficulties of bi-cultural identities when one is required to adopt and adapt the values of both collective and individualistic cultures.

### **2.1.9.9.3. Collective Narcissism**

Collective narcissism is a type of narcissism where an individual has an inflated self-love of his or her own in-group. It can be exhibited by an individual on behalf of a group or by a group as a whole. (Golec de Zavala, Cichocka, Eidelson, & Jayawickreme, 2009). Fundamentally however, collective narcissism always has some tie to the individuals who make up a narcissistic group (Golec de Zavala, Cichocka, Eidelson, & Jayawickreme, 2009). Collectively narcissistic groups require – just as an

individual narcissist requires – external validation (Duchon & Drake, 2009). Organisations and groups who exhibit this behaviour typically try to protect their identities through rewarding group-building behaviour (Duchon & Drake, 2009). Indeed, the strong group culture suggested to be prevalent in the medical profession with possible sanctions should an individual deviate from the interests and image of their group identifies (by accessing psychological services) can be thought in terms of collective narcissism. Their perceived superior social positioning in society is also validated by the general public who rely on them as doctors for their good health.

#### **2.1.9.9.4. Classic Elite Theory**

Classic elite theory is the belief or attitude that some individuals, who form an elite – a select group of people with intellect, wealth, specialised training or experience, or other distinctive attributes – whose views on a matter are to be taken the most seriously or carry the most weight (Bottomore, 1993). It is perceived that views of those from elite groups are most likely to be constructive to society as a whole; or whose extraordinary skills, abilities or wisdom render them especially fit to govern (Bottomore, 1993). As with collective narcissism, JDs certainly fall into a social group comprised of intellect, wealth and specialised training for which the public rely for their health. In line with this theory, a culture of JDs whose group attributes suggests leadership, capability and power; classic elite theory can be used to aid our understanding of JDS' reluctance to seek psychological help for themselves where this profession may have connotations which threaten their group identity.

#### **2.1.9.9.5. Section Summary**

Within the literature on the Medical Identity as a British-Asian JD, four main constructs were highlighted as influential factors towards this phenomenon: renegotiating own cultural identity (Kramer, Kwong, Lee, & Chung, 2002; Esmail, 2007), norms of acceptable behaviour (Cooke, Halford, & Leonard, 2006; Davidson & Schattner, 2003), cultural conceptions of being a doctor (Tate, 2010;

Adshead, 2005, and position in medical hierarchy (Kramer, Kwong, Lee, & Chung, 2002; Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger, 2011).

The overarching message of the literature is that JDs are likely to hold assumptions on the qualities that contribute to the perceived ideal group member within this profession. Typically, they may base their identity as a doctor on the qualities which they perceive as promoting acceptance. This involves conformity to the perceived norms of acceptable behaviour. The accepted identity of a doctor as 'coping' and holding power and authority over patients seems to contradict with the possible perception of Counselling as 'not coping' and evidencing vulnerability, and as such acting as a barrier to accessing such services.

Asian populations tend to perceive medicine and the profession as prestige and supremacy (e.g., Pangananamala and Plummer, 1998), and therefore place non-medical professions such as Counselling and Psychology in a devalued category which pertains to weakness. However, the literature on this construct focused on non-medical Asian populations. No studies were found in the literature search pertaining to Asian doctors' views and beliefs on the medical profession and specifically their views on accessing mental health services as a coping strategy. Therefore, the results for this search have limited relevance. Due to the perceived prestige and supremacy thought to be attached to the medical profession in Asian cultures, it may be reasonable to assume that the results for this search are experienced on a more potent level than the non-medical Asian population. However, no empirical evidence was found in the literature search to support this claim.

Theories offered by Hochschild (1983) on emotional labour and Tajfel and Turner (1986) on the social identity theory are discussed to enrich the understanding on how JDs develop and maintain their identities within the profession.

Emotional labour is the process of adapting one's behaviour and displayed emotions to that of the perceived desired image which is required in the workplace. Displaying an image of strength,

wellbeing and coping (Thompson et al., 2001) does not allow the notion of accessing professional psychological support to compromise their identity. Similarly, the social identity theory provides explanations on promoting acceptance within a desired group.

Within the literature for gender, attitudes of male JDs (e.g., Adshead, 2005; Brewin & Firth Cozens, 1997; Curran, 2008) and the attitudes of female JDs (e.g., Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger, 2011; Moller-Leimkuhler, 2002) were reviewed in relation to accessing psychological services such as Counselling Psychology. However, no literature could be found that related to the medical profession for this construct, and specifically no literature could be found concerning British-Asian JDs. The literature that was reviewed mainly involved the general non-medical population and in some cases, studies conducted in non-UK countries (e.g., Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger, 2011). Therefore the literature for this construct has limited relevance when applied to JDs in the UK. However, despite this limitation, it can be assumed that JDs still experience similar occurrences than the general population, whether on a more potent level or otherwise.

Gender role socialisation theory was reviewed to enrich the understanding on the contribution of gender towards accessing psychological services. Addis and Mahalik (2003) asserted that role socialisation models explain behaviours and attitudes in men and women as a by-product of norms, cultural values, and belief systems; and that each component teaches individuals about appropriate gender roles. Where this theory does enrich the understanding for any given single culture, it does not satisfy for an explanation on cross-cultural socialisation or when several cultures meet in the same setting. That is, where international JDs have brought with them their own cultural beliefs and views on accessing psychological care, and how this merges with the cultural norms which may differ to their own. This theory does not capture how individuals who find themselves in this position may manage their gender roles when they may be exposed to various cultures in the workplace. If the role socialisation models are thought of as a by-product of conforming to the gender norms and expectations of a given culture, then what it does not capture is how the 'expectations and norms'

are created in an environment where different cultures with different values and beliefs merge in the construction of a new unified and unique culture within a certain group. Specifically, this does not satisfy the knowledge of how gender role socialisation is socially constructed for JDs given the exposures to various cultures and their different norms. It therefore does not explain the process involved in constructing these norms and to the point, how they have come to co-construct their beliefs and attitudes which may place them at a distance to psychological services.

The concept of individualism-collectivism was offered as a theory to contribute to the understanding of cultural influence on seeking psychological help. According to Triandis (1989), attitudes and values endorsed by a certain culture will affect the way an individual will seek help. Given the significant numbers of doctors in the UK that are from Asian populations; a population which is mainly thought to be from a collective culture (Leong, Wagner, and Kim, 1995), this theory has particular relevance in contributing to our understanding of the social construction of barriers to accessing psychological services for Asian JDs. However, as with gender role socialisation models, it does not capture the how an individuals may interact in the social construction of a new culture, and how this may impact on their identities as a JDs. In the construction of this new culture with its own attitudes and values which JDs may find themselves embedded, this theory does not satisfy for understanding how exposure to various cultures may influence their views on accessing psychological services. Clearly more research is needed to contribute to the understanding social processes involved in this complex issue.



## **2.2. Section Two**

### **2.2.1. Development of coping strategies within the medical culture**

The subjective experience of ill-health, whether psychological or physical, is not taught or much discussed in medical school, and most doctors find out the hard way through being ill themselves (Adshead, 2005). For many doctors, illness is something that not only has to be managed and overcome as quickly as possible, but also essentially happens to other people (Tattersall, Bennett, & Pugh, 1999).

Within the literature search, one main strategy is suggested to be adopted by doctors to cope within the British medical environment: clinical detachment. This will be detailed and discussed below along with the constructs which forms it.

### **2.2.3. Clinical Detachment**

Writing about the teachings of the eighteenth century surgeon-anatomist William Hunter, Richardson (2000) explained that Hunter urged his students to gain a 'necessary inhumanity' by dissecting the dead. Hunter knew that trainee doctors could not be too tender and that this inhumanity would stand his students in good stead in dealing with the surgery of the day, which in the days before anaesthesia, antisepsis or transfusion, needed to be not just accurate but fast if it was to be successful. According to Richardson (2000), we now call this necessary inhumanity 'clinical detachment', or something similar, which sounds less emotive and more scientific.

It is argued that the term more accurately describes the alienation required of doctors in some circumstances than do the modern sanitised coinages, such as 'clinical detachment'. 'Detachment' and 'objectivity' imply separation, not engagement. This creates distance not only from patients but also from the self. The process may well be required, but where it becomes too extreme or

prolonged, it can damage everybody, including patients, family members and the doctors themselves if psychological ill health becomes apparent (Richardson, 2000).

In a study examining emotional expression, Komiya, Good, & Sherrod (2000) found that reluctance to seek counselling was greater for individuals who were not open about their emotions. Similarly, persons who were less skilled at dealing with emotions have also been found to be less likely to seek help, in general, as well as less likely to seek help from a mental health professional. This study was carried out using participants from the general population. However, given the clinical detachment that JDs are required to adopt, and therefore their possible distancing from their emotions, this phenomenon is a likely contributing factor toward the construction of barriers to seeking professional psychological services.

Further to this, Good, James, Good and Becker (2005) referred to this concept of clinical detachment as the 'medical gaze' in which doctors learn to see what 'relevant data' is and to speak the 'language of medicine'. The researchers go on to suggest that early in medical training, doctors enter the molecular worlds of disease and therapeutic interventions and the world of medical practice and medical culture. They learn socially accepted behaviours – when to speak, how to listen, and what is relevant to the clinical task. They fail to learn "what medicine cares about". That is, Good et al.'s research suggests that doctors place their social roles above their scientific roles of medicine; how they manage their roles as a socially accepted doctor, takes precedence. Whilst this research focuses on the social processes that may contribute to the medical culture, it fails to capture the contributions each individual has on shaping the culture in which they are embedded. It seems to take a positivist lens where it is assumed the medical culture pre-exists the individual doctors and that each doctor is therefore required to adapt their existence to fit into their workplace. Whilst the 'medical gaze' or clinical detachment may be a concept contributing towards JDs' reluctance to associate themselves with psychological services, taking a social constructivist lens would allow the investigation of the process involved and contribute to the understanding of the construction of this

phenomenon. That is, how the concept of clinical detachment has been constructed and adhered to among today's JDs to contribute to their views on psychological services and its appeal to them.

The following sections detail the ways in which the literature suggests clinical detachment is achieved and how it may impact on seeking therapy: avoiding proximity to mental health issues, their socially constructed views on being a patient, becoming a medical machine, and non-expression of emotion.

#### ***2.2.4. Avoiding proximity to mental health issues***

For many doctors, illness is something that not only has to be managed and overcome as quickly as possible but also essentially happens to other people. Wishful thinking and emotional distancing from distress are common methods that doctors use to cope with work stress, but these strategies are actually associated with increased stress and risk of mental health problems, presumably because they only work in the short term (Tattersall et al., 1999).

Robertson, Walter, Soh, Hunt, Cleary and Malhi (2009) conducted a study using a questionnaire design, and found that that most students enter medical school with a negative attitude toward psychiatry as they believe there is a stigma around the specialty. Further, the researchers claim that psychiatry has the common perception among medics to lack a scientific foundation and therefore has limitations in its treatment (Robertson, Walter, Soh, Hunt, Cleary, & Malhi, 2009). In support of this, Wigney & Parker (2007, 2008) found in their study that the lack of prestige and respect from the medical profession fostered a negative perception of psychiatry as a career and that there is clearly a need to address stigmatising attitudes within the medical hierarchy.

With a socially constructed negative view on a mental health specialty within the medical profession as suggested by the evidence, there is room for argument that professions in the mental health field without such medical foundation, i.e., counselling and psychology, may be received with even less

enthusiasm; denying or rejecting the need of such services as these services are reserved for patients.

### ***2.2.5. Views on being a patient***

Mckevitt & Morgan (1997) in their qualitative study using open-ended interviews found that by resisting illness, doctors believe they are also maintaining their separation from patients. Thus illness and patienthood are to be resisted not merely because they are inconvenient or unpleasant but also because they are not appropriate for the doctor, not appropriate for the doctor's relationship with patients and not appropriate for the doctor's identity. The idea that the doctor may not get sick suggests that, for doctors at least, doctors and patients constitute discrete and mutually exclusive categories, each with its own set of attributes: power and weakness, knowledge and ignorance, ability to cure and need to be cured. The researchers go on to explain that to be a patient appears to imply the assumption of a status which is inimical to a doctor's own professional status and identity. Doctors therefore learn to resist illness and may prefer to deal with any health problem themselves. Observing this as a perceived norm, the socially constructed norm may be that self-prescribing and 'corridor consultations' (Taylor, Graham, Potts, Richards, & Ramirez, 2005; Davidson & Schattner, 2003; Adshead, 2005; Adams, Lee, Pritchard, & White, 2009; Tattersall, Bennett, & Pugh, 1999) have been observed and created as the acceptable coping mechanism as opposed to the utilisation of professional consultations with a psychologist. With images and beliefs on being a patient that is incongruent with the socially constructed values and beliefs of a good and competent doctor, reaching the contemplating stage of seeking psychological help may seem a necessity to avoid. Taking this evidence together, it appears that JDs may have co-constructed a culture where seeking psychological help belongs to the pre-contemplative stage (Prochaska and Diclemente, 1992) of access to the services.

### ***2.2.6. Non-expression of emotion***

Persaud (2004), an author and Consultant Psychiatrist, explained that two key tasks required of doctors are to hide negative emotions and to display positive emotions, even when feeling the opposite. Constantly hiding deep dislike for colleagues and difficult patients is stressful enough but if combined with forcing positive emotions, this can push an individual closer to 'burnout' (Gross & Levenson, 1997). It therefore seems that an implicit rule of being an acceptable JD would be to avoid dealing with any psychological distress by displaying an image of coping. This does not leave room for Counselling Psychology or acknowledgement of emotional functioning.

### **2.2.7. Perceptions and Use of Counselling Psychology**

The influence of cultural values on help-seeking behaviour can be particularly important in cultures that have close networks. Counsellors and Psychologists may be seen as "out-group members" who are not part of a social network or family (Atkinson, Whitely, & Gim, 1990; Yeh, 2002).

In a study by Kushner and Sher (1991), results indicate that a strong predictor of one's help seeking behaviour is the extent to which the person is fearful of the treatment sought. Treatment fearfulness is a negative predictor of whether or not the person seeks help from a mental health professional such as a Counselling Psychologist. If the person decides to seek professional help, treatment fearfulness will also determine who they will seek for help (e.g., type of professional help sought). Treatment fearfulness is associated with the hesitation that one experiences prior to seeking help. It is culturally influenced and tends to be very complex. Kushner and Sher (1991) described some potential sources of treatment fears including fear of: embarrassment, change, treatment stereotypes, and stigma. Fear of treatment entails three main factors: 1) *therapist responsiveness* (apprehension about the professional's competence and demeanour), 2) *coercion concerns* (apprehension about change), and 3) *image concerns* (fear of being stigmatised and embarrassed by others). In a similar study, Vogel, Wester, Wei, and Boyson (2005) found that levels

of fearfulness of psychological treatment, comfort level of self-disclosure, and attitudes toward seeking counselling influenced treatment expectations. Other factors such as being psychologically open, having interpersonal openness, and being able to self-disclose information. Further, people's knowledge of counselling services have been positively associated with better attitudes toward mental health service (Goh, Xie, Wahl, Zhong, Lian, & Romano, 2007). Although these studies used non-medical participants, it would be reasonable to assume that British-Asian JDs may also experience these factors. However, this may possibly be on a more potent level due to their perceived prestigious status in society as discussed earlier, and their possible concerns about their image within a British institution where racism has been thought to exist towards black, minority and ethnic (BME) doctors, as suggested by key researchers in the area of Asian doctors working in the UK (Bornat, Henry, & Raghuram, 2009; Esmail, 2007; Mistry & Latoo, 2009). The following sections will detail the sub-category which make up the category 'Perceptions and Use of Counselling Psychology'. These are: 'Credibility' and 'Cultural Conceptions of Cure'. These are discussed in turn below along with the constructs which form them.

### ***2.2.8. Credibility***

The construct of credibility is thought to contribute towards the barrier to help-seeking. Sue and Zane (1987) proposed that an important ingredient in promoting treatment utilisation among ethnic minority clients involves minimising problems with perceived credibility of the treatment or treatment provider. Indeed, Sue and Sue (1990) describe credibility as a constellation of characteristics which make a service worthy of belief, entitled to confidence, reliability and trust. The ethnicity of the therapist and perceived cultural competence may be an important factor in credibility beliefs. Support for this model has been found by Akutsu, Lin and Zane (1990) who demonstrated that perceptions of the therapist's credibility were indeed the most powerful predictor of utilisation intent among Asian populations. There is potential for incongruities at various levels, to include problem conceptualisation, means for resolution, and goals for treatment –

widely opposing ideas between therapist and client is likely to impact upon how credible the client perceives the service to be (Sue & Zane, 1987). Asian doctors therefore may not view psychological services as a credible source of help.

### ***2.2.9. Competing professional power***

The concept of hierarchy of professions, and therefore power allocation through traditional professional status, has significance in mental health care. Psychiatry has traditionally had the primary position of power within the mental health services in the UK (Kenny, 2004). The compelling power of medicines and the high degree of professional confidence developed by medical doctors, combined with consciousness of these factors by other professions such as Counselling Psychologists, contributes to guardedness between professions (Irvine, Kerridge, McPhee, & Freeman, 2002) and in turn impacts on their attitudes towards accessing psychological help for themselves; counselling psychology is not for them as it does not 'cure'.

Irvine, Kerridge, McPhee, & Freeman's (2002) study although from a positivist philosophical basis, can be interpreted through a social constructivist lens to complement the findings. That is, the evidence from these studies suggests that certain professions place individuals in positions in a hierarchy depending on the prestigiousness of their employment. Social constructionism would allow the exploration of these understandings by looking at the social processes which have constructed the meanings attributed to each profession. This perspective could allow for a deeper knowledge on the process of construction of beliefs and attitudes within a given culture towards accessing psychological treatment. Further, a social constructivist perspective would allow for the exploration of the complex interaction of different cultures in creating a unique one. No studies were found in the literature search from a social constructivist basis which complemented and supported the positivist studies presented in this review.

### ***2.2.9.1. Mumbo Jumbo for patients***

Mumbo jumbo is an English phrase or expression that denotes a confusing or meaningless subject.

According to the Concise Oxford English Dictionary (2011):

*“Mumbo Jumbo is a noun and is the name of a grotesque idol said to have been worshipped by some tribes. In its figurative sense, Mumbo Jumbo is an object of senseless veneration or a meaningless ritual”.*

Within the literature search, there were suggestions that doctors view the psychological profession and practice to involve ‘senseless veneration’ and ‘meaningless ritual’, and therefore quite possibly viewing the psychologist as a ‘grotesque idol’ (Robertson, Walter, Soh, Hunt, Cleary, & Malhi, 2009; Craddock, et al., 2008; Curran, 2008). Indeed, this may provide and contribute to the understanding of the under-utilisation of counselling and psychological services.

### ***2.2.9.2. Confidentiality and a fear of exposure***

Given the ready access the medical community has to medical and confidential information, it has been suggested that JDs have concerns regarding the confidentiality relating to seeking psychological help for themselves; doctors do not trust the system to keep their medical information safe (Department of Health, 2008; Davidson & Schattner, 2003) and this creates a barrier to seeking psychological services. Confidentiality breaches, combined with professional attitudes discouraging admission of vulnerabilities, have been reported to influence doctors’ reluctance to seek professional mental healthcare (Center, Davis and Detre 2003). Furthermore, the British Psychological Society (BPS) stated that if a psychologist feels a client is at risk of harming him/herself or others, the psychologist may have to break confidentiality (BPS., 2005, 2008). This may raise fears of the counselling psychologist or mental health professional feeling that the client (the JD) may harm his patients due to his mental ill health.



### **2.2.9.3. Theoretical suggestions to understand JDs' development of coping strategies within the British medical culture**

According to psychoanalytic traditions, we avoid particular thoughts and so implement avoidance strategies quite consciously. For the most part, however, defences are brought into play without any conscious will (Lemma, 2003). There are three main defences within psychodynamic theory which may contribute to the understanding of the category 'development of coping strategies within the British medical culture': denial, projection and compartmentalisation.

#### **2.2.9.4. Denial**

Denial involves blocking external events from awareness. It is thought to be used by individuals to avoid dealing with painful feelings or areas of their life they do not wish to admit. JDs may deny that they are struggling emotionally with the demands of their work, pointing to how well they function in their job without the need for psychological help.

#### **2.2.9.5. Projection**

Projection is the misattribution of a person's undesired thoughts, feelings or impulses. Projection is used especially when the thoughts are considered unacceptable for the person to express, or they feel completely ill at ease with having them. Projection is often the result of lack of insight and acknowledgement of one's own motivations and feelings. JDs may project their vulnerability and feelings of not coping on to their patients, therefore creating the belief that therapy is not for them as 'coping beings'.

### **2.2.9.6. Compartmentalisation**

Compartmentalisation in psychodynamic theory refers to an individual separating parts of oneself from awareness of other parts and behaving as if one had separate sets of values. For example, a JD remains in the 'doctor' mindset and does not allow oneself to be a 'patient'.

### **2.2.9.7. Section Summary**

Within the literature for 'Development of Coping Strategies within the British Medical Culture', one main factor was suggested to be employed by JDs to assist in their managing their emotions: clinical detachment.

The take home message from the literature on this concept appears to be that it is common practice and a necessity for medics to adopt a distance from their emotions and operate as a 'medical machine' stripped of feelings. The evidence takes a realist perspective where the researched phenomenon exists independently to the researcher and research participants. For example, Robertson, Walter, Soh, Hunt, Cleary, & Malhi's (2009) research suggests that the culture where psychiatry is considered to be a 'lesser' profession for doctors due to a reported lack of scientific foundation, exists independently of the people within that culture. It pre-exists the doctors' entry into the medical workforce to which they must adapt. This research gives some useful insight into the ways in which JDs may organise their thoughts and beliefs of mental health and its impact on their access to such professional services. However, a social constructivist perspective would argue that the culture does not pre-exist its members, but rather it is those that belong to a given culture which constructs the culture itself. Therefore, looking at the research from a social constructionist lens, a process has been at play where JDs have co-created the meanings of mental health services and its perceived impacts if they were to allow themselves within close proximity of them. There was an absence of research in the literature search which investigated such processes.

Defence mechanisms derived from psychodynamic theory were offered to understand the development of coping strategies for JDs. Denial, projection and compartmentalisation were stated as possible defence mechanisms. These theories are useful in understanding how JDs may be organising the management of their coping strategies and their mental health as a whole, and therefore contributing to their construction of barriers to psychological services as a collective.

## **2.3. Section Three**

### **2.3.1. Unacceptability of Difference**

Individuals who seek psychological help are viewed as less socially acceptable and less favourable, and receive more negative treatment from others (Sibicky & Dovidio, 1986; Vogel, Wade, & Haake, 2006) presumably because they are regarded as stepping away from the social norms and therefore viewed upon as 'different'. Indeed, Yamawaki (2007) found that the fear of stigmatisation for receiving counselling significantly influences willingness to seek psychological services. These studies were, however conducted using participants from the general population and therefore the extent to which this applies to JDs particularly those from British-Asian populations is unclear.

A quantitative study using questionnaire surveys, conducted by Adams, Lee, Pritchard and White (2010) found that their respondents felt that doctors with a history of depression were discriminated against in various ways. For example, 1073 (87.1%) respondents agreed with "Doctors are less likely to appoint a doctor with a history of depression". Doctors overwhelmingly endorsed the statement that doctors should portray a healthy image with 1193 (96.4%) in agreement.

The following sections will discuss the literature on 'unacceptability of difference' and how this may impact and contribute to barriers to psychological treatment. Within the literature search, two main factors were thought to be an outcome of this category: 'discrimination' and 'experience of stigma'. Recruitment and career advancement are thought to be compromised when JDs are discriminated

against. Stigma of mental health issues and shame are discussed in relation to the experience of stigma.

### **2.3.2. Discrimination**

There is evidence to suggest that discriminatory practices against doctors evolved from medical school. For example, discrimination against BME groups has been found in three separate studies using questionnaire-survey designs (Esmail & Everington, 1993; Esmail & Everington, 1997; Coombes, 2004) at the time when students applied to study medicine, as short-listing was suggested to be based on whether applications had Asian or English names. Given the evidenced discrimination towards BME groups in medical populations, it may be possible that in their striving to be accepted, British-Asian JDs may have a more potent reluctance to seek psychological help than the general medical population.

### **2.3.3. *Recruitment and career advancement***

Chew-Graham, Rogers & Yassin (2003) found in their study that the medical culture dictated that a mental health problem may be viewed by their participants as a form of weakness with implications for subsequent career progression.

In 2003 a British Medical Association (BMA) survey revealed that in ethnic minority doctors, more than 80 percent believed that their ethnicity had a negative effect on their career advancement (Cooke, Halford, & Leonard, 2006). However, this study focused on overseas trained doctors in relation to racism in the workplace and strived to seek positivist assumptions on the issue.

Therefore factors such as acculturation and language barriers and appearance were studied rather than the processes involved in the creation of a unique culture of British JDs. How these factors may contribute towards the barrier in accessing psychological services is unknown. Further, the study

employed the use of self-reports and therefore the data cannot be treated as empirical evidence that a problem exists with racism in the medical community. The results however, can be used to suggest that participants felt their ethnic backgrounds were a significant factor in relation to the success of their careers.

Taking these discussions together from Chew-Graham, Rogers & Yassin (2003) and Cooke, Halford, & Leonard (2006), it can be argued that admitting to a mental health problem can be viewed by individuals as having a hindrance on career progression. This is possibly perceived to be more potent for those from ethnic minority backgrounds. Therefore, the studies suggest that admitting to mental health problems and being from an ethnic minority background may contribute towards the construction of the barriers in associating themselves with lower status psychological services (Esmail, 2007; Wigney and Parker, 2007, 2008).

#### **2.3.4. Experience of Stigma**

Many questions have been raised as to what exactly is stigma. On review of the literature, many use Goffman's definition of stigma in an attempt to define the concept: "An attribute that is deeply discrediting" and reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3).

#### ***2.3.5. Interdependence***

Doctors have an enormous sense of obligation to medicine, and taking time off is often seen as 'letting the team and the patients down' which may possibly lead or contribute to stigmatisation of being an 'ill doctor'. Many doctors approach their work with a sense of 'collective martyrdom', whereby it is considered normal to sacrifice oneself for ones' patients and profession (Rowe and Kidd, 2009). While sacrificing some things to pursue your passion is one thing, it is a different matter to lead an unbalanced, unhealthy life in the name of medicine. Similarly, Iversen, Rushforth and Forrest (2009) found in their study that doctors feel they do not have time to be a patient, or that

they are somehow letting the side down if they were to take any time off of work for illness or to receive any treatment. These findings are also replicated by Forsythe, Calnan and Wall (1999) in their study using a postal survey. However, these studies are focused on the general medical population and are not specific to JDs. Further, these studies do not address questions around the meanings behind a 'lack of time' to be a patient and whether this is an actual perceived barrier to

### ***2.3.6. Shame***

Shame and embarrassment was a recurrent theme in terms of accessing healthcare for doctors (Rosvold & Bjertness, 2002; Richards, 1989; Forsythe, Calnan et al., 1999; Adshead, 2005).

Specifically, the following factors were reported to have encouraged a sense of embarrassment in seeking help for themselves: exposing self to peers personally and emotionally (Pullen, Lonie, & Lyle, 1995; Davidson & Schattner, 2003; Mckevitt & Morgan, 1997; Shadbolt, 2002); feelings of failure for not being able to cope (Leao, Martins, Menezes, & Bellodi, 2011; Mckevitt & Morgan, 1997; Richards, 1989; Thompson et al., 2001; Adams, Lee, Pritchard, & White, 2010); worrying that illness/concerns may be trivial (Davidson & Schattner, 2003; Mckevitt & Morgan, 1997; Rosvold & Bjertness, 2002; Richards, 1989; Thompson et al., 2001; Shadbolt, 2002); and having mental health issues (Pullen et al., 1995; Davidson & Schattner, 2003; Mckevitt & Morgan, 1997; Rosvold & Bjertness, 2002; Richards, 1989; Baldwin, Dodd, & Wrate, 1997a; Shadbolt, 2002; Hassan, Ahmed, White, & Galbraith, 2009).

A study by Mckevitt and Morgan (1997) found that medical doctors who reported experiences of psychiatric illnesses initially lacked the insight needed to recognise the nature of their problem.

They described feeling tired, overworked or under stress, but were not necessarily aware that their symptoms might point to a psychiatric diagnosis. Realising that they had been labelled as mentally ill, all the participants experienced embarrassment, shame or horror. In addition to discomfort at the stigma that generally attaches to a diagnosis of psychiatric illness, they were dismayed that they, as doctors, were so diagnosed.

Echoing this finding, a study by Mukherjee, Fialho and Wijetunge (2002) suggested that doctors may experience high levels of shame associated with being ill, perhaps more than the general population. This is likely to be worse when the problems are psychological in nature. Doctors, like the rest of the population, are affected by stigmatising images of mental illness and, therefore, create a barrier against its treatment.

### **2.3.7. Theoretical suggestions to understand the unacceptability of difference as a JD and its contributions to the barriers to psychological treatment**

#### **2.3.8. Conceptualising Stigma**

Link and Phelan (2001) are quick to recognise that the creation of stigma is a social process. They proposed a model in an attempt to conceptualise stigma. According to this model, stigma exists when four specific components converge:

1. Distinguishing and labelling differences;
2. Associating human differences with negative attributes;
3. Separating 'Us' from 'Them'; and
4. Status loss and discrimination.

Subsequently, they concluded that if all these components are present, then stigma will exist with the facilitation of a power situation, for example, where a dominant group has more power over the other, for example JDs not seeking psychological services over JDs who seek psychological services.

Because of the importance of power in stigmatisation, Link and Phelan (2001) proposed that it is critical to ask the following set of questions: Do the people who might stigmatise have the power to ensure that the human difference they recognise and label is broadly identified in the culture? Do the people who might confer stigma have the power to ensure that the culture recognises and

deeply accepts the stereotypes that they connect to the labelled differences? Do the people who might stigmatise have the power to separate 'Us' from 'Them' and to have the designation stick? And do those who might confer stigma control access to major life domains, like educational institutions, jobs, housing, and health care, in order to put really consequential teeth into the distinctions they draw? To the extent that we can answer "yes" to these questions, we can expect stigma to result. To the extent that we answer "no", some of the cognitive components of stigma might be in place, but what we generally mean by stigma would not exist (Link & Phelan, 2001).

Given the strong literature base on the construct of stigma in relation to doctors and mental health, it would be reasonable to consider the application of this theory to the medical culture; consequently contributing towards the barrier of accessing psychological services. This theory also highlights the power situation within the medical culture and its influence over the attitudes, behaviour and arguably emotions of JDs.

### **2.3.9. Maintaining Social Bonds**

Drawing from the work of Scheff (1990), it may be apparent that a reason for conforming to implicit rules may lie in human nature being intrinsically social and, as such, the most crucial human motive is the maintenance of social bonds and therefore to avoid situations outside the norms of a social group to which one belongs. Scheff argued that maintaining a social bond requires interaction and this involves two kinds of systems: communication systems (for example, language) and deference-emotion systems (a system involving the control of informal sanctions, for example the punishment of embarrassment, humiliation or shame). The communication system involves both verbal and non-verbal cues (Scheff, 1988) and goes beyond conversing for a successful interaction. The interaction must also be monitored to preserve attunement (Scheff, 1990) and one way to achieve this is the use of embarrassment and shame.



According to Scheff (1990), shame begins with a feeling that the social bond has been broken. In these situations, we sense a lack of deference or respect, as well as negative evaluation of self by others and ourselves. The relevant shame can be acknowledged or unacknowledged. According to Scheff (1990), acknowledging shame for what it is discharges the shame. Recognising the shame prevents anger, which is one of the triggers that become the recursive loop. Acknowledging shame also creates a situation where it is possible to feel pride: pride at repairing or preserving the social bond. Unacknowledged shame creates the feeling of being trapped and results in some predictable consequences and symptoms, for both the person and their social bonds.

To summarise the idea surrounding shame and its cycle, Scheff (1990, p. 88) devised a diagram, which is shown in Figure 1.

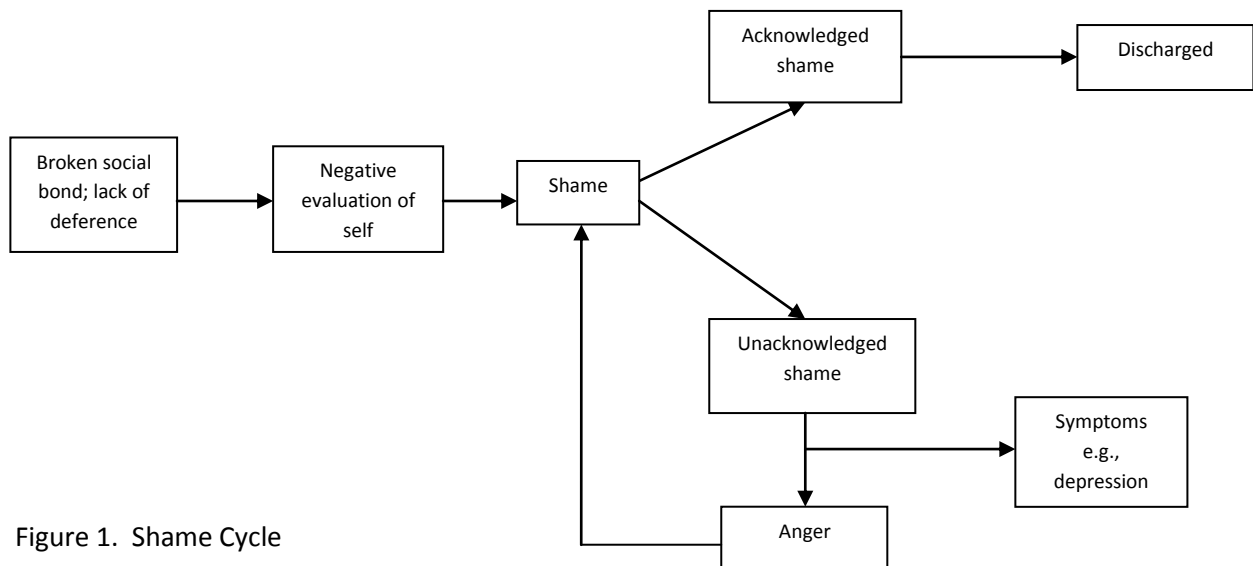


Figure 1. Shame Cycle

Goffman's (1967, 1963) work can be used to describe this further. Goffman explained that in every situation, there are virtual and real selves. The virtual self is made up of the idealised expectations that go along with a particular self or identity. The real self is made up from the individual's actual

behaviours. Embarrassment is an interactional device that keeps these two selves from getting too far apart. Goffman (1963) went on to explain that in every situation and with every behaviour we run the risk of not living up to the situation's idealised expectations [coping well as a JD and not having to access psychological services]; embarrassment is, thus, a constant threat. If we fail to live up to the expectations, we will be embarrassed in front of others; something we are motivated to avoid.

### **2.3.9.1. Section summary**

Within the literature for unacceptability of difference as a JD, discrimination and experience of stigma have been suggested to occur if an individual does not 'fit' into the image and social norms within the culture to which they belong.

Several attempts by different theorist have offered a definition of the concept of stigma. However, many use Goffman's version of "An attribute that is deeply discrediting" and reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p.3).

The literature suggests that within the phenomenon of stigma, JDs are likely to fear the loss of power and authority; qualities which are suggested to contribute towards the identity of being a successful JD. Two main constructs are thought to contribute towards this fear: social unacceptability, e.g., Vogel, Wade, & Haake (2006) and Adams et al. (2010); shame and embarrassment, e.g., Mukherjee, Fialho, & Wijetunge, (2002).

The difference between the two constructs which contribute towards stigma is that social unacceptability is an external concept where the outcome is influenced by external control such as discrimination. Shame and embarrassment on the other hand is an internal construct where the feelings are only known and felt by the bearer.

The literature suggests that these components are of particular interest to the stigma of mental health as a JD as they imply a threat to them standing out from the norm and not conforming with the majority. As highlighted by the literature, these constructs have the power to discriminate the JD (who stands out from the norm) in various ways (Adams et al., 2010). The fear of this consequence therefore may significantly contribute towards a barrier in accessing professional mental health services.

Two main theories were reviewed to enrich the understanding of the stigma of mental health as a JD: conceptualising stigma (Link and Phelan, 2001) and maintaining social bonds (Scheff, 1990; Goffman, 1967, 1963).

Link and Phelan's model of stigma proposed four main components which they claim to make up the concept of stigma with the presence of a dominant group. They highlighted the importance of power for stigmatisation to take place. Given that power and authority is such a presence in the medical culture, as discussed in section one (Tate, 2010; Parsons, 1987), this model demonstrates the significance in its contribution towards the barriers in accessing mental health services for JDs.

Similarly, Goffman (1967, 1963) and Scheff's (1990) descriptions of humans' motives to maintain social bonds were reviewed. Scheff (1990) explained that creating a feeling of pride helps to preserve social bonds. Therefore, pride can be argued to be compromised if mental health issues were to be attached to JDs and therefore creating a rupture in their social standing and bonds.

## **2.4. Section Four**

### **2.4.1. Chapter Summary**

This final section summarises the key issues previously discussed, presents criticism of the current literature base for JDs and their views and attitudes towards seeking psychological services for themselves, and then outlines the aims and objectives within this present research.

### **2.4.2. Key Issues**

There appear to be several theories and models that can be applied when seeking to understand the concept of JDs and their reluctance to personally associate themselves with psychological services. Although, as of yet, none appear to provide a comprehensive explanation for this phenomenon, the literature thus far suggests some constructs which may contribute towards the psychosocial barriers for JDs in accessing psychological services:

- The identity that a JD holds for oneself is suggested to contribute significantly towards their help-seeking behaviours, as they are suggested by the literature to conform to in-group behaviours to maintain their belonging in their group.
- The development of coping strategies within the British medical culture is thought to be a noteworthy contribution. It is thought that JDs manage psychological difficulties by separating themselves from their mental health and any form of mental health issues. This way of coping appears to have impacted on their construction of views on mental health services.
- JDs may feel the need to avoid deviations from the norms of an accepted doctor and deny or minimise the existence of discrimination and difference in the workplace. Avoidance of mental health issues and services are also thought to be another way of achieving acceptance and to avoid the feelings of shame being brought upon them.

- It has been suggested that JDs' perceptions of Counselling Psychology impacts on their use of the service.

However, there is little empirical research, in the field of doctors' help seeking behaviours and the barriers to doctors seeking psychological help which focuses on JDs. Given that this group of individuals are still in training grades, and rely on their senior colleagues for the success of their careers, it is important to understand the way they manage themselves psychologically by investigating the social processes involved. The empirical research appears to have gone straight into formulating ways to offer a better psychological service to the medical profession (Curran, 2008; Davidson & Schattner, 2003; Issaksson Ro, Gude, & Aasland, 2007; Kay, Mitchell, Clavarino, & Doust, 2008; Tattersall, Bennett, & Pugh, 1999). However, these studies do not appear to acknowledge that doctors in mental health difficulty may still be in the pre-contemplative stage (Prochaska and Diclemente, 1992) of accessing psychological care. Therefore, any service from this field that is offered to them will be underutilised which is not a promising or constructive way of using Counselling Psychology resources. Until a better understanding of the processes behind the 'facts' is gained, Counselling Psychology and related mental health professions may be continuing to offer a service which is not needed by the medical sector.

Due to the literature review methodology, it must be noted that there is a possibility of omissions of relevant publications which may not have been available in the journal databases used for this study. Therefore, the data used to inform the literature review was only based on the resources available in this search.

### **2.4.3. Criticisms of the Literature**

Of the empirical literature base available, much is resultant from studies conducted in the general medical profession or on medical students. Research focussed on JDs is rare, and research on British-Asian JDs was non-existent within the current literature search. Some literature was found

on the components which may be contributing towards the barrier of seeking psychological help as a British-Asian JD; however it mainly focussed on the general Asian population. This creates problems with the ability to apply the findings to British-Asian JDs. Further, many of the studies reviewed used a quantitative research design which limited the expansion of participants' views and beliefs. It was therefore unclear how the participants had arrived at endorsing certain statements.

The theoretical literature is more comprehensive however, it is equally compartmentalised. It focuses on theory development for general populations and does not cater to the specific needs associated with JDs and their mental health needs, namely the complex culture within which they are embedded.

Much of the literature that was available was not recent, in some case decades old. Therefore, there are questions around the level of relevance of the data to the current study due to changing social norms and structures. The more recent literature uncovered in the search (e.g., Robertson, Walter, Soh, Hunt Clearly and Malhi, 2009; Adams, Lee, Pritchard and White, 2009; Yamawaki, Pulsipher, Moses, Rasmuse and Ringger, 2011) mainly used quantitative questionnaire survey designs from a positive perspective. Using a social constructivist methodology would complement these findings by offering a theory to explain the phenomenon. Further, the recent studies largely used samples which had limited relevance to the current study (e.g., Yamawaki, Pulsipher, Moses, Rasmuse and Ringger, 2011; Judd, Komiti and Jackson, 2008).

#### **2.4.4. Aims and Objectives of this Research**

This research project aims to investigate the barriers which may be hindering the access to counselling and psychological services for JDs. In doing so, this research aims to readdress the balance of empirical evidence available for the issue. Grounded theory offers a way of exploring these individual perceptions and processes whilst also seeking for commonality in experience and establishing a framework and theory from which to hang it. It is hoped that this information can

then be used to inform future practice for counselling psychologists and the mental health profession when and if working with this client group.

# **Chapter Three**

## **METHODOLOGY**

### **3.0 Overview**

This chapter begins with detailing the research paradigm, followed by a discussion of the philosophy of a qualitative research paradigm and issues of rigour in section one. This discussion also provides a rationale for the use of a qualitative method for this current research study. Section two provides an exploration of epistemological frameworks. Section three details the choice of method of analysis and a rationale for the use of a Constructivist Grounded Theory Method. A brief summary of the chapter is given in section four.

### **3.1 Section One**

#### **3.1.1 The research paradigm**

The study set out to find what theory accounts for how a culture has been created amongst JDs where psychological services are not widely utilised given the high rate of psychological problems reported (e.g., Davidson & Schattner, 2003; Curran, 2008) .

From these objectives, it seemed appropriate to adopt a qualitative method as this allows for the gathering of rich data through semi-structured interviews and exploratory research. According to Creswell (1994), by selecting a qualitative paradigm, the researcher needs to address the ontological, epistemological, axiological, rhetorical, and methodological assumptions. Within the ontological assumptions, reality (of the research issue) is subjective and multiple, as seen by participants in the study. Epistemologically, the researcher interacts with what is being researched. Axiological assumptions place the role of values as value-laden and biased due to the subjective nature of the data. Finally, rhetorical assumptions involve the personal voice and accepted



qualitative words of the participants. A qualitative paradigm not only suited the research study, given the aims and objectives, but also was congruent with the researcher's background in counselling psychology in which much of people's subjective views and beliefs are based upon their interaction with the external environment.

### **3.1.2. Philosophy of qualitative methodology**

The philosophy of a qualitative research paradigm aims to generate rich data, which are then analysed in a systematic way, to provide a detailed and well-grounded description or explanation of the phenomena under study. This is done through the examination and exploration of the participants' "lived experience" of the phenomena under study. Whereas quantitative methods aim to test pre-existing hypotheses, qualitative methods provide a process through which we can examine phenomena that have not previously been theorised. Qualitative methods are able to hold on to the complexity of situations allowing the study of process, which quantitative methods, with their inevitably reductionist stance, fail to allow. Thus qualitative methods are often advocated as the best strategy for discovery, exploring a new area, and generating hypotheses (Miles & Huberman, 1994; Cochran & Rabinowitz, 2000).

### **3.1.3. Rigour**

Qualitative research is often criticised for a lack of reliability and validity. This is mainly because critics apply positivist evaluations of rigour in their evaluation and regard qualitative research as "merely subjective assertion supported by unscientific method." (Ballinger, 2006, p.235). Whilst positivist traditions base their research on reliability, validity and generalisability to ensure quality and trustworthiness of their work, qualitative research has its own sources of rigour.

Demonstrating reliability and validity, the case of data collected by qualitative methods can be difficult. Such data are unique to the specific context and to the individuals involved in a particular study, and so it lacks reproducibility (Rolfe, 2006). Also, qualitative research seeks to represent the

subjective, personal meanings held by respondents, and involves interpretation of data that is inevitably influenced by the values and judgements of the researcher, both of which limit objectivity (King, 1996).

The fundamentally different ethos and processes involved in qualitative versus quantitative research would suggest that judging the standards of qualitative research by concepts developed for quantitative research could be misleading. Rather, the qualitative research should be assessed on its own merits. The term “rigour” has often been used as an equivalent to reliability and validity for qualitative methods, and several authors have proposed ways of increasing the rigour of qualitative research and hence ensuring the quality of the work. Mays and Pope (1995) suggest that rigour in both quantitative and qualitative studies can be ensured by systematic and self-conscious research design, data collection, interpretation and communication, but that qualitative researchers should also:

- Be explicit about methods used, so that another researcher could analyse the same data in the same way and come to essentially the same conclusions and;
- Produce a plausible and coherent explanation of the phenomena under study.

Elliot, Fischer and Rennie (1999) have also described ways of enhancing the rigour of qualitative research, in the form of seven “guidelines”. These guidelines will be employed in the current study and are outlined in Table 1 (chapter four).

## **3.2. Section Two**

### **3.2.1. Epistemological frameworks**

Broadly speaking, qualitative research allows the creation of three types of knowledge: 1) realist knowledge, 2) phenomenological knowledge, and 3) social constructionist knowledge (Willig, 2012).

The assumption which underpins realist research is that there is something to be found. That is, the phenomenon under research exists independently of the researcher and participants' conscious awareness or influence. The role of the realist researcher is therefore to uncover and investigate the processes which characterise and shape the behaviour and or thinking of a given group of participants (Willig, 2012; Snape and Spencer, 2003). According to Willig (2012), researchers of this framework are more akin to that of a detective as their aim is to discover facts to aid the understanding of the research phenomenon. However, the interest of this study is to explore how the views and beliefs on accessing psychological services have been constructed by JDs through social interactions and processes. It does not aim to uncover any facts or truth.

Phenomenological research aims to explore the subjective experiences of participants. Their thoughts, feelings and perceptions of how they experience the research phenomenon is investigated rather than the social processes which have influenced them. This approach would allow the research to understand how JDs experience their roles and how they perceive psychological services. Whilst this knowledge would be useful and interesting, the remit of this epistemology would not allow the aims of the current study to be met where knowledge, experience and how these have contributed to barriers have been created.

Social constructionist knowledge states that the meanings of 'things' or phenomena (realities of the world, i.e., our lived experiences of objects, activities, relationships, human nature) are created or 'constructed' by the social world. Things do not have a meaning until people create a meaning for them. Social constructionism, therefore, emphasises the importance of culture and context in

understanding what occurs in society and constructing knowledge based on that understanding (Derry, 1999). Symbolic interactionism is a form of social constructionism which posits that meaning is negotiated and understood through interactions with others in social processes (Blumer, 1986; Dey, 1999; Jeon, 2004). This theoretical underpinning takes the assumption that social context is centralised in the research inquiry (Fassinger, 2005).

### **3.3. Section Three**

#### **3.3.1 Choice of method of analysis: Grounded theory method**

Grounded theory originates from sociology, specifically from symbolic interactionism, which posits that meaning is negotiated and understood through interactions with others in social processes (Blumer, 1986; Dey, 1999; Jeon, 2004). These social processes have structures, implied or explicit codes of conduct, and procedures that circumscribe how interactions unfold and shape the meaning that comes from them. The goal of grounded theory is to develop an explanatory theory of basic social processes, studied in the environments in which they take place. Grounded Theory Method comprises a systematic, inductive and comparative approach for conducting inquiry for the purpose of constructing theory. It is about constantly involving researchers with the data. The premise of the method is that the researcher should not go into the research with a hypothesis, but to have an open mind. The distinguishing characteristics of GTM include: (1) simultaneous involvement in data collection and analysis phases of the research; (2) creation of analytic codes and categories developed from data, not from pre-conceived hypotheses; (3) the development of theories to explain behaviour and processes; (4) memo-making, that is, writing analytic notes to explicate and fill out categories, the crucial intermediate step between coding data and writing first drafts of papers; (5) theoretical sampling, that is, sampling for theory construction, not for representativeness of a given population, to check and refine the analyst's emerging conceptual categories, and; (6) delay of the literature review (Charmaz, Grounded Theory, 1995).

Whilst grounded theory shares phenomenological research's interest in description and understanding there is an avowed focus upon the inductive development of theory to explain the phenomenon of interest. Research based upon grounded theory is done to produce abstract concepts and propositions about the relationships between them (Chenitz & Swanson, 1986). Grounded theory research can focus upon description, theory and process. Both phenomenological research and grounded theory are exploratory methods, but grounded theory aims to develop theoretical explanations of the relationships among categories of data as the research proceeds. This method therefore will explore the nature of JDs' interactions in the medical culture i.e., the processes involved behind their beliefs, views and attitudes towards psychological health seeking behaviours.

### **3.3.2. Rationale for using a Constructivist Grounded Theory Method**

A constructivist approach to grounded theory is suited to this study because, as Charmaz explained, the data does not provide us with a window on reality, but rather the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts (2000). That is, studying the culture and context of JDs' medical training, and their interactive processes, allows the discovery of what the JDs interpret as reality in relation to accessing psychological services.

Given the researcher's background in Counselling Psychology where much of the training involves working with the subjective experience of clients where the words that are spoken are accepted and value-laden; choosing a qualitative paradigm was not only suited to the research study, given the aims and objectives, but also a perspective which is congruent with the researcher's world view where much of people's subjective views and beliefs are based upon their interaction with the external environment.

Using a constructionist qualitative method was felt to be appropriate for the present research study, in which the aims were to investigate the psychosocial processes involved in the construction of the

beliefs and attitudes that have been contributing to the creation of barriers in accessing professional psychological help or support for British-Asian JDs. The method of analysis chosen for this research study is therefore a constructivist grounded theory method (Charmaz, 2006).

## **3.4. Section Four**

### **3.4.1. Section Summary**

This chapter has discussed the philosophy of qualitative research methodologies, exploring the implications of what this kind of research paradigm can do and its epistemological assumptions. The limits to using this method of choice were highlighted, and ways to ensure the rigour of the qualitative research were explored.

# **Chapter Four**

## **METHOD**

### **4.0. Overview**

Section one of this chapter outlines the design and planning of the current study. The researcher's position is acknowledged. The interview schedule development along with the inclusion and exclusion criteria for participants are detailed. Finally attempts to ensure the quality of the research by way of ethical scrutiny is discussed and the steps taken to sustain the 'rigour' of the analytical interpretations are then detailed. Section two presents an account of the participant recruitment and a description of the sample involved in the study including their demographics. Section three contains a description of the method and procedures implemented and finally, section four details the method of data analysis.

### **4.1. Section One**

#### **Design and Planning**

##### **4.1.1. Design**

The study involved a series of one-to-one semi structured interviews with JDs who identify as people that would not or will not avail themselves of professional psychological services. A Constructivist Grounded Theory (Charmaz, 2000, 2006) approach to data collection and analysis was used.

Adopting this qualitative method allows for gathering of rich data of the phenomena and it suited the research aims of exploring the psychosocial constructs that support it.

### **4.1.2. Researcher's position**

Elliot, Fischer, & Rennie's (1999) first guideline of "owning one's perspective" states that qualitative researchers should aim to recognise and be transparent about their values, interests and assumptions, to enable both themselves and readers to reflect on how this might influence the way in which the findings are understood. Although this is often seen in terms of potential bias, some authors maintain that it can be advantageous to have some knowledge or experience of the phenomena studied, as this 'sensitises' the researcher to potentially important constructs (Strauss & Corbin, 1998).

The researcher was a 28 year old female from a British-Chinese background that, broadly speaking, encompasses co-constructed views of an Eastern culture of respect for authority, especially that of the medical field, and places emphasis on academic success yielding great financial prospects and less so on soft subjects, such as Counselling Psychology. Anything pertaining to vulnerability to mental health can be regarded as shameful in the Eastern culture (Chung, 2007; Komiya & Eells, 2001; Yoon & Jepsen, 2008). Concurrently, the researcher's upbringing has incorporated co-constructed western views and beliefs which place a greater emphasis than Eastern beliefs on psychological care. Furthermore, in most cultures, there is a stronger link of females to counselling professions, be it as a client or the therapist herself (Hammer, 2010; Komiya & Eells, 2001).

### **4.1.3. Interview schedule development**

The use of semi-structured interviews is based upon a number of assumptions about the strength of this method of data collection. Interviews are a flexible research tool, which allow modification of the line of enquiry, exploration of interesting responses, investigation of underlying motives and interpretation of non-verbal messages, which other tools such as questionnaires cannot match. A semi-structured interview schedule was designed by the researcher, with stem questions covering key research questions and additional prompts to facilitate clarification and further exploration of



ideas. The schedule was reviewed and discussed with the researcher's supervisor and any suggested amendments were incorporated into the final version. The stem questions remained largely the same across the process of data collection, with only minor changes to prompts made to allow for more focussed exploration of particular points.

#### **4.1.4. Inclusion criteria**

The aim of this research was to ascertain the beliefs and attitudes that have been contributing to the creation of psychosocial barriers in accessing professional psychological help or support for JDs. As psychological services tend to be underutilised by this population (Taylor, Graham, Potts, Richards, & Ramirez, 2005; Davidson & Schattner, 2003; Adshead, 2005; Adams, Lee, Pritchard, & White, 2009) coupled with a significant rate of mental ill-health in doctors (Baldwin, Dodd, & Wrate, 1997; Curran, 2008; Lloyd, 2002; Mukherjee, Fialho, & Wijetunge, 2002), it was decided to recruit participants from this group to provide a theory to satisfy the aims of the study. To ensure participants would contribute the required data, the inclusion criteria for participation were:

- Would not or will not avail themselves of professional psychological services.
- A medical JD of any grade of post-graduate training.
- Has not accessed psychological services in the past.

#### **4.1.5. Exclusion criteria**

- Medical students.
- Consultant grade doctors.
- Past experience of accessing psychological services.

### 4.1.6. Ethical scrutiny

A research proposal was submitted and was reviewed by Roehampton University's ethics board. Information pertaining to the scope of research, forecasted interview questions to be used, recruitment and interviews methods were covered. A further interview with the research team was attended for assurance purposes.

### 4.1.7. Rigour

Following Elliot, Fischer and Rennie's (1999) seven guidelines, steps were taken by the researcher to ensure the rigour of the current study. This is outlined in table 1.

**Table 1. Rigour of the Current Research Study.**

<b>Guidelines</b>	<b>Actions taken to meet guideline</b>
1. Owning one's perspective – being explicit about the researcher's theoretical orientation, experience, interests and assumptions, can enable readers to consider how these may have impacted on interpretations made.	The researcher has 'owned' her position (see researcher's position). Supervision was sought as well as regular attendance at grounded theory group throughout the research process to keep the researcher's position transparent. A reflective diary as well as memos were kept throughout the research process.
2. Situating the sample – providing the descriptive data about the research participants and their life circumstances to enable readers to judge the range of people and situations to which the findings may be relevant.	Relevant demographic details of all the participants were collected (see section two). However, the researcher has been sensitive to balance the need for situating the sample with the need to ensure the anonymity of the participants.
3. Grounding examples – providing examples of data illustrating the researcher's interpretations, so readers can judge whether the researcher's understanding adequately fits the data and whether alternative understandings might be possible.	The processes of analysis are outlined in section four. The participants' own quotes were used in the results so that it covers and fits with other narratives on the same issues.
4. Providing credible checks – assessing credibility of findings by any of the following methods: (a) checking interpretations with respondents or others similar to them, (b) checking analysis for discrepancies, overstatements or errors, or using multiple analysts, (c) comparing two or more perspectives, or 'triangulating' findings with other methods of data collection or sources.	Constant comparison methods were used to identify information that was repeatedly present and relevant to the participants. Supervision was used and a grounded theory group was regularly attended to discuss the transcripts and data analysis. A weekly research seminar was attended during the initial phases of the work to discuss the topic area and the appropriateness of the chosen research method.

5. Coherence – representing findings in a way which is coherent and integrated, yet maintains their complexity and does not oversimplify the data.	Supervision and regular attendance at a grounded theory group as well as a research seminar were used to interrogate the relevance and coherence of chapters.
6. Accomplishing general versus specific research tasks – including a range of respondents or situations appropriate to the level of understanding required, and specifying the extent to which findings may be applicable to other respondents or situations.	Participants were included from different levels of training, specialties as well as from different postgraduate deaneries.
7. Resonating with readers – presenting findings in such a way that readers judge it an accurate representation of the subject matter or to have increased their understanding of it.	Supervision and the production of draft chapters at a regular grounded theory group provided an opportunity to assess the resonance of the data with the reader.

## 4.2. Section Two

### Participants

#### 4.2.1 Recruiting participants

The study was approved by the research and ethics committees at Roehampton University. Upon approval, recruitment of participants began by contacting the RCP to place an advertisement on their website. The JDs were also approached by sending out recruitment letters through their individual supervisors, who were contacted through the RCP. As the London Medical Postgraduate Deanery is the largest deanery in the UK and represents a large majority of the UK's JDs, they were also approached to place an advertisement on their notice boards. This kept costs down since they were regional (within and including the outskirts of the M25) and, therefore, kept travel costs to a minimum. The participants were recruited from six different hospital trusts in the UK.

Interested JDs were asked to respond to the recruitment advertisements and letters by email, telephone or by post. The researcher allowed eight weeks for potential participants to respond.

### **4.2.2. Demographics (situating the sample)**

Originally, twelve participants had responded to the recruitment advertisements. However, due to reported busy schedules, inadequate compensation and ambivalence in participating, the research resulted in securing eight individuals.

Those who participated ranged from two months of postgraduate training to up to six years. Seven out of the eight participants were male. Only one participant was from a Caucasian background, the remaining had an Asian or East Asian origin. Therefore, the majority of the participants who volunteered to participate were Asian or East Asian males.

The research not only used participants from different deaneries covering the UK but also each participant was of a different training grade and specialty, ranging from year one to year six of being a JD.

Each participant has been given a pseudo name in the results section to ensure anonymity and confidentiality.

## **4.3. Section Three**

### **Procedure**

#### **4.3.1. Defining the scope and feasibility of the study**

The research topic was conceived during the researcher's employment at the Royal College of Physicians. Following this research interest, the researcher attended weekly research seminars at Roehampton University as well as regular meetings with her research supervisor to discuss the issue and to formulate a suitable research question and its clinical relevance and usefulness to Counselling Psychology. Originally, the research question of: "What are Junior Doctors' views and beliefs towards accessing psychological services, such as counselling psychology, for themselves?" was devised. However, after further interrogation of the researched topic with professional research

colleagues, the limitations of such a title were acknowledged. The sample consisted of junior doctors who did not access psychological services. They were also largely from an Asian background and the majority were male. This sample therefore made it necessary to look more closely at social and contextual factors which may have influenced the data and participant self-selection. A new title of “Psychosocial barriers to accessing psychological services for Junior Doctors: A grounded theory study” was therefore developed.

Feasibility checks regarding numbers of potential participants and methods of recruitment were also carried out in the early stages of the research through consultation with research colleagues at Roehampton University.

#### **4.3.2. Informed consent**

Consent was obtained from respondents wishing to participate (who would not or will not avail themselves to professional psychological services), and a copy of the consent form was given to each participant at their interview for signing.

As suggested by McLeod (2007), prior to each interview, the participants were fully informed, by means of an informed consent form, about the research procedures, the risks entailed, and any personal responsibility for potential negative consequences of participation. They were also informed that the researcher’s role was that of a researcher and not a counselling psychologist, but should they require any therapeutic services, then a suitable professional would be recommended to them.

#### **4.3.3. Interview method**

Using the CGTM, a semi-structured interview was conducted with each JD. Methods for interviewing proposed by Fontana (1994) and O'Connor (2001) were implemented in the study to ensure an equal positioning between interviewer and interviewee. These will be discussed in turn:

*Scheduling interviews at a time and location that is convenient for both parties* – Due to the negotiations of time and place, the interviews were either held at the researcher’s work premises (RCP); the JD’s trust work place; or over the telephone. These different contexts of conducting the interviews yielded different qualities and types of information, which will be discussed in the results section.

*Using a relatively unstructured and flexible interview schedule so that participants can assume more power over the direction of the conversation* – All interviews commenced with the researcher outlining the purpose and method of the study, emphasising the steps taken to ensure confidentiality, and the conditions under which confidentiality might be broken. Participants were asked to sign a consent form at the beginning of each interview if it was a face-to-face interview. For telephone interviews, the consent form was emailed to the participant and they were requested to confirm their consent via email.

Stem questions were phrased in a non-directive way to allow for participants to speak freely and assume more power over the direction of the conversation. Stem questions focussed on participants’ views towards psychological services and reasons for not accessing such services themselves, their perceptions of consequences for placing themselves in the client role of a psychological consultation, their views on the process(es) involved in the creation of barriers to access (to psychological service), whether they perceived psychological services to be helpful to them if their perceived barriers were removed.

The interviews were delivered in a non-threatening, sensitive and encouraging style. The interviews lasted approximately one hour (approximately five minutes’ introduction and to establish informed consent, approximately fifty minutes for the ‘interview proper’ and approximately five to ten minutes for debriefing).

At the conclusion of the interviews, participants were thanked for their contributions and asked to sign a declaration form that they were interviewed in an ethical and professional manner.

Participants who were interviewed over the telephone were emailed the form and requested to reply with their written agreement of the interview style.

#### **4.3.4. Audio recording interviews**

With the consent of each participant, each face to face as well as the telephone interviews were audio recorded with a Dictaphone. An additional telephone recording device was used for the telephone interviews. Consent was obtained from each participant prior to the Dictaphone being switched on.

#### **4.3.5. Ethical considerations**

As pointed out by McLeod (2007), there are ethical issues involved in conducting interviews that have the potential to re-stimulate painful memories or unresolved painful conflicts. There was a possibility that some of the JDs were suffering or had suffered from mental ill health and the interview had the possibility of stimulating these emotions even more by bringing them to the surface. There was also the challenge to keep the interview centred on the research task and to obtain meaningful personal material from the participant without the interview turning into a counselling session (McLeod, 2007). This was addressed by offering a 5-10 minute debriefing session to each participant to discuss any concerns or difficulties that may have arisen during the course of the meeting. None of the participants reported any difficulties, presumably because of the research information sheet that was provided prior to each interview. The participants were prepared for what would be entailed, which may have played a factor in their decision to proceed with participation. During the debriefing session, participants were also provided with a debriefing sheet that detailed appropriate helplines and helpful contacts should they wish to speak to someone at a later date.

### **4.3.6. Confidentiality and anonymity**

From the background research conducted for the proposal, ethics and doctoral application, there was ample evidence to suggest that confidentiality may be a particular concern for JDs in terms of seeking professional help for mental ill health (e.g., Curran, 2008; Davidson & Schattner, 2003; Issaksson Ro, Gude, & Aasland, 2007). Therefore, as with all research, strict confidentiality guidelines, in particular, the BPS guidelines (The British Psychological Society, 2002), were followed and the confidentiality procedures were reiterated to each participant. A basic necessity in all research is to disconnect information about client identity (e.g., name, address, place of work) (McLeod, 2007; The British Psychological Society, 2002). In this way, even if an unauthorised person found access to the research data, it would be very difficult for him or her to know from whom the data had been collected. To ensure confidentiality and anonymity even further, additional procedures were followed: the research data was identified only by a pseudo name along with biographical information about research informants, was stored in a secure place; notes and audio recordings were destroyed after the completion of the study; and information was omitted from a report if it compromised the identity of a participant.

## **4.4. Section Four**

### **Data analysis**

#### **4.4.1. Initial and focused coding**

Glaser and Strauss (1967) originally developed Grounded Theory and there are now several different versions that vary in details of method and philosophical background. The researcher followed procedures described by Charmaz (2006). These are summarised below:



Once the data was collected from each interview, it was transcribed verbatim and the first stage of analysis, known as 'initial coding' began. Initial coding is the process of breaking down the data into distinct units of meaning. As a rule, this starts with a line-by-line analysis in an attempt to identify key words or phrases (codes) (Charmaz, 2006). According to Charmaz (2006), these initial line-by-line codes help to break the data into categories.

After the initial coding process, focused coding began for each transcript. This is done to synthesise and explain the larger segments of the data. Therefore, as in initial coding where the transcript is analysed line-by-line, focused coding involves analysis of paragraphs (Charmaz, 2006). Focused coding means using the most significant and/or frequent earlier codes to sift through large amounts of data (Charmaz, 2006).

Transcribing and analysing the data immediately after each interview in the CGTM, allows the incoming information from participants to determine the information sought, which is encouraged by the flexible interview schedule (see above). This is referred to as theoretical sampling—the seeking and collecting of pertinent data to elaborate and refine categories in the emerging theory (Charmaz, 2006). Conducting theoretical sampling can keep the research from becoming stuck in unfocused analysis (Glaser & Strauss, 1967; Glaser, 1978; Charmaz, 2006).

Taped interviews were transcribed on the left-hand side of the transcript page, and the categories were identified on the right-hand side (see section below for example). A file labelled according to the category identified was established and copies of the corresponding section of interview transcripts were placed in the folder.

#### **4.4.2. Memoing**

In parallel with data collection and coding, memoing also took place. A memo is a note to self about the developing hypotheses regarding a category or a relationship between categories. Memos provide a store of ideas that can be revisited when mapping out the emerging theory (Charmaz,

2006). According to Glaser (2004), memos are an excellent source of directions for theoretical sampling as they point out gaps in existing analyses and possible new related directions for the emerging theory.

#### **4.4.3. Constant comparison methods**

Information provided by participants earned its way into the theory when constant comparisons of data revealed the repeated presence of specific content areas in actual participant data. Using 'actual participant data' has implications for using the participants' own language at all levels of coding. The purpose of this is to ground the data in the theory constructed and add to the credibility of the findings (Strauss & Corbin, 1990).

The CGTM depends on using constant comparative methods as making comparisons between data, codes, and categories advances the conceptual understanding. This is because defining analytic properties of categories influences the treatment of these properties to rigorous scrutiny (Charmaz, 2006). Constant comparisons were used to identify information that was repeatedly present and relevant to the participants. The process involved three types of comparison. Incidents were compared to each other to establish underlying uniformity and varying conditions. The uniformity and conditions generated concepts and hypotheses. Then, the concepts were compared to more incidents to generate new theoretical properties of the concept and more hypotheses (Glaser, 2004). The purpose was theoretical elaboration, verification of concepts, densification of concepts by developing their properties and generation of further concepts. Finally, the concepts were compared to each other (Glaser, 2004).

Through constant comparison in the course of coding and memo writing, links between categories were explored and integrated. The category that was found to emerge more frequently than others and was connected to many of the other emerging categories became the 'core category' for the

research. The core category is the variable that appears to account for most of the variation around the concern or problem that is the focus of the study (Charmaz, 2006; Glaser, 2004).

#### 4.4.4. An example of coding

The table below shows an extract from an interview transcript with details of the coding process.

The interviewee was a second year postgraduate medical training and was British Asian. The participant was asked in the interview on his views of culture and ethnicity and their impact and influence on the research issue.

<u>Extract from interview transcript</u>	<u>Initial coding</u>	<u>Focused coding</u>
<p><b>And how about culture in terms of ethnicity – would that have an influence at all?</b></p> <p><b>Possibly. I mean, we’ve looked into studies where you’ve got certain cultural groups which are from a strong family orientated background and they can always talk to their family, as long as you’ve got someone to talk to, you can do. But also you got sort of, cultural people who don’t have that . But to be honest, I’ve not had any</b> firsthand experience about that, this is all basing on research that I’ve read before. I can’t tell you from my personal experience, but this is possible what happens, I don’t know.</p>	<p>Focussing on academic studies; deviating from own thoughts; deviating from own experience of belonging to an ethic minority group; focusing on a collective experience; avoiding being different to the group; avoiding individuation; focusing on different cultures without naming them; naming opposite end of spectrum; avoiding identifying self on spectrum; Denying any first-hand experience</p>	<p>Group identity</p> <p>Avoidance of deviating from group norms</p>

The following chapter presents the results of the study based on the method of data analysis described in this section.

# Chapter Five

## RESULTS

### 5.0. Overview

This chapter is divided into the following sections. Section one contains a brief description of each participant. Section two presents the suggested theoretical finding along with the body of the data analysis including the themes, subcategories and concepts. Quotes are presented to enable the reader to follow the narrative and ascertain whether the analysis is a meaningful and coherent account of the data. At the end of each section, a reflexive statement is provided to highlight the factors which may have influenced the interview process and data analysis. A chapter summary is then provided to sum up the main points that have been put forward in this section.

### 5.1. Section One

#### 5.1.1. Description of Participants included in the study

Seven males and one female participated and were interviewed as part of this study. Of these eight participants, seven were from an Asian background, and one was from a Caucasian background. All eight interviews were recorded and transcribed. Due to difficulties in participants agreeing a convenient time to meet, two participants requested for their interviews to be held over the telephone. Of the remaining six, three interviews were held at the researcher's work premises (RCP London) and three were held at the hospitals where participants worked. Participants were asked to select a convenient time to meet for the interview. Two interviews were carried out during the participants' work hours whilst the remaining six chose to have the interview during their days off or after work. Three participants were in their first year of postgraduate medical training, one was in their second year, one in their third year, one was in their fourth year, and two were in their sixth year. In order to protect participants' anonymity, pseudonyms were allocated. However, care was

taken with selecting Asian names to avoid offending any cultures due to some heritage and meanings which may have been allocated to them. See table 4.1 for a brief description of each participant.

<b>Pseudonym</b>	<b>Year of postgraduate training at the time of interview</b>	<b>Place of interview</b>	<b>Type of interview</b>	<b>Time chosen by participant for interview</b>	<b>Cultural background</b>	<b>Gender</b>
Arjun	1 (2 months into first year)	RCP, London	Face to face	After work	East Asian	Male
Kamal	1	Hospital setting, Essex	Face to face	Day off	Asian	Male
Sayem	4	Client's home, Yorkshire	Telephone	Day off	Asian	Male
Ranjit	6	Hospital setting, Sussex	Face to face	During work hours	Asian	Male
Arfan	6	RCP, London	Face to face	Day off	Asian	Male
Mumtaz	3	RCP, London	Face to face	Day off	Asian	Female
Andrew	1	Hospital setting, Essex	Face to face	During work hours	Caucasian	Male
Inderjit	2	Participant walking in street, London	Telephone	Day off	Asian	Male

Table 4.1. A brief description of participants included in the study

## 5.2. Section Two

This section presents the hierarchical index system that emerged from the interview data of factors that contribute towards the psychosocial barriers that prevent JDs from accessing professional psychological services. The qualitative findings are presented using an index 'tree' format. The core category of the index tree was derived from the semi-structured interviews, and is informed by three main themes and their respective sub-categories. Using grounded theory, modifications were then made as the analysis evolved.

All participants' narratives generated three conceptually linked themes: 'medical Identity', 'development of coping strategies within the British medical culture' and 'unacceptability of difference' which informed the core category of 'psychosocial barriers to accessing psychological services by JDs'.

The participants of the study provided an abundance of information and this resulted in an index tree. This index tree is displayed over the page in Figure 5.1. The core category is presented along with its themes by which it is informed is discussed in the following order, according to hierarchical themes, subcategories and concepts:

- Medical Identity
- Development of Coping Strategies within the British Medical Culture
- Unacceptability of Difference

In the proceeding sections each theme, subcategory and concept are discussed in turn in relation to the grounded theory. In line with social constructionism (Charmaz, 2006; Burr, 2003) and symbolic interactionism (Blumer, 1986), the data was analysed in relation to the social and contextual context of both researcher and participant. For example, gender influences, the position of Asian culture, power relations and how JDs locally negotiate issues related to mental health.

Extensive quotes from the interviews with participants have been utilised to allow a thorough scrutiny of the analysis by the reader. For clarity the themes will be discussed in the order shown above. The title of each new theme will form a new section and the corresponding sub-categories are sub-headed.

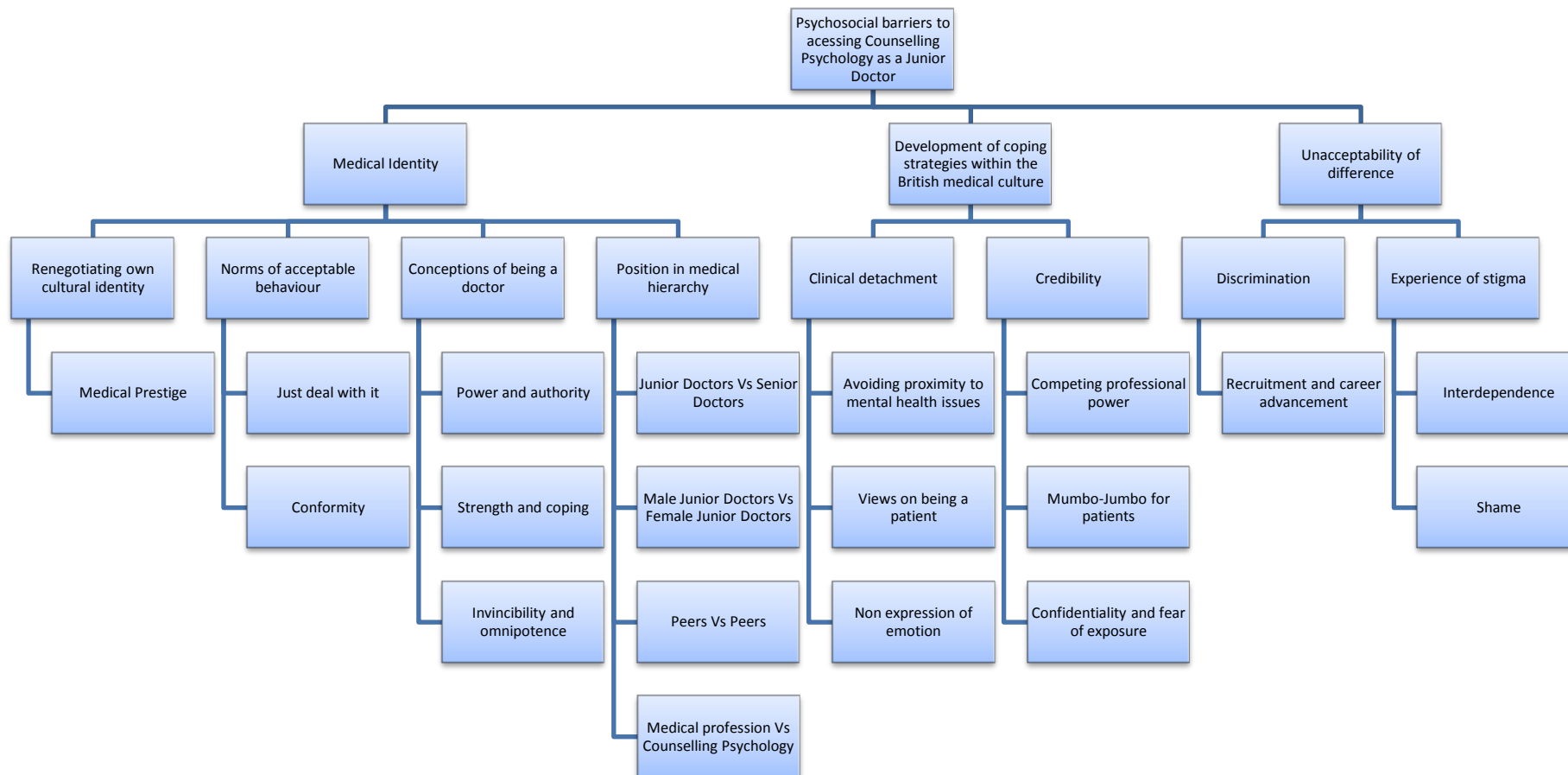


Figure 5.1. Index tree for 'psychosocial barriers to accessing Counselling Psychology as a Junior Doctor'.



## **A grounded theory**

Consistent with Grounded Theory the themes (which are underlined and in italics below), sub-categories and concepts of this research were suggested to give the following theoretical finding.

The development of *'medical identity'* for JDs incorporates a group identity which requires individuals to display stereotypes of strength and coping and power and authority in order to maintain their social positioning and respect from non-medics and colleagues alike. JDs are encouraged to disregard personal attributes in a bid to conform. As such a prestigious social positioning is perceived to be developed it seems important to maintain this guise by way of *'development of coping strategies within the medical culture'* which appear to be acceptable. That is, strategies which do not compromise their qualities of power, authority and strength. If they were to deviate from the norms of the medical culture and seek psychological treatment, there was a sense of inherent fear of the consequences as though there was an *'unacceptability of difference'* within the culture in which they work. This loss of sense of self combined with a powerful yet fragile group identity leads to an increase of and informs the construction of 'psychosocial barriers to accessing psychological services for junior doctors'.

The following sections give extensive detail on the individual categories.

### **5.2.1. Medical Identity**

Participants reported an array of factors from 'Medical Identity' that contributes to the barriers of accessing psychological services as a JD. In discussing their identities as JDs, participants frequently spoke about issues which formed the following sub-categories: 'renegotiating own cultural identity', 'norms of acceptable behaviour', 'conceptions of being a doctor' and 'position in medical hierarchy'.

The four sub-categories have been structured by grouping appropriate concepts that arose from the analysis of the data. The concept associated with the sub-category 'renegotiating own cultural identity' is 'medical prestige'. The concepts utilised to comprise the sub-category 'norms of acceptable behaviour' are: 'just deal with it' and 'conformity'. The concepts that constitute the sub-category 'conceptions of being a doctor' are 'power and authority', 'strength and coping' and 'invincibility and omnipotence'. The sub-category of 'position in medical hierarchy' was categorised into the concepts of 'junior doctors Vs senior doctors', 'male junior doctors Vs female junior doctors', 'peers Vs peers' and 'medical profession Vs counselling psychology'.

The index tree for the 'Medical Identity' category is displayed in Figure 5.2.

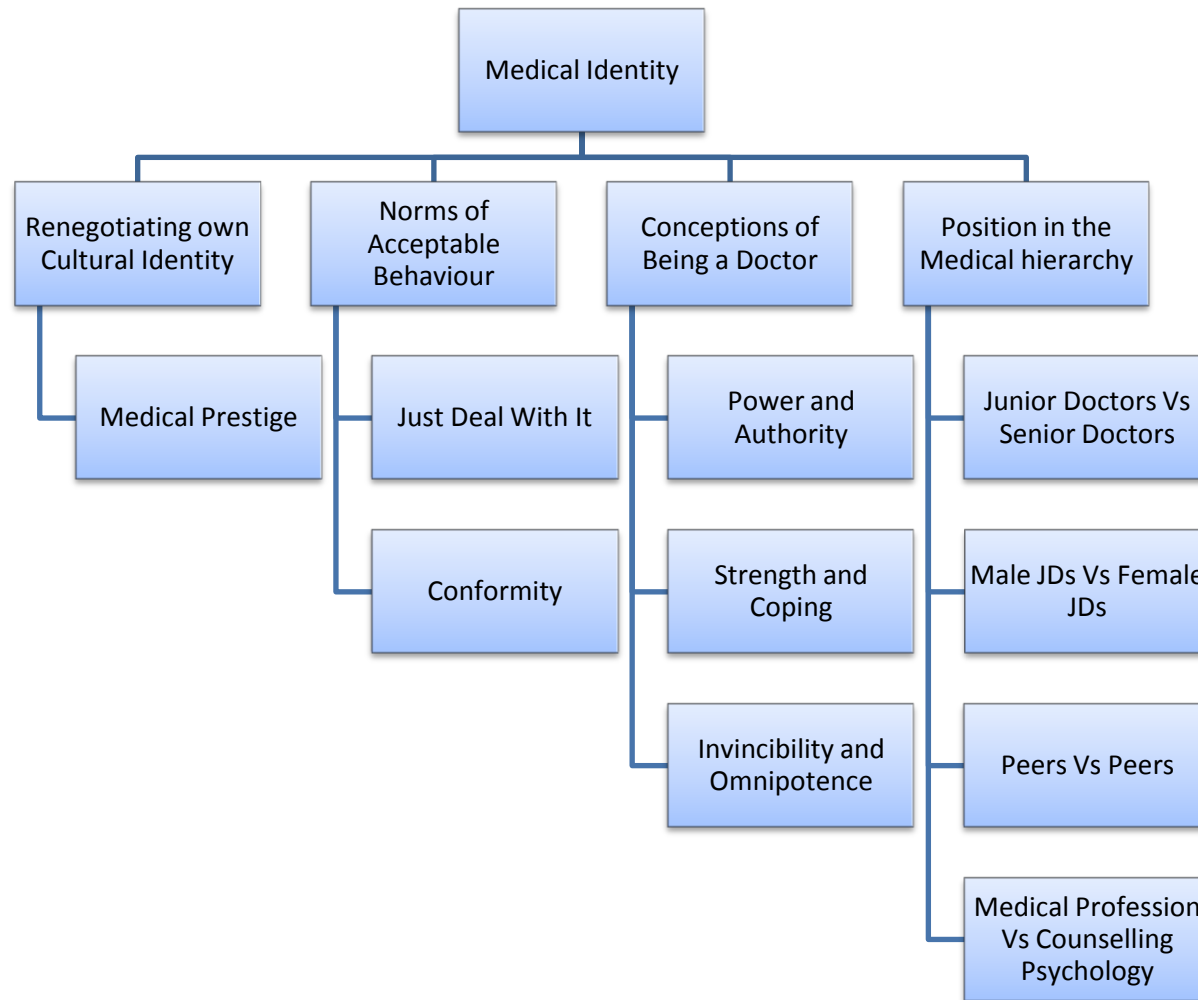


Figure 5.2. Index tree for 'medical identity'.

### **5.2.1.1. Renegotiating own cultural identity**

With seven out of the eight participants coming from an Asian background, it appeared to the researcher that the participants' narratives revealed the need to renegotiate their own identities to adapt and adopt the identity required in the medical culture in order to be accepted. There was a sense of struggle and need to conform to what they perceived to be 'facts of the trade'. That is, to be a good British doctor, one needs to conform and not stand out or be different in any way. There appeared to be a belief that the portrayal of a good JD involves one's appearance and what they do as opposed to who they are as individuals; opposite to the philosophy of counselling psychology.

Ranjit explained:

*"People don't like being outside the norm because you won't progress in surgery. You need to be a particular way, you need to dress a particular way, you need to communicate in a particular way, you need to be seen as professional in order to progress".*

Inderjit said:

*"You have to conform to an extent to be accepted. But it's just a job where you've got to deal with what everyone else has done before you. You don't want to be seen as different".*

Mumtaz reflected:

*"Out there [in the medical environment], there's two perceptions, without anyone actually having to say it, I pick up the message that you're a doctor, you've got to deal with it, it may be a sign of weakness if you do access these services and that you're not coping very well, you're not strong enough to be a doctor and something like that emotionally".*

Kamal stated:

*"If your seniors aren't treating you well, or they're being a bit rude to you, you can't think is this person discriminating against me because of my race or because of my personality?".*

Andrew, a White-British participant reinforced this view:

*"There's the stereotypical British stiff upper lip who is not going to be conducive to someone accessing psychological help".*

### **5.2.1.2. Concept: Medical Prestige**

The researcher as a trainee Counselling Psychologist felt the participants spoke about their roles as doctors as automatically granting them supremacy in society. Some participants spoke about the profession placing them on top of the professional hierarchy and therefore unwilling to adopt an equal positioning with a non-medical professional such as psychologists. There was a sense that non-medical professions were seen as inferior to medics. For example, Sayem stated:

*“They [doctors] still have that sub-conscious attitude of being the leader, you know, doctors are leaders whether or not they like it really, and so I think it would be a struggle to adopt a different role in a consultation really”.*

Inderjit explained:

*“I just feel that when you go to a psychologist and tell them what you’re going through, you get a better result from a colleague. But if one of the public goes to the psychologist for different reasons, I’m sure a psychologist could relate to that. But I don’t know if they could relate to someone, you know treating someone in a hospital setting”.*

### **5.2.1.3. Sub-Category: Norms of Acceptable Behaviour**

As an extension of the previous sub-category (renegotiating own cultural identity), this section details participants’ views on what they felt constituted specific forms of acceptable behaviour within the medical work place. Again, it felt to the researcher that the emphasis was on displaying behaviours in line with those which are perceived to be acceptable by the profession rather than acting in accordance with what one feels is right for that individual. For example, Ranjit explained:

*“If you deviate from the norm in other aspects like you dress really bizarrely if you are slightly bizarre in your techniques, or you are outside of what is perceived as normal in social techniques, if you are eccentric with a junior in that particular way that somebody doesn’t like, anything else can have an adverse effect on your career”.*

The concepts that constitute this sub-category are: ‘don’t complain’; ‘just deal with it’; and ‘conformity’. These are detailed in turn, below.

#### ***5.2.1.4. Concept: Just deal with it***

Participants appeared to speak about the need to conform to the implicit rule of not complaining in the workplace and 'just dealing with it' as though the rule were a given fact. The words 'got to' 'should' 'have to' 'need to' came across very strongly as though there would be a sanction if these perceived rules were not adhered to. The researcher felt that there was a sense of the participants having to suppress and deny their emotions in order to manage their public appearance. 'Just dealing with it' equated to not acknowledging any psychological distress and continuing with the daily demand of their jobs.

Inderjit stated:

*"You've got to be seen as someone who doesn't complain, you've got to be seen as somebody who gets on with it, and anything out of the ordinary, then...you've got to be a conformist".*

Similarly, Arjun said:

*"There is an inherent stress related to the job that we do. You should be able to have a mechanism, whichever mechanism that is to deal with that.....if you're unwell, you're unwell you have to deal with it...I think in this medical business, you have to sometimes deal with things because, it's your career, it's up to you".*

Andrew explained:

*"There's the stereotypical British stiff upper lip who is not going to be conducive to someone accessing psychological help, as with the feeling of "just cope with it".*

Mumtaz said:

*"I mean, obviously it varies between different consultants and doctors and things but at the moment, my general feeling is that you don't need to go to these services, you should be able to manage this on your own...I personally would access it, just to have somebody to talk to, you know, to get some advice and things like that. But what I get from my colleagues and peers is that, no.1, you don't have time during the daytime to talk about these things and no.2, you just deal with these things on your own and no.3, you just try and detach yourself as much as possible, which I don't think is very healthy"*

### **5.2.1.5. Concept: Conformity**

Although the 'implicit rules' were not reported as evidence for any sanctions, the participants spoke of them as though they were concrete rules to which they must be rigidly obeyed. It appeared that these rules may have been created by observing the behaviours of their peers and seniors. In their strive to avoid deviating from the norms of the masses and therefore rejection, the participants appeared to conform to the majority and therefore co-creating its unique culture. Consulting a psychologist for any mental-health issues may not appear to be the 'wrong' thing to do, but rather it is not seen to happen in the medical culture, and therefore it may not be a 'safe' action to take.

Ranjit explained:

*"They're not written down [rules of the medical workplace], they're not on the job form, they're not written anywhere but it's about how you come across to your colleagues...If you don't adhere, you don't progress.....People don't like being outside the norm because you won't progress in surgery. You need to be a particular way, you need to dress a particular way, you need to communicate in a particular way, you need to be seen as professional in order to progress in surgery".*

Inderjit stated:

*"You've got to be seen as someone who doesn't complain, you've got to be seen as somebody who gets on with it, and anything out of the ordinary, then...you've got to be a conformist".*

Kamal said:

*"There is a lot of conformism in this field, so like, there's some eccentric characters and if they're good, they're admired, but sometimes I get the impression that if people stand out a bit it's not really admired"*

Mumtaz explained her difficulties with conforming in the medical field:

*"If a consultant is going for dinner and invites you for a group dinner, and you don't really want to go because you've got another appointment to go to, and they [peers] were like, no no no, you have to go, this is the consultant, you have to be in with them, you have to be there, you know, really have to be. I call it brown nosing, there's a lot of that, I have to say, and if you don't do that, then it is seen that you won't get ahead in your career".*

### **5.2.1.6. Sub-Category: Conceptions of Being a Doctor**

All participants mentioned the qualities which they perceived to constitute the image of being a good doctor. These qualities appeared to form and contribute to the identity of being an accepted and respected JD. For example, Arfan explained:

*“The idea is as a doctor, you should be able to handle all scenarios, all situations because you’re often thrown into difficult scenarios and you have to be able to deal with them”.*

Similarly, Arjan said:

*“In medicine, you have to remain level headed, you have to prove to yourself and other people all the time, whether it’s to consultants, to peers, whatever...you have to show that you can deal with things”.*

Participants’ conceptions of what they perceived as being a doctor fell into four concepts: ‘power and authority’; ‘strength and coping’; ‘invincibility and omnipotence’; and ‘separating from patients’. These are detailed below.

#### ***5.2.1.7. Concept: Power and authority***

The participants narratives suggest that doctors are placed in a position of power where they are trained to lead rather than to be led. Consequently, this frame of mind has created a barrier to seeking professional psychological help for many as the co-constructed meaning of seeking help, amongst doctors, appears to be the view that being a client equates to being weak and vulnerable and, therefore, placed in the devalued position of ‘Them’, i.e., the inferior public. Many participants spoke about holding (or the need to hold) some sense of power and authority due to their perceived position in society and to maintain their position as ‘Us’. As doctors, the participants are armed with specialist knowledge and terms regarding various illnesses and diseases. The public rely on the doctors to use this knowledge to heal them and potentially to save their lives. This places them in a special and valuable place in society which it seems is maintained by dislocating themselves from the public.



Even outside of the medical environment, the participants maintained the dominant guise, asserting their power and authority. For example, and to add to the data pertaining to power and authority, each participant was aware that the researcher was a psychologist (a lesser profession), and each participant was requested to suggest a convenient time and quiet place to conduct the interview. Although seven out of eight of the participants chose to conduct the interview during their days off, most were either late by a minimum of 15 minutes and a maximum of 40 minutes.

Kamal described how his identity as a JD has placed him in a position of power:

*“Sometimes you can feel a little bit like a drill sergeant if you’re working on the on call and busy, you become a bit nasty and rude to patients. I did reflect on it, thinking about being in a position of some sort of power. Sometimes you can get away with things”.*

Ranjit explained:

*“Some doctors think of themselves as people who treat others not others who treat them”.*

Similarly, Sayem reflected:

*“I think some doctors would struggle because they are ridiculously hierarchical, and so I can imagine a consultant who is used to being the leader would find it difficult to rank things, it’s all about “the doctor is God” thing.....They [doctors] still have that sub-conscious attitude of being the leader, you know, doctors are leaders whether or not they like it really, and so I think it would be a struggle to adopt a different role in a consultation really”.*

Arfan’s explanation can be interpreted as follows: an increase in experience and clinical knowledge can widen the dislocation between doctor and patient and also increase the perception of power and authority held within the role:

*“The other day, I was having a discussion with a friend about going into psychiatry, and I was saying I’ve gone back in terms of dealing with the patients, so whereas before, the clinical knowledge wasn’t as good but you were polite to patients all the time, whereas now, clinical knowledge might have improved a little bit but the treatment of patients have gone downhill”.*

### ***5.2.1.8. Concept: Strength and coping***

The participants' narratives on their identity as JDs suggests some sort of rigidity in their opinions on seeking help for themselves. With the researcher being a member of the 'public' and therefore in a position lacking power and, thus, reliant on those with greater strength (as perceived by the researcher and seemingly the participants), there appeared to be a culture which has been socially constructed in which doctors do not seek help, regardless of the severity of the problem, especially if the problem is psychological. Indeed, all participants described their thoughts on the image they feel should be portrayed as a JD: strength and coping. For example, Kamal explained:

*"Well as a doctor, you have to portray yourself as healthy, isn't it? To be seen as confident perhaps. In terms of judgment, if it was thought your judgment was clouded, you would, your opinions would be doubted perhaps".*

Ranjit described:

*"I'm not sure what the sick leave rate is for medics but I'm sure they're not high, because most people will come to work until they die, and then they'll take time off work because they need to get the job done. And that comes with a personal sacrifice, you ignore depression, you ignore ill-health, you ignore all sorts of things. It doesn't come from any hospital trust, it doesn't come from human resources, it comes from oneself that you have to be at work because your patients depend on you..... it is conforming to a stereotype or what is expected which probably means being with your own mental health in a slightly different way".*

They therefore seem to detach themselves from mental health issues in order to maintain their image of strength and coping:

Sayem explained:

*"They're (doctors) terrible at recognising their own illnesses...I think the main reason is because of pride".*

Ranjit said:

*"Perhaps we don't recognise it ourselves, or perhaps we don't admit it ourselves. The classic signs of depression, we could question whether we actually have it or just signs of stress and then we'll deny it to ourselves or just fumble our way through and get really irate".*

### ***5.2.1.9. Concept: Invincibility and omnipotence***

The participants' socially constructed identity as a doctor and the meanings they have created for this have appeared to influence their self perceptions. The participants' narratives could be interpreted as though they perceive themselves as a more advanced race of human beings than the public. It appears they feel untouched by illness, more importantly psychological difficulties, purely due to their identities as doctors. Participants described how this workplace culture influences their views on their own mental health, and encourages a sense of invincibility and omnipotence in order to become a doctor.

Sayem explained:

*"Medical school is where you're converted from Joe Public to Medic.....it's all about "the doctor is God" thing".*

Ranjit disclosed:

*[Admitting to depression] "It takes away how strong you think you are. The medical condition that I had was a heart attack about 15 weeks ago, and up until that point, I thought I was immortal".*

This identity appeared to allow their psychological separation from patients and the public, who are reported to be 'weaker'.

Inderjit stated:

*"However ill I am, I don't want to see the doctor, even. It's just one of those things where you don't want to take that role as a patient. Generally, you see patients as weaker in a hospital, because they are and they're vulnerable".*

Similarly, Kamal explained:

*"Sometimes you can feel a little bit like a drill sergeant if you're working on the on call and busy, you become a bit nasty and rude to patients. I did reflect on it, thinking about being in a position of some sort of power. Sometimes you can get away with things".*

### **5.2.1.9.1. Sub-Category: Position in medical hierarchy**

Participants spoke about how their position in the medical family influenced their views on accessing psychological services and therefore contributing to their maintenance of their medical identity.

This sub-category comprised of four main concepts: 'junior doctors Versus senior doctors', 'male junior doctors Versus female junior doctors', 'peers Versus peers' and medical profession Versus counselling psychology'. These are detailed below.

#### ***5.2.1.9.2. Concept: Junior doctors vs. senior doctors***

The participants' discourse revealed a great deference to their seniors. Considering this in a wider social context, in any job, many individuals have the natural urge to progress and reach their desired potential. With doctors being typically rather deterministic, high achieving and competitive in character, progression in their careers has a strong driving force in their working lives. A major factor that determines JDs' progression can be their seniors. In a social constructionist's perspective, JDs may observe, at times on an unconscious level, and learn from their seniors what is accepted and unaccepted behaviour not only in the medical workforce but also as a member of 'Us'. As a result, great lengths are taken to ensure a good standing with those who have control over their succession and belonging:

All participants described the influence their seniors have over them in terms of accessing psychological services. They described their perceived perceptions of seniors' views towards psychological issues and accessing psychological services as a doctor, and needing to overtly subscribe to their views.

Mumtaz explained:

*"I mean, obviously it varies between different consultants and doctors and things but at the moment, my general feeling is that you don't need to go to these services, you should be able to manage this on your own..... if your seniors are open and tell you that it's ok to feel like this, then it would be a lot easier to access these services, it wouldn't be such a, not really a*

*stigma, but wouldn't be frowned upon, and wouldn't be such a big deal or such a strange thing to do, if they were more open about it".*

Ranjit reported:

*"Yes, it is conforming to a stereotype or what is expected which probably means being with your own mental health in a slightly different way. Possibly in a less open way or in no way at all because that's what your consultants and supervisors expect you, or what one feels they expect you to do.....The old consultant working ridiculous hours and the ridiculous stress conditions, and I suppose they [seniors and consultants]felt they coped, whether they did or not I don't know, but if you're perceived to have issues of coping that you can't deal with, they have an adverse effect about how you are perceived by your senior colleagues.....If they're [seniors and consultants] open, they could acknowledge how people would feel, and they're supportive, and encouraging, then you may feel able to access some [psychological]services".*

Kamal reflected:

*"Sometimes they [senior doctors and consultants] have a dismissive view towards mentally ill patients which probably increases the stigma in the environment and therefore make you feel more nervous about accessing the services".*

Andrew stated:

*"One would hope you'd get support from your seniors [on accessing psychological care]... What would I anticipate? I think you'd feel ostracised. I think you'd always be anticipating derogatory comments like from your seniors at whatever level. I think if your seniors are dismissive of, or kind of derogatory to people who can't do the jobs that are expected of them, then yeah, you're going to be reluctant in going to access professional help".*

Participants described their observation of their seniors and how this contributes towards their own identities as doctors.

Ranjit explained:

*"I see my consultants, they work and some of these guys are old old, but then again, they're immortal. The fact that they work ridiculous hours and perform amazing surgery, and do I want to be like them? Yeah, I do. Do I look at what they've done in their careers? Yes. And therefore does their view point influence me, do I respect their view point? Yes I do".*

Mumtaz said:

*“You look at your seniors as examples, you try and find the good things from the doctors that you’d like to be like, and you take them as an example and you try to be like them. But I wouldn’t like to take that from them where you have to detach yourself because I don’t think that was very good advice. But I don’t see anyone else dealing with it any different way, so you think that this is the accepted way to deal with it. You deal with it on your own and talk to colleagues if you’ve got the time and just forget about it after a period of time. So the way they [seniors and consultants] think about themselves and their own emotions, does influence you strongly on whether you’re going to access these services or not”.*

### **5.2.1.9.3. Concept: Male Junior Doctors Vs Female Junior Doctors**

The sense from the interviews was that male participants wanted to prove to the researcher that help is not needed whereas, for the one female participant, her view was that she would like to access help, but felt prevented by the profession. This interpretation can be further supported by demographics of the participants who decided to volunteer for the research (who would not avail themselves of psychological services). That is, seven out of the eight participants were male and would not consider psychological treatment for themselves.

Male participants generally held a negative view about accessing counselling psychology and other psychological services.

For example, Andrew stated:

*“If you needed to access support in that kind of [stressful] situation, I would have hoped that you’d be encouraged to look for an alternative career path.....It [Seeking counselling] is seen as though you haven’t developed your coping mechanisms, you’re not dealing with the stresses appropriately”.*

Inderjit’s view was:

*“I’m not very convinced by the fact that they do help within the medical environment”.*

Arjun explained:

*“I don’t think it is natural...they’re [psychologists] listening to you in a way that they can use a technique or a method to make them [clients] feel better”.*

Further to holding negative views about counselling psychology, the male participants tended to reject the need for support from such services.

Inderjit explained:

*“If it works for certain people and it works for them and they’re all for it, then good, but it doesn’t work for everybody unfortunately, and I believe it wouldn’t work for me.... counselling is not for me.....Personally, I don’t think it would help me. There might be other doctors who think differently but for me I don’t think it would help. I want to be able to talk to someone who has been through it – that would help.....I can’t relate to anyone unless they are from a medical background themselves. Because most psychologists are not from a medical background, they’ve never worked with patients like doctors have”.*

Ranjit said:

*“I probably wouldn’t seek formal help because I would always be critical of myself and try to figure out what’s going on for myself and part of medical practice is having problems, finding a solution, working through things, step 1 and the advantage of that is that you’re the clinician, again to go to someone, would that maybe go against the grain a little bit.....For a doctor to seek psychological therapy as a first instance, they would probably try and find all other routes first. I’m not someone that would seek psychological therapy as a solution to anything”.*

Sayem stated:

*“I think I would prefer to use other methods, like good friends...I would have to be pretty desperate to go down the psychotherapy route”.*

The views of the lone female participant differed to those of the male participants. The female participant appeared to be more psychologically open to her struggles than her male counterparts, but felt prevented from voicing them. Showing emotion, being feminine or being inclined to ‘softer’ approaches in coping were seen as less likely to allow for high social positions:

Mumtaz explained:

*“He said [consultant giving advice] you feel sympathy, you feel sorry for them, you feel what they’re going through, but at the end of the day, you have a job to do, so you can’t let yourself get too involved or emotional about it because what about the rest of the ward and the rest of the patients? I didn’t find that very helpful”.*

She went to say:

*“Out there, there’s two perceptions, without anyone actually having to say it. I pick up the message that you’re a doctor, you’ve got to deal with it, it may be a sign of weakness if you do access these services and that you’re not coping very well, you’re not strong enough to be a doctor, and something like that emotionally..... I don’t know if it’s seen as a weakness really to access these services, but you know, you can’t deal with things on your own”.*

Mumtaz also stated:

*“What I get from my colleagues and peers is that, no.1., you don’t have time during the daytime to talk about these things and no.2, you just deal with these things on your own and no.3 you just try and detach yourself as much as possible, which I don’t think is very healthy”.*

Mumtaz voiced her opinion on wanting to access psychological services:

*“At the end of the day, you become so numb to things, it’s not helpful, because this is the time when junior doctors need the help and the support, you need somebody to talk to, because this is the first time you’re seeing a lot of things, it’s like, not for the senior doctors because they’ve seen it all before and they’ve become used to it and desensitised to it, but for us as juniors, it’s the first time we’ve seen a child die, it’s the first time you see a baby die, and the support isn’t there.....I don’t know really, how you could deal with the death of a child at work, so I think if there were any services where you could speak to somebody, or if they had any advice or anything”.*

Mumtaz reflected on witnessing her female colleague’s struggle and the consequences of not receiving any psychological support:

*“I know one doctor who I worked with in the past 6 months in the special baby care unit, she was there to resuscitate a baby and the baby actually died and she actually transferred out, and then she eventually quit medicine altogether, because she said, I’m not dealing with this, coping with the death of that baby at all, and she didn’t get any support from the consultant, she didn’t get any help from anybody, and so she was left with this guilt that she was responsible for that baby’s death, so she’s now quit medicine completely, and she’s an excellent doctor”.*



#### **5.2.1.9.4. Concept: Peers Vs peers**

The participants' discourse suggested a fear of negative judgment from their peers which included the fear of losing respect from them. They explained the influence their peers' perceptions on accessing psychological services have over them.

Andrew reported:

*"I don't know any junior doctors who have sought psychological help. I'm sure there are those out there. It would be seen as moving away from the normal course of events".*

Arfan explained:

*"Some people who would really benefit from it are often felt, maybe felt that they are in a situation where they think, well maybe I shouldn't go for help, because if someone found out about this, I may look like I may not be able to do the job that I want to do. Because this inherent idea that if they were to do that, then they may not be regarded as highly by their colleagues".*

Kamal said:

*"If people found out, then it wouldn't have a huge impact. Perhaps people would respect them a bit less...there might be some doubts about, you know, are they just moaning...if someone took a month off because of stress, and that included psychological treatment, people might feel resentful, they'd think you're trying to pull a fast one".*

#### **5.2.1.9.5. Concept: Medical profession Vs Counselling Psychology**

On enquiring about the perceptions of mental health services and professionals, there was a sense of competing discourse between medicine and the psychological profession, whereby medicine appeared to be perceived as the more dominant of the two. There was also a sense in lack of deference towards the researcher who was a psychologist. A theme of weakness appeared to feature as a barrier to accessing psychological services which contradicts their identity as strong and coping doctors. Kamal explained:

*"People who are medical have a funny perception of psychiatry and psychology. They are trying to distance themselves, and therefore is some kind of insecurity or fear of mental illness".*

Arfan stated:

*“Doctors would probably think they [psychologists] are a bit too soft. They may think, it will just be a bit mumbo-jumbo softness that isn't going to help me”.*

Mumtaz's view was:

*“How can someone help, who hasn't had that responsibility?.....I don't see how you [the psychologist] can really put yourself in that person's [JD as a client] shoes to understand what they're going through, when that person [patient] actually dies. It is seen as a failure if somebody dies. Those emotions you feel, I can't see how you [the psychologist] would be able to understand that”*

### **5.2.1.9.6. Reflexive Statement**

I was interested to learn about participants' descriptions of their experiences of being a JD and how this contributed toward their identities. From my employment at the RCP and gaining exposure to mental health issues among doctors, some of the descriptions did not come as a surprise, for example, statements on their position in the medical hierarchy. However, I had not anticipated the extent to which they perceived their power. I was surprised at how the power also unfolded in the interview sessions. For example, participants' choice of interview site and time. Power was therefore played out both overtly by way of their statements and covertly by way of their interactions with me in, and also while organising the sessions.

As a trainee counselling psychologist, I was aware of the difficulties and challenges in having this status in employment and was interested to hear about JDs' experience of being in training grades. I was struck by the extent they felt influenced by their seniors to avoid attachment to any mental health issues and accessing psychological services. Further, I was surprised that participants' accounts were based on perceived consequences rather than actual events which they had witnessed.

It was interesting to see that out of the eight participants, only one was female. This was possibly due to an opportunity for male doctors to tell the psychological profession via the researcher that the service is not needed. Also it may have been an opportunity to convey the message directly that male doctors are strong and stoic and not weak and vulnerable. I was also struck by the differences in statements between the genders. If there would be an opportunity, it would have been interesting to recruit more female participants to see how their views compared to the lone female in the study.

I wondered why this category of gender differences in the medical profession and its relation to psychological issues and services had not emerged in research to date given the vast literature available for rates of access to psychological therapy for the general population. I was aware that being female myself may have influenced the interviews. Whereas the male participants were more factual with me in the sessions, telling me that they did not need counselling psychology (possibly maintaining their sense of power in the interview or they needed to follow more of a male script), the atmosphere seemed to be more relaxed with the female participant. I had wondered whether the female participant had felt more comfortable with me, (as a female trainee counselling psychologist), as I did with her as she expressed a wish to access psychological services but felt prevented from doing so. Indeed, after the interview had finished and Dictaphone switched off, she asked me for advice on managing her stress at work and for recommendations for psychological therapists. She disclosed at the end of the interview that she had volunteered to participate in the research as she had hoped to get some advice from me on her situation, and that that volunteering for the study would be a way to access some form of psychological advice. Presumably this was an acceptable and disguised way for her to gain psychological support.

### **5.2.2. Development of Coping Strategies within the British Medical Culture**

The participants' discourse suggested the development of their coping strategies within the workplace which does not encompass utilisation of psychological services. This was understood in terms of the participants' way to distance themselves from mental health and mental health issues in order to maintain their identity of strength and coping. The participants also spoke about their views of counselling and psychology. Their descriptions generally included power discourses to maintain their positioning in the social hierarchy and to further distance themselves from psychological issues. That is, counselling is not suitable for the medical profession, but acceptable for non-medics. To cope with any psychological unease then, the participants' accounts were understood by adopting two main strategies: 'clinical detachment' and acquiring certain 'perceptions and use of counselling psychology'.

The sub-categories have been structured by grouping appropriate concepts that arose from the analysis of the data. The concepts associated with the subcategory 'clinical detachment' are: 'avoiding proximity to mental health issues'; 'views on being a patient' and; 'non-expression of emotion'. The 'perceptions of counselling psychology' sub-category comprised concepts of 'credibility'; 'competing professional power'; 'mumbo-jumbo for patients' and 'confidentiality and a fear of exposure'.

The index tree for 'Development of Coping Strategies within the Medical Culture' category is displayed in Figure 5.3.

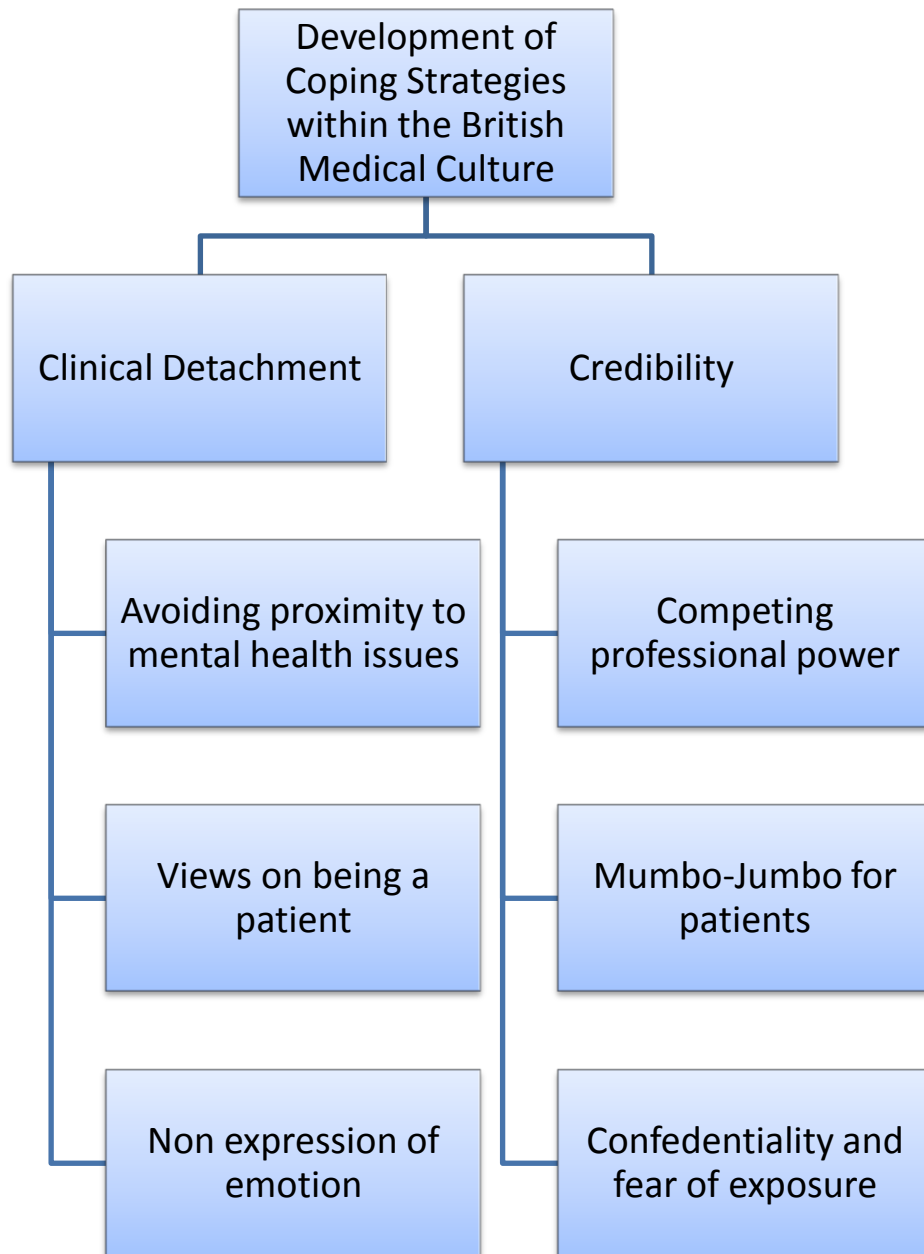


Figure 5.3. Index tree for 'development of coping strategies with in British medical culture'.

### **5.2.2.1. Sub-Category: Clinical Detachment**

There was a general consensus that as a doctor, an unwritten requirement is to become detached.

Mumtaz explained:

*“At the end of the day, you have to carry on with the rest of your day and the rest of your job. So you have to try and detach yourself, and that’s kind of the attitude I’ve got from others that you just detach yourself really..... I mean my friend that suffers from anorexia, she didn’t realise until she was far far down the line, she just carried on going going going, you just tend to not think about your own emotional, mental health”.*

Mumtaz went on to explain:

*“People who are medical have a funny perception of psychiatry and psychology. They are trying to distance themselves, and therefore is some kind of insecurity or fear of mental illness”.*

Kamal reported:

*“Well say in regards to patient care, a lot of the time, you’re encouraged to brush it aside and move on, so you try your best with a patient and it might go wrong, and it’s sort of forgotten about most of the time, you try and move on and try and not say anything again about it, that kind of thing”.*

### **5.2.2.2. *Concept: Avoiding proximity to mental health issues***

The participants’ perceived expectations and co-constructed norms of being a JD can be interpreted as an influence on a renegotiation of their coping strategies in terms of emotional distress. In their strategy to be the ideal or culturally accepted JD, the researcher felt that they appeared to avoid proximity to any mental health issues or services when talking about their views on the matter. This category was heavily saturated where all participants made reference to the difficulties in such an attachment:

Arjun explained :

*“I personally can’t get myself to do it [get professional help] unless I’m very depressed, and I haven’t been that depressed yet”.*

Arfan said:

*"I just don't feel like I necessarily want it [psychological help] to or need it to have any support like that. Maybe that's just my, sort of view on that"*

Ranjit reflected:

*"Perhaps we don't recognise it ourselves, or perhaps we don't admit it to ourselves. The classic signs of depression, we could question whether we actually have it or just signs of stress and then we'll deny it to ourselves or just fumble our way through and get really irate...For a doctor to seek psychological therapy as a first instance, they would probably try and find all other routes first. I'm not someone that would seek psychological therapy as a solution to anything".*

Sayem stated:

*"They're (doctors) terrible at recognising their own illnesses...I think the main reason is because of pride...I think I would prefer to use other methods, like good friends...I would have to be pretty desperate to go down the psychotherapy route".*

Inderjit's view was:

*"If it works for certain people and it works for them and they're all for it, then good, but it doesn't work for everybody unfortunately, and I believe it wouldn't work for me – counselling is not for me...Personally, I don't think it [counselling psychology] would help me. There might be other doctors who think differently but for me, I don't think it would help".*

Andrew reported:

*"If you needed to access support in that kind of [stressful] situation, I would have hoped that you'd be encouraged to look for an alternative career path....[On accessing help] You're gonna be acutely aware of the fact that you're seemingly different to everyone else".*

Kamal explained:

*"People who are medical have a funny perception of psychiatry and psychology. They are trying to distance themselves, and therefore is some kind of insecurity or fear of mental illness....Nobody wants to admit they've got a problem. There's a lot of focus on ambition I think, and getting ahead and building a CV and this kind of thing. So the encouragement is to focus on that sort of thing, and not to be held back by things like that [mental health issues]".*

Mumtaz said:

*"They probably all bury it all under the carpet (emotional concerns), and recognising that you're sick, I mean my friend that suffers from anorexia, she didn't realise until she was far far down the line. She just carried on going going going. You just tend not to think about your own emotional, mental health".*

Perhaps the participants' lateness for the interviews could also be interpreted and added to this concept. That is, the participants had volunteered for the project for various motivating factors. However, this also entailed sitting for some time and talking to a trainee counselling psychologist about mental health issues within their medical culture. Arriving late for the meeting may have been a way to convey the messages which they felt needed to be addressed whilst remaining on 'safe' ground and knowing that there would not be sufficient time to discuss anything in detail which pertained too 'unsafe', i.e., any personal psychological difficulties.

### ***5.2.2.3. Concept: Views on being a patient***

The participants spoke about their views on being a potential patient. These narratives could seemingly be viewed as a strategy to enhance clinical detachment in their roles as JDs.

Inderjit explained:

*"...because you can't help yourself, it's a role reversal almost. I would never put myself in that position, or if I found myself in that position, then I would try and switch off because it's just one of those things, you don't want to ever be the patient, because you're the doctor. You're treating others, not being treated.....[On being in a psychological consultation] You're put in a vulnerable position. Something you're not used to".*

Sayem said:

*"I think some doctors would struggle because they are ridiculously hierarchical, and so I can imagine a consultant who is used to being the leader would find it difficult to rank things, it's all about 'the doctor is God' thing".*



#### **5.2.2.4. Concept: Non-Expression of emotion**

Participants spoke about the perceived unacceptability and consequences of expressing their true emotions in the medical environment. For example, Kamal explained about the encouragement to detach from emotions in the workplace:

*“Well say in regards to patient care, a lot of the time, you’re encouraged to brush it aside and move on, so you try your best with a patient and it might go wrong, and it’s sort of forgotten about most of the time, you try and move on and try and not say anything again about it, that kind of thing.....You’re sort of encouraged not to have so much contact with your feelings so much because you’ve got to not be so emotionally involved with the patients, so that’s the encouragement”*

Arjan stated:

*“If you look at it, a lot of people...I haven’t seen many people who can’t cope with the Foundation Year 1, the House Officer year, but a lot of people when under stress like, I know a lot of people cried in the last few days, you know...on calls are stressful...I mean obviously, you can identify yourself with them, but if they start seeking for...if they’re very depressed, if they’re clinically depressed and start seeking for help, it’s not a failure as such but it just means that they just can’t cope with it, it’s just not for them”.*

#### **5.2.2.5. Sub-Category: Credibility**

Participants spoke about the credibility of psychologists. They highlighted the view that psychologists do not have the knowledge or experience needed to help doctors, which therefore contributes toward the barrier to psychological accessing services available to them. For example, Inderjit explained:

*“I can't relate to anyone unless they are from a medical background themselves. Because most psychologists are not from a medical background, they've never worked with patients like doctors have.....I don't know if they [psychologists] could relate to someone, you know treating someone in a hospital setting..... I'm not very convinced by the fact that they do help within the medical environment”.*

Mumtaz said:

*“How can someone help, who hasn't had that responsibility [as a medical doctor]? I don't see how you [psychologist] can really put yourself in that person's [doctor] shoes to understand what they're going through, when that person [patient] actually dies”.*

Mumtaz went on to explain:

*“The perception of counsellors...that they say things, answers that they probably give to everybody, that they're not going to give you advice on your specific thing, it's not tailored to you.....They're [psychologists] not hearing what you're saying or understanding you.....You're [psychologists] taught to give different set answers and you select which one is appropriate to the situation of what the person is telling you”.*

#### **5.2.2.6. Concept: Competing professional power**

There was a sense that participants were competing with non-medical professions to maintain their identities and status in society. They therefore discredit those who are not medical as being of no use to them.

Inderjit explained:

*“I just feel that when you go to a psychologist and tell them what you're going through, you get a better result from a colleague. But if one of the public goes to the psychologist for different reasons, I'm sure a psychologist could relate to that. But I don't know if they could relate to someone, you know treating someone in a hospital setting... I can't relate to anyone unless they are from a medical background themselves”.*

Sayem suggested:

*“I think some doctors would struggle [to seek psychological help] because they are ridiculously hierarchical, and so I can imagine a doctor who is used to being the leader would find it difficult to rank things, it's all about 'the doctor is God' thing” .*

### **5.2.2.7. Concept: Mumbo-Jumbo for patients**

Many participants spoke about their views on counselling and related psychological professions.

Whilst assuming knowledge of the profession, the participants exposed a lack of understanding regarding the profession and attributed mental health services as something for the general public.

Their narratives reflected a perception that the therapists would not relate to them individually, but in a stereotypical way. This can be understood in terms of a fear that sessions with a psychologist will entail a loss of power and authority and, therefore, a loss in the feelings of being unique and somewhat special.

Arfan stated:

*“Doctors would probably think they [psychologists] are a bit too soft. They may think, it will just be a bit mumbo-jumbo softness that isn't going to help me.....They [psychologists] do it day in day out...doing the run of the mill, going through the emotions type of thing...that certainly would be something that would come to mind for me because it's something that I do [saying things to patients without meaning it]..... If it's a formalised, structured type of meeting...that may then make me feel, actually, you don't really care, you're just doing your job and waiting for the next case to come in and see you”.*

Sayem reported:

*“I think it would be quite awkward, I think. I think another thing that would put me off [seeing a Counselling Psychologist] is the profession of the therapist having the view that you're a doctor, you should be able to cope with it. Also because I've treated people with stress and depression and anxiety, I'd be double guessing what the therapist was thinking. I think it would be a very difficult relationship because of all the background”.*

Arjan said:

*“I don't think it is natural...they're [psychologists] listening to you in a way that they can use a technique or a method to make them [clients] feel better..... They're not really listening to you.....It's good for patients but personally I don't feel like I want that”.*

### **5.2.2.8. Concept: Confidentiality and a fear of exposure**

In protecting their identities as JD, all participants described their fears of a breach of confidentiality and a fear of exposure should they seek psychological help. For example, Kamal explained:

*“You sort of feel it’s going to be recorded. It has the potential to, you know, officially it’s not meant to skin you but you’re always worried that anything might be. It might come back and bite you in the future”.*

Sayem also said:

*“If people found out, then it wouldn’t have a huge impact. Perhaps people would respect them a bit less...there might be some doubts about, you know, are they just moaning...if someone took a month off because of stress, and that included psychological treatment, people might feel resentful, they’d think you’re trying to pull a fast one”.*

Ranjit reported:

*“I’m not saying that doctors are evil, vindictive people, they’re not, but it’s like when I treat a person with drug addiction, I automatically have made assumptions whether sub-consciously without helping it, even though I like to think of myself as unbiased. You do automatically make assumptions... I think there would still be a fear that people might find out and make assumptions about you”.*

### **5.2.2.9. Reflexive Statement**

Being a counselling psychologist in training and therefore dependent on supervisors and academic superiors on the successful progression of my career, I was interested to see how the participants' own career status may have contributed to their experience of being JDs and importantly how this may have influenced the development of their coping strategies within their workplace.

Given that the participants learned about my ethnic background by way of my name on the recruitment material and the field of study which was being studied, I had wondered about the influence these factors had on their decisions to participate and the type of information offered to me in the interviews.

I had wondered how they perceived me, both as a trainee in my field of work, and as a member of the psychological profession. There was a sense that I was intruding on their culture when they were speaking about their views on 'proximity to mental health issues' and the 'credibility' which they gave to the psychological profession. Perhaps my own views on doctors and patient-hood may have silently interacted with the interview process.

### **5.2.3. Unacceptability of difference**

Participants spoke about the unacceptability of difference in the workplace. There was a sense that the participants needed to remain within the implicit medical cultural script of behaving, believing and thinking to manage their social roles as doctors. Their narratives on this seemed to reflect a fear of discrimination and stigma if they were to deviate from the implicit script.

The concept which comprised the sub-category 'discrimination' is: 'recruitment and career advancement'. The concepts utilised for the sub-category 'experience of stigma' are: 'interdependence' and 'shame'.

The index tree for this category is displayed in Figure 5.4.

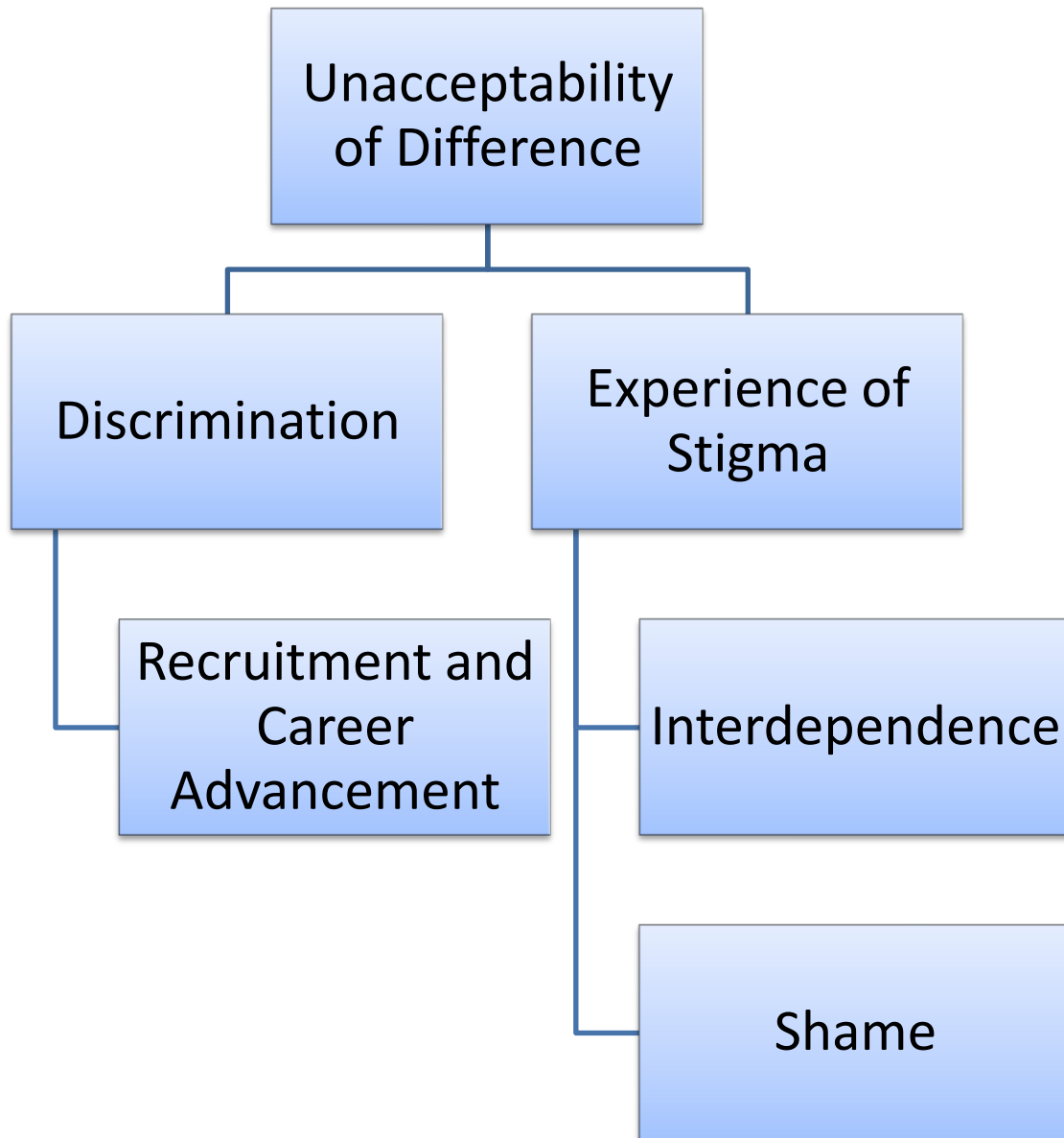


Figure 5.4. Index tree for 'unacceptability of difference'.

### **5.2.3.1. Sub-Category: Discrimination**

There was a sense that the participants needed to give a justification of their conforming to perceived implicit group norms to maintain their group identity. The justification was to avoid being placed in the out-group and therefore discriminated against. The researcher felt that the participants spoke whilst hiding behind their group identity and tended to steer away from references to themselves as individuals and their *own* views. This was interpreted as the participants' strategy to enhance their identities as a good JD, to maintain their coping strategy of distancing (from the self) and therefore to avoid deviations from the perceived norms of their culture and escaping discrimination.

Participants spoke about their fear of discrimination if they were to stand outside the norm of being a JD. For example, Ranjit explained:

*"a lot of promotions, a lot of those who progress in their career, as well as being skilled at your job, I mean, you can train a monkey to be skilled at surgery, it's not rocket science, but it's also the personality that goes with it, it's the person that goes behind it and whether you want them as colleagues or not".*

Inderjit said:

*"You've got to be seen as someone who doesn't complain, you've got to be seen as somebody who gets on with it, and anything out of the ordinary, then...you've got to be a conformist... You don't want to be seen as different. You can be seen as different in a positive light in that you put in more work, more hours than needed but you can't be seen as different in terms of being a positive, very spoken, jolly person, who jokes around a lot".*

The feared discrimination is reported to recruitment and career advancement.



### **5.2.3.2. Concept: Recruitment and career advancement**

Participants explained their fears and impacts of attaching themselves to psychological services on their careers.

Kamal explained:

*“Nobody wants to admit they've got a problem...there's a lot of focus on ambition I think, and getting ahead and building a CV and this kind of thing. So the encouragement is to focus on that sort of thing, and not to be held back by things like that [mental health issues]”.*

Andrew stated:

*“I'd be worried that it would impact on your training, in terms of, yes, it's all confidential but the quandary over letting supervisors and seniors know, because you're working for them, so, if it's going to impact your ability to do your day to day job, they should know. But then yes, the kind of knock on effect of, will that effect your standing in their view, and impact on kind of scores and training and your future career progress etc”.*

Arjan said:

*“When you don't get enough support properly from your seniors, it is quite stressful. It was stressful last year. But at the end of the day, you feel you just have to go through this, and if you don't go through this kind of problem, you'll never be a good doctor. That's part of your job. You have to go through it”.*

Inderjit reported:

*“It's justifying, the thing is when the consultants were at our stage years ago, they keep saying, you know, we had to do this and this, and do weekend on calls, with a 72 hour weekend, and they think we do less work than they did, and they keep comparing our work with what they did back then, and so they're thinking if we can't cope with it now doing less work and less pressure.....you can't ever be seen to be complaining because the speech comes out to you know, when I was your age, I was doing this, and this is what used to happen, and they're just going to go on about that”.*

### **5.2.3.3. Sub-Category: Experience of Stigma**

All participants spoke about the potential issue of stigma in relation to accessing psychological services as a JD. There was a sense of failure and weakness attached to such an action which came across rather strongly in their narratives. Further to this, it was interpreted from the participants' accounts that the feared social consequence of psychological treatment is the perceived negative judgments from others. For example, Andrew explained:

*"You're going to be labelled, that it's something you shouldn't have to do".*

Similarly, Mumtaz said:

*"If people found out that you were having counselling, I think people would see it as though you're not strong enough, that you're weak and maybe this isn't the right career for you".*

Arfan defined the stigma in relation to JDs accessing psychological services as:

*"a fragility about a doctor's personality".*

This sub-category comprised of two concepts: 'interdependence' and 'shame'.

### ***5.2.3.4. Concept: Interdependence***

Participants reported a social unacceptability which they perceived to exist among the medical profession, regarding seeking psychological help. The participants described a culture which seemed to involve interdependence and team working. Their descriptions appeared to be spoken with some unease about the potential of letting their teams down with mental health issues as though it would invite a form of social sanction. For example, Kamal explained:

*"If people found out, then it wouldn't have a huge impact. Perhaps people would respect them a bit less...there might be some doubts about, you know, are they just moaning...if someone took a month off because of stress, and that included psychological treatment, people might feel resentful, they'd think you're trying to pull a fast one...Because you're so*

*busy, so to be dealing with your own neuroses would be, could be quite potentially irritating for your team mates, and you might be seen as quite weak”.*

Arjan also reported:

*“In the hospital especially, it’s very much team work, you depend on each and every single person. If one of you starts getting upset, then you’re not going to be able to function properly, then you’re no good to anybody, then it puts the rest of the team out”.*

Participants also spoke about the need to live up to their seniors’ expectations. For example, Inderjit said:

*“If you’ve worked with someone who’s works for longer hours than you, in a high pressured situation, then they would look at you and say, we did this and we didn’t have what you have – by having to go to see a psychologist. I think that’s the thing there with the weakness”.*

Ranjit explained:

*“I think there is something in there about being seen as not being able to cope by my older peers”.*

### **5.2.3.5. Concept: Shame**

There was a commonly reported feeling of shame that is associated with mental health issues or accessing psychological services.

Sayem reported:

*“I think possibly if someone does get into trouble, they think they might be quite ashamed because they feel they should be able to cope with it and use their own resources and they probably think that well if everyone else is coping with it, I must be ok”.*

Andrew said:

*“You don’t know of many people that do, therefore if you’re in that position, you feel like the only one.... There is a sense of failure; a sense that it’s not the done thing; fear; embarrassment; uncertainty. If I were to get help, I would probably feel embarrassed. Potentially as if I failed. It doesn’t seem to be the done thing to do”.*

### **5.2.3.6. Reflexive Statement**

The stigma attached to mental health among the medical profession is well known. However I was interested to learn about the internal, silent communication regarding the stigma related to mental health and mental health services among the participants. They seemed to express the same views without explicitly communicating these to one another.

Whilst reflecting on the interviews, I found myself wondering if the participants' statements would have been dissimilar if I was from a different background. Given that the majority of participants were from an Asian background, and male; and that I am from an Asian background myself and female, I had wondered how these factors may have influenced the participants' accounts. Perhaps the male Asian participants may have volunteered to participate for the study after learning about my ethnic origin and gender from the recruitment material, by way of my name. Maybe they were able to disclose more to a female than if the interviewer were a male due to perceived gender role expectations. Further, I wondered whether the Asian participants' own backgrounds had an impact on their views on me being a Chinese counselling psychologist in training, and possibly displaying a lack of deference towards me for associating myself with mental healthcare as a member of the Asian population. Indeed, my own background includes an Eastern influence of stigma towards mental health issues.

### **5.2.4. Reflection on the results**

There was a difficulty during the data analysis stage when confronted with the demographics of the participants. As seven out of the eight interviewees were from an Asian background, this posed a potential dilemma when scrutinising the data from a social constructivist perspective. The ethnic origin of the majority in this study was in itself a finding from the research as it was not reflected in the original research question. Being faced with such a homogenous sample, I was obliged to divert my focus to more cultural issues and how this may have interacted with the results. This dilemma

created difficulties in interpreting the results. For example, I wondered whether it was appropriate to include a concept of gender differences given there was only one female. However given the social interactions which were observed between interviewer and interviewee, the data appeared to be of significant nature to include in the study. Further, it was felt and acknowledged that the research is of a social constructivist nature where the objective was not to achieve generalisability but rather to produce a theory which was grounded in the participants' accounts. Similar dilemmas were faced when interpreting the data from a cultural perspective as the original interview schedule included a limited exploration of Asian participants' understanding of their background and how this may have influenced their views on the research topic. Further, one Caucasian participant had volunteered for the study which places the research in a non-Asian JD analysis. Interpretations of the results therefore could not be based wholly from Asian culture specific contexts. It became to light during the analysis that it was difficult to separate out the individual 'cultures' of the individual participants and the impacts on the construction of their views on and beliefs towards psychological treatment. That is, given some of the Asian participants were also of British nationality, there was the complex interaction of various cultures which each participant was exposed to and was difficult to separate out. The analysis was therefore not exclusive to Asian cultures but rather the interplay of different experiences of social processes whom have come together to construct a new culture. Taking this perspective, it was possible to include the lone Caucasian participant whose own British background would have contributed to the experiences of the participants.

### **5.3. Chapter Summary**

Eight participants volunteered to take part in the study. Of the eight participants, seven were male and one was female. Regarding ethnic background, seven participants were Asian and one participant was Caucasian.

The data generated from the interviews was used to construct a core category of 'psychosocial barriers to accessing psychological services by JDs'. This core category was informed by the themes of 'medical identity', 'development of coping strategies within the British medical culture' and 'unacceptability of difference'. Each of these three themes consisted of additional sub-categories and concepts which contributed to an understanding of each phenomenon.

A reflexive summary was provided at the end of each theme section to highlight factors which may have influenced the interview outcomes and processes and data analysis. A further section detailing the researcher's reflections on the results was given.

The following chapter discusses the results in relation to the literature review and how the present findings contribute to the current knowledge base on the topic.

# **Chapter Six**

## **DISCUSSION**

### **6.0. Overview**

This research project has examined and produced a grounded theory to suggest the psychosocial barriers which may hinder access to psychological services for JDs. This final chapter discusses the clinical implications of this theory. A discussion of the limitations and strengths of the study followed by recommendations for future research are then outlined. Issues of rigour are then discussed and in line with social constructivist research, the impact of this study on the researcher will be considered and how this may have affected the outcome of the study. Finally, some conclusions are drawn.

### **6.1. Section One**

Throughout this study, results have lent support to a number of previous findings within the field of psychosocial barriers for doctors in accessing psychological services. Crucially, the findings of the grounded theory have extended the current knowledge base in the topic area. Particularly, the findings are specific to JDs and their views and attitudes to psychological services which was a topic that was absent in the literature search. A summary of the principal themes which inform the core category and which make up the grounded theory is presented below.

#### **6.1.1. Medical Identity**

The results from this study suggest a number of factors in identities of JDs which may contribute to the creation of barriers to accessing Counselling Psychology. These factors include: renegotiating own cultural identity, norms of acceptable behaviour, conceptions of being a doctor, and position in medical family. These are discussed in turn below.

### ***6.1.1.1. `Renegotiating Own Cultural Identity`***

The results have suggested the need for JDs to renegotiate their own cultural identities in order to fit into the British medical culture, and therefore being seen by others in a particular way. Each participant brought with them different experiences of social interactions and constructions of meanings to mental health issues. It was therefore difficult to separate out the different 'cultures' which they had been exposed to and how this had influenced their views. However, it seemed apparent that each individual's narratives had uncovered a need to renegotiate their own understandings to construct new meanings and experiences to which they felt obliged to follow. Whether or not they were in agreement with this does not seem to hold much importance; this is in line with other research (Cohen, Kay, Youakim, & Balaicuis, 2009). This indicates that JDs are at particular risk of developing psychological distress due to the complex process of 'renegotiating their cultural identities' to that of their workplace culture. However, as the results suggested, being a medical doctor carries a certain prestige which puts them on top of the social hierarchy, arguably more so in Asian populations (Kramer, Kwong, Lee, & Chung, 2002). This brings with it difficulties as assuming a prestigious medical identity has been reported to place them in the role of 'leaders'. The participants suggested that seeking psychological help would therefore compromise their positioning in society and they would therefore not be set apart from the general public, but rather would become one of 'them', which would be unacceptable to participants. The participants seemed to possess a desire to deviate from the norms of society by becoming a doctor. However, a powerful message from the results indicated that they did not want to, or felt unable to deviate from the norms of being a good JD.



### ***6.1.1.2. Norms of acceptable behaviour***

Participants indicated that there were a number of implicit rules to which they claimed they were obliged to abide by as a British JD to maintain their positioning and identity within society and in the medical environment. The results revealed two main implicit rules which were perceived by the participants as norms of acceptable behaviour within their workplace: just deal with it and conformity. This is in line with other research (Davidson & Schattner, 2003; Cooke, Halford, & Leonard, 2006) and suggestions have been made that this phenomenon may be more potent to doctors from Asian populations due to their extra efforts to incorporate a British identity. They may therefore feel they cannot be seen to be complaining but rather 'dealing' with everything that they are presented with in the medical environment. Seeking psychological help would therefore contradict the rules which appear to have been created and deemed as unacceptable behaviour; creating a barrier to its access.

### ***6.1.1.3. Conceptions of being a doctor***

The results found that the participants regard several qualities to be of importance which contribute to their conceptions of being a successful doctor. These qualities include power and authority, strength and coping, and invincibility and omnipotence.

Given that British-Asian doctors are suggested to struggle to maintain their power and authority within society and the medical environment (Miller, Kinya, Booker, Kizito, & wa Nqula, 2011; Esmail, 2007), the results suggest the stated qualities may be of greater importance than their White-British colleagues as they strive for recognition. This indicates a greater priority for British-Asian JDs to avoid phenomenon which are perceived to have a detrimental effect on their identity as competent doctors and therefore setting them apart from group norms. With this frame of reference, seeking psychological help would seemingly be unacceptable.

#### ***6.1.1.4. Position in medical hierarchy***

The results indicated that participants' views on accessing Counselling Psychology were dependent on their positioning in the medical hierarchy or 'medical family'. This supports previous research (Cohen, Kay, Youakim and Balaicuis, 2009). The present findings contribute to the work of this phenomenon as Cohen, Kay, Youakim and Balaicuis's (2009) study used participants who were in medical school. The current results demonstrate the continuous culture from medical school into JD grades.

The results of the current study found that the participants are heavily influenced by their seniors within the medical environment. Where the interviewees have stated they perceive accessing psychological support to be unacceptable by their seniors, this has also had a direct influence on their own views in doing so. Where junior generations in Asian cultures are more prone to showing deferential treatment to their seniors (Kramer, Kwong, Lee, & Chung, 2002; Sue & Sue, 1990; Chung, 2007), this particular finding is of great importance in understanding British-Asian JDs' reluctance to seek psychological support.

Where there has been a lack of empirical evidence for gender differences in seeking psychological help among JDs, the present findings indicated that male participants generally held negative views about Counselling Psychology and other psychological services. These results support the findings of other research using samples from the general population (Mansfield, Addis, & Mahalik, 2003; Ang, Lim, Tan, & Yau, 2004; Vogel & Wester, 2003; Cusack, Deane, Wilson, & Ciarrochi, 2004; Yamawaki et al., 2011; Judd, Komiti, and Jackson, 2008; Mackenzie, Gekoski and Knox, 2006). The results indicated that male participants held negative views mainly due to their positioning in society as medical doctors. They suggested that Counselling Psychology and the psychological profession would not be helpful to doctors due to a lack of medical background; they would struggle to relate to non-medical professionals. In contrast to the males, the female participant expressed a wish to seek psychological help but felt prevented to do so by the profession.

In line with other research on the general population (Vogel, Wester, & Larson, 2007; Rickwood & Braithwaite, 1994; Bayer & Peay, 1997; and Vogel, Wester, Wei and Boyson, 2005), the current study found that the results were supported in the finding where the participants were influenced by their peers' perceptions on accessing psychological services. The participants reported a reluctance to seek professional psychological help as they had not observed any of their peers doing so, therefore deeming the action to be inappropriate. This finding contributes to the knowledge in this field as no empirical evidence could be found to suggest this existence in the British medical culture.

With the JDs' positioning in their medical family, they seem to have created a culture where their medical identities have allowed a self-perception to set them apart from the rest of society. Any other perceived 'lesser' profession such as counselling psychology is therefore deemed as 'too soft' and unhelpful to doctors.

### **6.1.2. Development of Coping Strategies within the British Medical Culture**

The results indicated that participants adopted two main coping strategies within the British medical culture: clinical detachment and adopting certain perceptions and use of counselling psychology.

These are summarised and discussed below.

#### ***6.1.2.1. Clinical detachment***

The results suggested that the participants felt the need to detach emotionally to succeed as a doctor. They indicated that two strategies were adopted to maintain this detachment: 'avoiding proximity to mental health issues' and having particular 'views on being a patient'. This is also in line with other research (Tattersall et al., 1999; Richardson, 2000; Robertson, Walter, Soh, Hunt, Cleary and Malhi., 2009).

With the results indicating that JDs deny the strains and adversities of the profession, employing a detachment from mental health issues to achieve this as a coping mechanism may prove to do more

harm than good (Richardson, 2000). However, given the emotional realities do not seem to be embraced by the profession, one can understand why embarrassment may function in this capacity should a JD admit to mental ill-health or needing to seek professional psychological services.

The participants would not and could not put themselves in the position as a psychological client or patient due to their status and profession in the medical industry. They stated that patient-hood carried with it messages of vulnerability and weakness; qualities which JDs are thought to avoid (Davidson & Schattner, 2003). The participants actively stated their avoidance of putting themselves in 'a vulnerable position' due to their profession and supremacy; 'it's all about the doctor is God thing'. Clinical detachment appears to be a core requirement of being a 'good doctor' which seems to lead to active avoidance of their own mental health.

### ***6.1.2.2. Perceptions and Use of Counselling Psychology***

The participants' own backgrounds in combination with their workplace culture seem to have contributed towards their conceptions of 'cure' through a medical lens. The results suggested that their conceptions of cure in relation to counselling and psychology consists of one main concept: the 'credibility' of the therapist and the psychological profession.

Where the results have suggested an identity of invincibility, omnipotence, power and authority among JDs, the participants have suggested that psychologists are inferior to them and lack the expertise, experience and knowledge to be of assistance to doctors; they therefore cannot relate to them due to these factors, contributing towards the barriers to them seeking psychological help. These findings echo those of others in the field (Sue and Sue, 1990; Akutsu, Lin and Zane, 1990; Sue and Zane, 1987). The current results, however, provide more up-to-date data and relate it specifically to British JDs.

The findings suggested that the participants have a poor understanding of Counselling Psychology and related mental health professions, and importantly what the services can provide to them. This

is unsurprising given the powerful existence of omitting mental health care issues from their lives. However, given this omission, the participants seemed to base their seemingly negative views towards the profession, on assumptions.

Given the omnipotent place which they have placed themselves in society, the participants have attributed counselling psychology as a service which is suitable for 'the public' but not doctors, without acknowledging that doctors themselves can also become ill and need professional assistance. The fear of placing themselves in line with patients brings a fear of a breach in confidentiality, a fear of exposure, and a fear of being placed in an out-group among their peers. These results echo previous research (Department of Health, 2008; Davidson & Schattner, 2003). However, where these studies did not consider cultural factors, the present findings highlight the contributions of the participants' backgrounds to the understanding of this concept. That is, where British-Asian doctors may struggle to seek acceptance, gain and remain on a par with their peers, being exposed as having to seek psychological help may 'un-do' their hard work. Further, factors such as bringing shame to their families (both medical and personal) may play a role in the barriers in seeking help Kramer, Kwong, Lee and Chung, 2002; Durvasula and Mylvaganam, 1994).

### **6.1.3. Unacceptability of difference**

The participants' accounts strongly suggested an adverse reaction within their culture where deviations of the socially constructed norms are perceived to be unacceptable. With the majority of the sample coming from an ethnic background, this already brings with it a set of physical characteristics which automatically sets oneself apart from their White-British colleagues. Indeed, with one-third of doctors in the NHS coming from Asian populations (Esmail, 2007), a significant number of our physicians may feel their physical characteristics and cultural backgrounds a hindrance on their careers. Indeed, previous research has shown that this may be the case (Esmail & Everington, 1993; Esmail & Everington, 1997; Coombes, 2004). Further to this, JDs from Asian populations all bring with them their individual experiences from their own backgrounds which also

interact with their non-Asian colleagues and together have constructed a meaning of 'difference' in the medical workplace.

The participants reported a fear of two main occurrences should they appear too 'different' from the norms of the British medical culture: discrimination and experience of stigma.

### ***6.1.3.1. Discrimination***

All participants spoke about the fear of discrimination should they venture away from the social norms of the British medical culture. The psychosocial aspects of being a British doctor seemed to have a powerful influence on the participants' construction of views towards accessing psychological services. By way of striving for recognition and acceptance by their seniors and peers, Asian participants seemed to actively deny their unavoidable 'different' characteristics which overtly set them apart from their White-British colleagues.

Where previous research has shown that mental health issues in doctors invited discrimination in various ways (Adams et al., 2010), the current findings contributes to this knowledge. That is the results of this study suggests that linking counselling and psychology for JDs with queries around the right career choice and capability is thought to be an immediate consequence of negative labelling and loss of status as a capable doctor for the participants; the labelled person may be placed on a lower position in the hierarchy and therefore discriminated against. JDs may feel the additional need in comparison to their seniors to actively avoid proximity to counselling and psychology to maintain their positioning in society and to increase their chances of recruitment and career advancement.

### ***6.1.3.2. Experience of stigma***

A stigma has been reported to be attached to mental health services for doctors and a perceived stigma towards doctors accessing/wishing to access such services. The reported perceived stigma has been defined as “a fragility about a doctor’s personality”. These factors are thought to contribute towards the barriers of accessing such help for themselves. These findings are in line with previous research (Bhugra, 1989; Mukherjee et al., 2002; White et al., 2006; Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger, 2011). Where previous work has documented the presence of stigma for the general Asian population in regards to mental health and the use of psychological services (Kramer, Kwong, Lee and Chung, 2002; Durvasula and Mylvaganam, 1994; Sue, Arredondo, & McDavis, 1992), the present findings suggest a same existence; however it is complicated by the medical culture. That is, the results suggested that a separate medical stigma exists for mental health issues where a fear is reported around the questioning of the capability as a doctor. The combination of cultural as well as medical stigma around mental health issues and services seem to create a combined force in avoiding proximity to mental health issues and services. Should any individual JD come into contact with psychological issues, then shame has been reported to exist by the participants. In comparing themselves with their peers, the participants expressed an observation of not needing any external assistance in coping with the (psychological) demands of their jobs. An internal sanction of feelings of failure and inadequacy was reported to exist if they did not follow this same pattern of behaviour.

## **6.2. Section Two**

### **6.2.1 Strengths and limitations of the study**

#### **6.2.1.1. Limitations**

There were some limitations with the present study and these are discussed below. However, it is important to note that these limitations were largely unavoidable, as they are inherent in conducting qualitative research and are inevitable when relying on participants volunteering to take part.

#### ***6.2.1.2. Sample size and response rate***

One major limitation is the small sample size as a result of the low response rate. A lack of financial or other incentives being offered to participants may have contributed to this along with the research topic itself. However, although the sample size was small, it was enough to generate data to suggest a theory. Indeed, the purpose of this study was to look at processes, therefore using rich qualitative data was appropriate. Using large sample sizes reminiscent of quantitative studies would not have allowed such a detailed analysis of the interviews. Nevertheless, further research with a larger sample size is still needed before one can determine whether these findings are a true reflection of the general trend.

#### ***6.2.1.3. Sampling bias***

Steps were taken to address the issues of sampling bias. For example, recruiting participants from different NHS trusts and from different stages in their careers. However, sampling bias may still have occurred.

It is possible that participants who were willing and wished to access psychological help but had not done so because of their profession, did not participate due to possible concerns about experiencing emotional distress during the interview.



Participants were restricted by exclusion criteria. Thus certain potential participants were omitted, such as those who have accessed psychological services in the past. Including these participants may have given an additional insight into their perspectives on the research issue. In addition to those excluded when defining the sample, several potential participants were unable to contribute to the study due to scheduling difficulties, time restrictions and a lack of financial incentive.

#### **6.2.1.4. Demographics of sample**

With seven out of eight participants coming from Asian populations, the makeup of the sample was an unexpected finding of the research in itself. As the study did not specifically aim to explore this homogenous group, the analysis of the data posed some difficulties. The interview schedule included limited exploration on their cultural backgrounds and how this may have influenced their views on the topic area. Concepts which may have been included in the core finding were therefore eliminated as there was not sufficient data to ground the theory.

Further to this, the research recruited mainly Asian participants, which made it necessary to focus on cultural issues. This presented the dilemma and questions of incorporating the lone Caucasian participant in the data analysis. Similar quandaries were experienced with the lone female participant as only one out of eight participants was female. The lone female and lone Caucasian participants seemed to enrich the understanding of the themes. For example, the statements made by the Asian participants were similar to that those made by the lone Caucasian participant when discussing the positioning in the medical hierarchy. This suggests that the views and attitudes are not exclusive to the Asian participants. One way of interpreting this is that non-Asian JDs reinforce the views and attitudes that Asian JDs may hold. However, this claim is only speculative.

With opportunity permitting, it would have been useful to focus the study on British-Asian male participants. A more in-depth exploration of their cultural backgrounds in the interview schedule would have been included. As it stands, the present findings incorporate a lack of material about

this from the participants which has made it difficult to identify the importance of the British-Asian cultural issues. An exploration of these issues may have given some insight into the questions raised in the present study. That is, why mainly male British-Asian JDs volunteered for the research which asked for JDs who would not access psychological services and their motivations to participate. Although the present findings have touched on these issues, a more in depth exploration would have given a better insight, grounded in the data.

#### **6.2.1.5. Strengths**

There were numerous strengths to this study, the majority of which were associated with the appropriateness of the chosen qualitative method: a constructivist grounded theory approach. This method allowed for the exploration of the social and contextual influences on the participants' experiences. To the researcher's knowledge, this is the first study to have investigated these psychosocial processes and influences specifically on JDs and their perceived barriers to accessing psychological services.

Adopting a qualitative method allowed a rich understanding of the research issue from the participants' perspectives. The open-ended questions and high level of anonymity offered participants to talk freely about their experiences. Indeed, they offered data from this method of questioning which would not have been able to be addressed by quantitative methods. Measures such as questionnaires are limited in that they only provide a superficial description of real life experience. Responses given by participants clarified specific aspects of the research issue that would not have been possible using forced-choice quantitative assessment methods.

Importantly, this study has built upon and contributed to the existing small knowledge base in relation to JDs and their views on accessing psychological health care. It has also given some useful insight into a homogenous group of British-Asian JDs. This is a valuable piece of research that can guide future studies, and results can serve to inform Counselling Psychology and related professions

on appropriate therapeutic interventions to improve access and effectiveness of practice with this client group.

## **6.3. Section Three**

### **6.3.1. Issues of rigour**

During the research process, every effort was made to maximise the rigour of the findings. As is the nature of qualitative research, this involved the study being fully 'immersed' in the data, involving personal contact with the participants and continually reading and re-reading the data. Efforts to achieve rigour have been outlined in Table.1. These methods served to increase confidence in the findings and the interpretation made (Elliot et al., 1999). However, no matter how diligently steps are taken to ensure rigour, the researcher still has to interpret the words of the participants. There are therefore potential sources of biases in interpretation. That is, the researcher's characteristics are likely to have influenced the participants' accounts in the interview process and also the researcher's interpretation of the data. The problem of interpreting meanings is a feature of qualitative research, and conclusions are always particular to the researcher who interprets. Therefore, the ability to make generalisations from the findings are limited. However, qualitative methods such as grounded theory do not strive for generalisability; rather it aims to uncover the individual meanings and perspectives which individuals attribute to their experience (Strauss & Corbin, 1990; Charmaz, 2006). Indeed, it has been suggested that the results resulting from qualitative research should be considered according to their applicability. That is, the degree to which readers can accommodate the findings to their own contexts, rather than on their literal generalisability (Strauss & Corbin, 1990). Thus, an understanding by those who read the work should be the focus, rather than deriving the generalisable 'truth' of the findings. This fits with Elliot et al's (1999) view that findings should resonate with the reader and provide a credible account that makes sense of the experience of participants and increase understanding of the research topic.

## **6.4. Section Four**

### **6.4.1. Clinical implications and recommendations**

Where previous research has looked at elements of psychosocial barriers to psychological services for British JDs (Cooke, Halford, & Leonard, 2006; Davidson & Schattner, 2003; Persaud, 2004), this current study has highlighted that the topic area is still relatively poorly understood. The significant number of participants from Asian populations was an unexpected finding of the study. This allowed the exploration of the Asian culture and its possible impacts on the study. To the researcher's knowledge, this study is the first to explore British-Asian populations working as JDs in Britain and how these factors may contribute to barriers in accessing psychological services. Given the significant numbers of Asian doctors working in the NHS, it was surprising to find a lack of research looking at this homogeneous group, as it has been suggested that this population may face additional psychosocial challenges in their work compared to their White-British colleagues (Esmail, 2007; Cooke, Halford, & Leonard, 2006). Further to this, the current study demonstrated the interaction and collusion of different cultures (Asian as well as non-Asian, male and female, senior and JDs) and how this influences the co-construction of a medical culture.

In terms of clinical implications, the results of this study have highlighted a number of areas where psychological research might be utilised in order to provide further understanding of the barriers to accessing psychological services for JDs. This understanding can therefore aid counselling psychologists in their work with this specific client group. Clinical implications are outlined below.

#### **6.4.1.1. Implications and recommendations for knowledge**

There is a large body of theoretical literature which addresses elements of the research topic (Hochschild, 1983; Tajfel and Turner, 1979; Addis and Mahalik, 2003; Lemma, 2003; Link and Phelan, 2001; and Latoo, 2009; Golec de Zavala, Cichocka, Eidelson and Jayawickreme, 2009). However, each individual theory was not sufficient in addressing all the elements of barriers for JDs in accessing psychological services. There is a prominent lack of empirical evidence which focuses on such a homogenous group as Asian JDs. This study attempts to readdress this balance.

Not only is this research adding to the current knowledge base, it is also raising awareness. It is well known that many JDs experience a significant level of psychological distress which they feel must go unaddressed for various reasons (Hawton, Malmberg, & Simkin, 2004; Lydall, 2007; McManus, Keeling, & Paice, 2004). The current research has suggested that the cultural backgrounds of British-Asian JDs may pose additional difficulties and struggles in their professional roles. It is therefore important not only for senior doctors to be mindful of their juniors who are from ethnic minority populations, but also for counselling psychology and related therapeutic professions when/if working with this client group.

#### **6.4.1.2. Implications and recommendations for research**

As mentioned, research into this area is limited, with little investment in trying to understand the processes involved in the creation of psychosocial barriers. Research that is available tends to look at the 'what' of the problem; what the issues are which created the barriers, but little is known about the 'how', i.e., the processes involved in the construction of the 'whats'. This current study has attempted to address this gap in the research which is important if a psychological service is to be effective in helping JDs. Continued research effort and funding is needed to explore this topic further. It is of interest to the researcher to conduct the following studies to explore the

phenomenon of barriers to psychological care for, JDs further, and add to the current empirical literature:

- Senior doctors' perceptions of their juniors in seeking psychological help.
- The usefulness of focussing on increasing psychological openness in JDs rather than targeting willingness to seek help.
- British-Asian JDs' perceptions on being a doctor from an ethnic minority group within a British institution and how this may impact on their views on psychological services.
- White-British JDs on working with colleagues from Asian cultures and how they may perceive their Asian colleagues if they were to seek psychological help.
- Do psychological services need to be modified to reduce the barriers of access for British-Asian JDs?

Clearly, much more research is warranted on this topic in general. The topics for further research are numerous.

#### **6.4.1.3. Implications and recommendations for clinical practice**

The current study has raised numerous issues which are suggested to be unique to JDs. Their striving for acceptance and recognition within the NHS may create additional difficulties for them in seeing a psychologist. It is important for Counselling Psychologists and related mental health care professionals to be mindful of these factors when/if seeing clients from this group. Where Counselling Psychology uses principles from individualistic models, requiring a need to focus on the self, practitioners need to be mindful of the JDs and workplace culture where the focus is on teamwork and being mindful of others. It may be suitable to adapt the usual process of therapy and negotiate a more appropriate method of delivering psychological support to JDs to reduce barriers and to promote credibility and effectiveness among this client group.

## **6.5. Section Five**

### **6.5.1. The impact of the research process on the researcher**

Although the researcher had several years of counselling psychology experience through clinical placements, she was an inexperienced research interviewer and had never experienced conducting a qualitative piece of research. It was both a challenging and interesting experience albeit frustrating and overwhelming at times. A great deal was learned which has had a direct impact on her professionally and personally.

The exposure to the participants' accounts and the analysis of the data thereafter has allowed the researcher to reflect on her own ethnic and cultural background, questioning the impacts which this may have had on her clinical work with clients. It has also addressed the personal journey that was taken to arrive at a career in counselling psychology as a British-Chinese individual and how this may have influenced the research outcome.

## **6.6. Section Six**

### **6.6.1. Conclusions**

The primary objective of this study was to explore the psychosocial barriers which may be hindering the access to psychological services for JDs. This aim was achieved and a theoretical model of the phenomenon was generated. Research has only just begun to investigate these barriers for JDs. The research identified psychosocial barriers which appear to co-exist, contributing to the processes involved in not seeking psychological help. Only by improving our understanding of this complex area can we hope to find an effective way of delivering psychological assistance to JDs.

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**What are junior doctors' attitudes and beliefs towards accessing psychological services such as counselling psychology for themselves?**

I am a doctoral counselling psychology student at Roehampton University looking for junior doctors who do not or would not avail themselves to psychological services for professional help with any psychological difficulties such as stress, depression, emotional exhaustion, burnout, etc.

Research highlights that junior doctors are suffering from a high level of psychological distress (to the point where some have even considered suicide) but are unwilling to seek professional help to alleviate this, and potentially exacerbating the problem. The aim of this research is therefore to look into the reasons why this is. By gaining an understanding of junior doctors' views, beliefs and attitudes on the issue, this will help identify more appropriate services to work with them.

If you are interested, you will be asked to attend an interview lasting approximately 1 hour to 1 hour 15 minutes at a location convenient to you.

If you are interested in taking part in the study or would like more information, please contact the researcher, Amanda Chan at:

**Amanda\_Chan8@hotmail.com**

**Tel: 07967 128835**

Thank you.



## ***ETHICS BOARD***

### **Recruitment information**

**Title:** What are junior doctors' attitudes and beliefs towards accessing psychological services such as counselling psychology for themselves?

Thank you for expressing an interest in this research. I hope that the information below will help you in making your decision of whether to take part. If you have any questions that have not been answered here, please do not hesitate to contact me.

#### **Brief description of research project.**

Practicing medicine can have a negative impact on your health according to an article published in the British Medical Journal as it is well documented that many doctors are affected by psychological problems – particularly depression and alcohol or drug issues. However, despite this knowledge, the literature suggests that although doctors would benefit from seeking professional help such as counselling psychology to assist with alleviating the stress due to job demands and other issues, only a small minority actually makes use of the services available – the proposed research aims to look at the reasons for this, in terms of their beliefs and attitudes, with particular focus on junior doctors.

#### **What are the potential benefits for you, and for me?**

It is hoped that by taking part in the research, you will benefit with a greater understanding of your *own* views and an opportunity to gain an awareness of peers' perceptions on the subject area.

Your participation will help me by providing first hand information as to what prevents junior doctors from accessing psychological services. This information will greatly help to determine whether there is a need to develop specialised services to address psychological distress in junior doctors.

### **What will taking part involve?**

Participating in the research will involve attending an interview lasting approximately an hour to an hour and fifteen minutes.

The interview will be audio recorded for transcription purposes.

### **How will participants remain anonymous?**

Although the session will be tape recorded, your contributions will be anonymous where a pseudo-name will be used in the write-up. The tape recording will also be destroyed immediately after transcription which will take place approximately a month after the interview.

Nobody else will have access to the transcription tape, or the details you provide with regard to your contact information etc.

### **What difficulties may arise from participating?**

This may be a sensitive issue for you and as such, you may find that speaking about your experiences and views makes you more aware of things which feel difficult or brings things up that are upsetting for you. You will be provided with emotional support through suggested therapists, organisations and help lines – particularly those specialised for doctors such as 'SupportLine'. You will also be able to contact the researcher should you need a de-briefing session.

Further, you are able to withdraw from the research at any time after participating, should you feel uncomfortable about your contributions. All you need to do is contact me with your ID number that will have been allocated to you. However, please note that data in aggregate form may still be used/published.

## **What to do if you are interested in participating.**

Please contact me, preferably by telephone or email. We can then discuss further, giving you the chance to answer any questions you may have. We will agree on the practical arrangements, such as when and where to meet. I will also send you a Letter of Agreement, which outlines how I will use your material, which I will ask you to sign and return.

Amanda Chan

School of Human and Life Sciences

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Tel: 07967 128835

[Amanda\\_Chan8@hotmail.com](mailto:Amanda_Chan8@hotmail.com)

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

### **Director of Studies Contact Details: Details:**

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***ETHICS BOARD***

**PARTICIPANT CONSENT FORM**

**Title of Research Project:** What are Junior doctors' attitudes and beliefs towards accessing psychological services such as counselling psychology for themselves?

**Brief Description of Research Project:** This research is aiming to investigate why professional psychological services are not used more widely by junior doctors despite research showing that many suffer from psychological difficulties such as depression, stress and anxiety. If you are interested, you will be asked to attend an interview lasting approximately 1 hour to 1 hour 15 minutes at a location convenient to you. The interview will be audio recorded for transcription purposes.

**Investigator Contact Details:**

Amanda Chan

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Chana@roehampton.ac.uk

(Tel: 07967 128835)

**Consent Statement:**

I agree to take part in this research, and am aware that I am free to withdraw at any point after participating. Should I decide to withdraw from the research, I will contact the researcher with my ID number that will be allocated to me at the time of attending the interview. However, I understand that data in aggregate form may still be used/published.

I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name .....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

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## ***ETHICS BOARD*** **Debriefing Information**

**Title of Research Project:** What are Junior doctors' attitudes and beliefs towards accessing psychological services such as counselling psychology for themselves?

**Brief Description of Research Project:** This research is aiming to investigate why professional psychological services are not used more widely by junior doctors despite research showing that many suffer from psychological difficulties such as depression, stress and anxiety.

Thank you for your time. I'm aware that you may have spoken about some very difficult experiences, which may have brought back uncomfortable memories.

I would now like to offer you some time to talk about anything that may have come up for you during the interview.

Is there anything that you would like to talk about that came up from this interview?

If you think of anything later, I will be available by telephone or email to answer any questions that you may have about this research.

However, should you wish to discuss any issue that arose for you during the course of the research in greater depth, for which you may need more specialist support than I am able to offer, you may find the following sources of support useful.



### Practitioner Health Programme

Tel: 0203 049 4505

[www.php.nhs.uk](http://www.php.nhs.uk)

A free, confidential service for doctors and dentists. They have set up an agreement with the GMC and the GDC that allows them to see and treat practitioner patients without informing them of individual cases.

### BMA Counselling British Medical Association

Tel: 08459 200 169

Provides 24/7 telephone counselling by qualified counsellors.

### Doctors' SupportLine

A helpline offering peer support to doctors and medical students who want to talk through personal problems. All calls are answered by trained volunteer doctors. Completely anonymous and confidential.

Tel: 0870 765 0001

Website: [www.doctors supportline.org](http://www.doctors supportline.org)

Email: [deirdre@doctors supportline.org](mailto:deirdre@doctors supportline.org)

The British Psychological Society has a list of Counselling Psychologists and can be found at <http://www.bps.org.uk/e-services/find-a-psychologist/psychoindex.cfm>

Tel: 0116 254 9568

The British Association for Counselling and Psychotherapy and United Kingdom Council for Psychotherapy have a list of therapists, the sites to search for which can be found at <http://wam.bacp.co.uk/wam/SeekTherapist.exe?NEWSEARCH> or [http://www.psychotherapy.org.uk/find\\_a\\_therapist.html](http://www.psychotherapy.org.uk/find_a_therapist.html) . Alternatively, you could ring 0870 443 5252 or 020 7014 9955 if you don't have access to the internet.

You are able to withdraw from the research at any time, should you feel uncomfortable about your contributions. All you need to do is contact me with your ID number that will have been allocated to you. However, please note that data in aggregate form may still be used/published.

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**Declaration:**

I confirm that the interview was conducted in an ethical and professional manner.

Name of participant:

Signature:

Date:

Researcher name

Signature:

Date:

**Researcher (R): What are your views and attitudes towards accessing psychological services such as Counselling Psychology for yourself?**

Participant (P): I'm aware that there are some services out there that you can talk to, like a telephone service, if you're stressed or anything like that. The thing is, I don't think doctors talk very much amongst themselves about these types of stresses and problems that they have. About actually accessing these services, I think, my what I've seen, the attitude has been that you just get on with things, and you just deal with them yourself. I mean, sometimes you could talk to people at work, but you really find it so busy, I mean I could give an example from this weekend – a child died, and it was the first time that I had seen a child die, and the registrar has also someone in the family who has cancer, and the child died of cancer, so both of us were quite upset over the weekend, but the attitude that we got from our consultant is that you shouldn't be too involved, you shouldn't get too upset, you can feel sorry for them, but at the end of the day, you have to carry on with the rest of your day and the rest of your job. So you have to try and detach yourself, and that's kind of the attitude I've got from others that you just detach yourself really. I personally feel that I am able to access these other services easily. I mean, they're not very well advertised for one, it's not really spoken about – you can feel stressed, you can feel upset, you can feel about your day to day work, but it's not really spoken about too much amongst the doctors themselves, it's just the sort of attitude that you get on with it – You've got other patients to see, you've got other jobs to do. You can just deal with it either on your own, or just venting to somebody else. But even in the daytime, there's not even enough time to do that really, to take time out to process what you've actually seen. So my attitude to psychological services, I would, especially now, after this weekend, because it was quite horrendous, I would prefer if it was spoken about openly, you know, you can feel upset, how to cope with that after seeing these situations, it would be nice to have someone say to you that there are these services out there. And I personally would access it, just to have somebody to talk to, you know, to get some advice and things like that, but what I get from my colleagues and peers is that, no.1., you don't have time during the daytime to talk about these things and no.2, you just deal with these things on your own and no.3 you just try and detach yourself as much as possible, which I don't think is very healthy.

**R: And you say that you try and deal with it on your own – what do you mean by that?**

P: What I did really is just take time out, maybe at the end of the day to be by yourself really, just to think about what you have just seen, just thinking about it on your own really and making yourself understand that this is life, this is what you're here for, this is what it's gonna be, this is what you're going to see, it's not going to be the first time, it's not going to be the last time that you're going to see it, and just thinking about it really. You're just taking time out to process what you've seen. That's my way of dealing with it really, but actually, I would actually like advise and things about how

to actually deal with it because even last week, there was a case where there was a mother, my hospital is actually quite busy and can be quite dirty, you get a lot of cases, difficult cases, last week a mother came in, a pregnant mum and she had a sudden cardiac arrest so she had to have an emergency crash section in A&E where there's no facilities there. It was quite horrific and very gory and a lot of blood all over the place as there's not enough...you're not in theatre so you can't do it, and nobody scrubbed up, and so the baby was born in terrible conditions as well, and there's wasn't even enough equipment to deal with the baby downstairs in recess. I wasn't there, but I was speaking to one of the nurses who was involved and she I can't sleep, because every time I think, I can see this mum and how she had to have an emergency caesarean section in A&E and everybody's covered in blood. So I don't think services are there, I mean I'm sure they are there, but they're not readily available for us, so things like, you can see people who died but still, you have flash backs, so it's kind of difficult to deal with, but my way of dealing with it, so far is just to try and think about it and process it on my own and understanding that this is part of my job I suppose.

**R: So what's I'm hearing is that you would like to be able to access the services but you feel like you can't.**

P: Exactly. I don't know if it's seen as a weakness really to access these services, but you know, you can't deal with things on your own, you need these services, whereas others they say it's part of the job, accept it, deal with it and don't need that services, I don't know if there's that kind of perception around accessing psychological services that it's seen as a weakness. I mean, I would really [access services], but I don't think it's readily available. Out there, there's two perceptions, without anyone actually having to say it, I pick up the message that "you're a doctor, you've got to deal with it, it may be a sign of weakness if you do access these services and that you're not coping very well, you're not strong enough to be a doctor" and something like that emotionally.

**R: Something about the doctor fixing people rather than the other way around.**

P: Yeah – you're there for the patient but you can't let yourself get emotionally involved or attached. I mean, even the consultant said, there's a difference between empathy and sympathy, when that child died. He said, you feel sympathy, you feel sorry for them, yo feel what they're going through, but at the end of the day, you have a job to do, so you can't let yourself get too involved or emotional about it because what about the rest of the ward and the rest of the patients? I didn't find that very helpful. It would have been nice to have somebody to talk to, or even to have 5 minutes to go off the ward, away from crying relatives to have some time to yourself but there wasn't even that and I think that makes thing worse later down the line when you're trying to deal with it, trying to get on with your normal everyday things, and then you have this thing at the back of your mind which is still replaying. Whereas if somebody was much nicer, if somebody acknowledges that this is normal, you'll feel sad, and you'll feel upset because it was your patient, then I think that would help you a lot more in the longer run.

**R: So there's something about being a good doctor means not acknowledging your emotions. You have to detach your emotions from the job.**

P: I mean, that's what I've got from my consultant, but that's not how I'm feeling. Because I do get involved and I do get attached, because they're children at the end of the day, I don't think you could help it. Whereas compared to before, when I did my care of the elderly job, it was much more kinder to let the person go rather than continuing to resuscitate and continuing to be aggressive, so there was a kind of an acceptance there, it was very different there, and I think in that area as well, death was spoken about a lot more because it was kind of expected and it was discussed about how to make it dignified, how to deal with it, how to make it comfortable for the patient, the relatives, the family and it was all discussed. Whereas with children you don't expect death, and I think amongst the seniors in the team, nobody knows how to deal with it really, the best thing is just to brush it under the carpet and just not think about it, so that you can carry on being a good doctor, having a clear head – just detach yourself. That's what I've got so far.

**R: So there's quite a clear message to detach yourself, which I can imagine is quite difficult.**

P: Yeah. I am finding it difficult. I mean. A good time for your research because it is the first time I've seen a child die, and it wasn't very nice the way she dies as well. It would have been nice for someone to be there to acknowledge those feelings but no one was really. And the registrar, I felt so sorry for her as she's got a close family relative who's got cancer as well and she was like, I'm not going to think about it" and that's how she managed to get on with the rest of her day.

**R: So it's having to separate your feelings with the rest of your work, which is quite impossible really?**

P: It is impossible because the rest of the day, practically I was forgetting things and mixing things up and you can't keep a clear head. I mean, this happened in the morning, so I had the whole rest of the day until 9pm to get through it, and by the end of the day, we were both just so exhausted, physically and emotionally drained. I mean, I've got these two days off. The registrar doesn't have any time off. I don't personally feel that was good advice or that it's healthy either.

**R: What would happen if you did voice your concerns and difficulties in the work environment, with what you are dealing with?**

P: I mean, I go by specifically what went on this weekend and last week. What would happen, I don't know really, I think it would be met with the "you should get over it" kind of attitude really. I mean,

I'll back to work tomorrow and I'll speak to them about it but all you can do is speak to other nurses and doctors about it. But to actually say, maybe I should speak to someone professional, get some advice, that would be met with, "no, that's really lame". I think, from what I get from the department and the other doctors. I don't know really, how you could deal with the death of a child at work, so I think if there were any services where you could speak to somebody, or if they had any advice or anything. I mean, obviously it varies between different consultants and doctors and things but at the moment, my general feeling is that you don't need to go to these services, you should be able to manage this on your own.

**R: So it's more or less frowned upon to access the services.**

P: From my own feeling at the moment, yeah. You don't go around telling people, yeah I spoke to these people – it's not that kind of thing, you know, "spoke to them over the phone because I was feeling stressed" and stuff. If I did access the services, it's not something I would go around telling people that I did. I'd probably do it, and not tell anybody about it.

**R: Say that you did access the services and people did know about it, what would happen?**

P: Nothing would happen. I guess it's just me – I'd probably feel embarrassed if somebody knew about it because of the attitude about it. If it was open and people spoke about it, and it here are some numbers, if you get stressed, you can call them and talk about it. I mean I don't even know who I would even go and talk to at the end of the day. That was the first response from my consultant, you know, don't get involved, you've got the rest of your day to get on with. I mean, who else would I go and speak to? They're your seniors, they're the ones you would go to to speak to and get some comfort from. But if that's their attitude, I don't even know who I'd go to, but if they did find out, I'd probably feel embarrassed. If everybody else found out, just from that attitude.

**R: What are your views that seeking psychological help means deviating from the norm of being a junior doctor?**

P: I agree with that, I think. I mean I'm sure that some doctors do it, but I don't think very many do at all. I probably shouldn't say it but the registrar, the way she dealt with it on the weekend was to drink alcohol, so I think that's another, I mean, I don't drink but I'm guessing that that's a release for a lot of people in the medical profession, is to go and drink alcohol. A lot of my close friends are non medics, so it's not as if I feel bad if I go, but I don't want to burden them with what I've seen because they're not going to be to understand, but I do agree with that statement. Personally myself, I'm a junior doctor still, but I haven't heard, apart from one doctor who suffers from anorexia, who has psychiatric issues and who needs help. She was the only one who I know of who actually sought

help through these services. So apart from that, I don't know anybody else who has accessed any psychological professionals.

**R: When you found out that your friend was getting psychological help, did your views of her change at all?**

P: No, I thought it was best for her to do it actually. Somebody professional to talk to, and she did definitely need help, so it was good. I sort of encouraged her to speak to somebody, because there's only so much your friends you, but you also need professional help. So I was happy for her that she took that step and did that.

**R: Was it just you that she told or did she also tell other people?**

P: Well with her, people could see she was losing weight, she dropped her weight right down from the stress at work, but nobody said to her, we're worried about you, nobody acknowledged that she was unwell, everyone just tried to ignore it and just carry on as normal. She really wasn't coping and it was affecting her work as well, and then when it starts affecting her work, she couldn't even come into work some days, it wasn't even sympathy, it was just annoying because it affects the other doctors, putting doctors off the rota, so people became annoyed with it because they thought she should be able to deal with it, why didn't she seek help earlier, that type of thing, but at the same time, nobody even acknowledged that she was unwell. Whereas she was saying, she really would have liked it if somebody came up to her and said to her, are you ok? Nobody even said that to her. So when she got help she was happy for her, encouraged her to go for help.

**R: How does deviating from the norm of being a JD affect your career, if it affects it at all?**

P: I feel that the way I dress is different to everyone else because I wear a Punjab scarf and stuff, so there's not many other doctors who do so and that hasn't really affected me, because it's more about the work you do rather than the way you dress. I think personally, if you can do the job, then that's more important. How would it affect my work? I mean, I personally feel that if I access services, it would actually help me better because this isn't going to be the last time I see a child die, and if I had some advice about coping mechanisms, I think personally that would be excellent for myself. And then I would be able to maybe give some advice to others, maybe recommend services to them openly, rather than feeling embarrassed. So personally for me, if I deviated from the norm and accessed those services, I would feel embarrassed, but personally it would be a good thing. Deviating from the norm – I can give another example of a friend who doesn't conform very much to what doctors are like – she's very chatty, I mean I've been told that you have to...I can give an



example, silly example, but if a consultant is going for dinner and invites you for a group dinner, and you don't really want to go because you have another appointment to go to, and they were like, no no no, you have to go, this is the consultant, you have to be in with them, you have to be there, you know, really have to be, I call it brown nosing, there's a lot of that I have to say and if you don't do that, then it is seen that you won't get ahead in your career. That's the thing, if you're seen as too soft, if you're seen as not conforming very much, because at the end of the day, they're trying to figure out if you're good to work for them, if you fit in, if you go drinking with them, if you go rugby playing that kind of thing. There is a stereotype amongst some specialties where you have to be like them, you have to be like the rest of the team – drinking, rugby playing type of person then you'll fit in and it will be good for your career. You've got to do that otherwise at the end of the day they're going to have to decide whether they want to work with somebody who doesn't really conform, doesn't really fit in with these ideas, or if it's somebody who does, but not have a lot in common with, and obviously it's going to be the person that they have a lot more in common with, so that's probably how it can affect your career in the long term. If you don't really conform, then you're seen as difficult, you're seen as a bit odd, you're seen as not completely reliable or easy to work with, so you're less likely to be given the job, so there's that kind of attitude.

**R: There seems to be quite a lot of competitiveness within the career, and if you go for professional help then you are seen as not conforming and not up to the job and somebody else will take the better position.**

P: Yeah, I'm fortunate enough that at the moment, I'm in paediatrics so what they've done is, this is the one good thing and why I chose paediatrics, because it's nothing like that. It's a lot different, like compared to surgery, that is very true and sometimes General Medicine it is also very true. In paediatrics, it's very much about, is your general personality going to fit in with the general personality of a paediatrician, are you gentle or soft, so you do chose a career where you feel your personality will fit in with the general personality of that specialty. With surgery, it's very competitive, every junior doctor in that specialty will all try and be friends with the senior doctors, they do have to conform, they go out even if they don't want to. Just so that they can get a good reference to get a good position and job, and be actually become a surgeon. I'm lucky in paediatrics because I don't have to have these constant interviews every couple of years so I've got a job secured for eight years so I'm quite lucky in that way. It probably will affect me in some way when I need a consultant post because it will be about who I know and how well I know them, but at the moment, at the junior doctor stage that doesn't affect me, but I do know that it does affect a lot of my other peers a lot and it's quite stressful for them.

**R: Do you feel that there would be different rate of doctors accessing psychological services by specialties, given the different personalities grouped within them?**

P: Yeah, I think so, I think it definitely does. It's funny you know, I wouldn't have thought about this before you mentioned it, but you would definitely not be accessing psychological services as a surgeon. If you did, you would be seen as completely soft. Surgeons are notorious for not becoming attached to their patients. I saw that as well when I was working with them, and I guess that's why a lot of surgeons go into surgery because they don't want to talk to people when they're awake. You ask surgeons generally why they went into surgery, and they'll tell you that it's because they don't really like communicating with people, I just like it when they're in surgery, I can do opening, cutting, taking out, and that's their job – that's the bulk of their job in theatre. So then, that type of person, you have to be quite tough or quite hard. I don't know what that character is really but you have to be quite detached, I think. So you wouldn't openly say that I'm going for psychological help as a surgeon. You're not going to tell your colleagues and peers because you'd be laughed at I think when you're in that specialty. Whereas in paediatrics, I mean I was actually quite surprised at my consultant's responses at the weekend from that child dying, because I would have thought that it is very very hard to see a child die and I was expecting a little bit more support than that, so now I'm kind of thinking, woaw, that's not what I was expecting. I would have thought that they would say something like, you can see somebody, it's difficult, to actually tell you that there are actually services available if you want to speak to somebody, but they didn't. So I'm thinking, even in paediatrics you can't talk about these type of things as well, but that's not what I was expecting at all. I would have thought that if any specialties were going to access psychological services, it would have been paediatrics, but if they're not doing it as well, then I'm like thinking that maybe none of the services encourage accessing the services then.

**R: What are your views that doctors are less likely to recognise their own illnesses?**

P: You just spend so much time burying your emotions, I mean, I don't to be honest with you, I don't know how people cope with things really. I mean, when I go back to work tomorrow and I'll say to others you know, when you saw your first child die, what did you do? How did you cope? They probably all bury it all under the carpet, and recognising that you're sick, I mean my friend that suffers from anorexia, she didn't realise until she was far far down the line, she just carried on going going going, you just tend to not think about your own emotional, mental health. Sometimes you feel you're just a robot, you just have to go in, you've got a list of patients, you've got to see them, for A&E patients, 4 hours, the target is to clear that, then you've got to cover the wards, you've got your list of jobs there, then you've got to go somewhere else, clear that, so sometimes you just feel like a robot running around all over the place, so there's not enough time or hours in the day already, and so to actually stop and think that it's actually affecting me psychologically. You don't have the time to do that and by the time you get home, you're just exhausted and then on top of that, you've got exams and revision, so everything does get pushed back to the back of your head, trying to forget about it, and if you have a friend you can rant to and let go to, then you can do that.

But I go home, I try to talk to my family but they don't really want to know, it's not really a nice thing to talk about. I mean, I'm lucky I've got a medical family. My sister's a doctor, but it's like nobody wants to hear about it, even after work, it's like, you've left work, don't talk about work. Because in the end, we're all going through the same thing, we all see horrible things and you tell each other, and we're like, well now we're all miserable. So at home, we don't want to talk about work to each other, so that's probably one of the problems, but generally it the attitude is just, well I don't know how to deal with it, nobody gives you advice on how to deal with it, but whatever it is, it's just, get on with your work, make sure the jobs are done and that's it. I mean mental health issues are not recognised in themselves, I think doctors are terrible at doing that, and that's really bad, because if we can't acknowledge the stresses and difficulties we have in our day to day lives, we're not going to be very good at spotting it in other people.

**R: It's almost like you're not allowing yourself to recognise that because doctors don't get ill.**

P: Yes that's right, because if you do, what's going to happen? You're going to get so upset, how are you going to get on with your work? In the hospital especially, it's very much team work, you depend on each and every single person. If one of you starts getting upset, then you're not going to be able to function properly, then you're no good to anybody, then it puts the rest of the team out. I mean, when my aunt died, I got upset which wasn't very long ago, and they were like, well just go home because you're not going to be able to do the work, and so it's just like, go home and be upset, don't come to work and be upset. But I strayed because the team needs that person. Already in paediatrics, there's not enough doctors, so you have to be there for the rest of the team. So it's like either deal with it in your own time and come to work and do the job, or don't come to work and just deal with it on your own at home, because you're not going to get the jobs done properly. So I don't think we're very good at recognising illnesses in ourselves.

**R: Gosh, it sounds like a harsh environment.**

P: Talking about it now, it does seem quite harsh, but at the time, you don't acknowledge it, you're just like, ok fine, I'll just do that, it's fine, I'll just manage on my own, it's ok. Talking to you now, I can see it's not a very nice thing.

**R: Some doctors believe that psychologists would not understand what doctors go through and therefore would not be able to help. What is your take on this?**

P: I agree with that to some extent. I actually feel bad coming to tell someone a picture of what happened to me with the child and what I saw and making somebody else upset from what I've

seen, and that's one aspect of it. Another thing is, it's really difficult to explain...you're there for that person, you're there to try and treat them and get them better, and when they don't get better, it's kind of like a failure on your part, so it's like, how can someone help, who hasn't had that responsibility, or who isn't there dealing with that person day in day out, I don't see how you can really put yourself in that person's shoes to understand what they're going through, when that person actually dies. So I have to agree with it. I mean it's probably myself and the lack of knowledge I have but I can't see how you would be able to understand that. Those emotions you feel when somebody dies, and it is seen as a failure if somebody dies, well that's what my understanding is. I mean you do say we did everything that we could, but there's still that feeling of what if we did this or what if we did that. I know one doctor who I worked with in the past 6 months in the special baby care unit, she was there to resuscitate a baby and the baby actually died and she actually transferred out, and then she eventually quit medicine altogether, because she said, I'm not dealing with this, coping with the death of that baby at all, and she didn't get any support from the consultant, she didn't get any help from anybody, and so she was left with this guilt that she was responsible for that baby's death, so she's now quit medicine completely, and she's an excellent doctor. So...it's probably an arrogance on our part, that we understand how she must feel, and even when we try to tell her, it's not your fault, you did everything you could, then for a person who hasn't got any background in medicine or resuscitating a baby, or anything like that, to understand what she must be going through, I don't know how they would be able to do that.

**R: Would you say that that's a barrier then in doctors accessing psychological help?**

P: I think so actually. Thinking about it now for myself, I think it probably would be. You'd want somebody to relate to you, somebody to give you advice and practical advice and tips and things like that, but if somebody isn't in that hospital working how you're working, then how would they be able to give you practical advice and tips and things like that, so for me, you're right, that is one of the barriers for me in accessing those type of services.

**R: So if a psychologist had a some medical knowledge, and had worked in a hospital setting, would that be more encouraging for doctors do you think?**

P: Definitely, I think so. I think a person who has a medical background, who has been there, done that, worked in that stressful environment. It's really chaos when you're trying to resuscitate a baby, it's like you really have to make a conscious effort to forget everything and everybody around you, you've got mum's screaming, dad's panicking, everybody's having such a horrible, stressful time, that it would really be so helpful if you have somebody there who has been there, done that, maybe give some examples from their background for practical advice and things like that. But for somebody who hasn't been there, done that, and to tell you and to give you advice on things, that's not really feasible. So somebody who has been there done that. Really understands how things are in the hospital and can give you advice as well, I think would be very very helpful. And also you'll see

that this is a real doctor who is talking about these kind of things as well – it's not such an embarrassing or frowned upon thing as well, so I think that kind of dimension would be helpful as well.

**R: To what extent do you feel that your consultants and supervisors influence your views on accessing psychological services?**

P: It really does. If they're open, they could acknowledge how people would feel, and they're supportive, and encouraging, they you may feel able to access some services, I mean not actively encouraging you know, you should all go and seek professional help, but just telling us, if it's difficult, the death of any child is difficult to see and be involved in, and if you feel you're not getting the support here, then there's always these professional services available, then it would just open up and make it easier to access these services because you wouldn't feel like a weirdo because I'm accessing these services, I'm not coping when everybody else is, everybody else has seen children die and can cope, it's just me, I'm accessing these services when others don't need to. But if your seniors are open and tell you that it's ok to feel like this, then it would be a lot easier to access these services, it wouldn't be such a, not really a stigma, but wouldn't be frowned upon, and wouldn't be such a big deal or such a strange thing to do, if they were more open about it. So when you get the thing of, oh, you detach yourself now, then that's going to lead you down the other route of these are my seniors, they have seen a lot more children die than I have, the way they deal with it is by detaching themselves, separating feeling, sympathy, empathy, then you think well may be that's what I need to do. Because you look at your seniors as examples, you try and find the good things from the doctors that you'd like to be like, and you take them as an example and you try to be like them. But I wouldn't like to take that from them where you have to detach yourself because I don't think that was very good advice. But I don't see anyone else dealing with it any different way, so you think that this is the accepted way to deal with it. The you deal with it on your own and talk to colleagues if you've got the time and just forget about it after a period of time. So the way they think about themselves and their own emotions, does influence you strongly on whether you're going to access these services or not.

**R: Are these views acquired from your work on rotations, or from medical school as well?**

P: Actually my medical school was very good in that type of thing, they were there, they were friendly, if you had any problems, they said you can come and speak to us, they were always encouraging, and we had the student BMJ where there were always adverts saying if you're stressed, if you're upset, if you have issues, you can call this number. Even in our medical school there was a registry office where you got all your paperwork done and things like that, there's leaflets and posters and things like that, if you need somebody to talk to, phone this number, it's a free helpline 24hrs a day, so in medical school it didn't exist, it's from work. At the end of the day, you become so numb to things, it's not helpful, because this is the time when junior doctors need

the help and the support, you need somebody to talk to, because this is the first time you're seeing a lot of things, it's like, not for the senior doctors because they've seen it all before and they've become used to it and desensitised to it, but for us as juniors, it's the first time we've seen a child die, it's the first time you see a baby die, and the support isn't there. So I think it's definitely from my rotations. I mean, even the first time I saw a person die, I was thinking about that for weeks and weeks, and nobody even said anything, then somebody realised and said, oh I forgot, because it's the first time you've seen somebody die isn't it? I was like, yeah it is, and it's still bothering me 2 weeks down the line. So you just have to not think about it and move on and think about the patients and what you can do for them.

**R: So it's kind of more or less expected of you to be like a robot and not be emotionally attached.**

P: That's what I'm getting at the moment, especially from this weekend – you're meant to be completely cut off, and I don't think that makes a very good doctor. That's the problem, I don't think you become a better doctor by detaching yourself. Even the registrar said one of the nurses started to cry when that child died and the consultant said to her, you can't do this, you can't be like that, and even one of the other nurses said, yes, we have to be professionals, and the registrar was telling us that the research says if the family can see that the member of staff who was looking after the child was upset, they actually feel like they care, and it helps the family feel better as well, that you're human at the end of the day and you do get upset by these things. But then on the other side of things, it was just frowned upon by the consultant and the nurses because we have to be professional, and I was just standing there and thinking this is impossible, I can't do this. I also felt awful because I just had to ignore that whole area of the ward where the relatives were just grieving, I had to ignore them completely, I didn't know what to say, didn't know what to do and felt completely useless, and so just ignored them and concentrated on other patients and thought I need to do this this and this, but it doesn't make you feel very good at all to be like that. They say professional, but what does that mean at the end of the day at times like this? Doesn't make you feel better to be like a robot, if professional means being a robot, it's not very nice.

**R: What is it about counselling services that's frowned upon?**

P: I said it wasn't a stigma, but maybe it is. If people found out that you were having counselling, I think people would see it as though you're not strong enough, that you're weak and maybe this isn't the career for you, if you can't handle seeing children die then maybe this isn't the specialty for you, do something else. Maybe that is the stigma then. The fact that you're worried about others finding out and thinking you can't handle the job and a child dying so then maybe this isn't the specialty for you because you've got a whole career ahead of you of children dying at some point along the line. That's my main thing really.

**R: To what extent do you feel that race and gender has an impact on rates of access to psychological services for doctors?**

P: Gender, I think, women are more likely to seek help than men. I don't know why that is, well they're just kind of...well the males I've worked with don't get very emotional, it's always the females that get upset. So I think that's probably why, I don't know. When you say, I go really upset about that person, I'm really sad about that person, the males tend to say, well going to happen isn't it? Whereas if you talk to your female colleagues, they'll say yes it was really sad wasn't it that it happened, and their more willing to talk about it, so definitely, I think gender has a role to play. I'm probably wrong, but females would be more likely to seek help rather than males. Race, I can't answer that one really. I don't think there is any difference really in the race, personally, I don't think so.

**R: What are your views that counsellors say things on automatic response without meaning what they say?**

P: That's the other thing as well, the perception of counsellor that they say things, answers that they probably give to everybody, that they're not going to give you advice on your specific thing, it's not tailored to you, they're not hearing what you're saying or understanding you. I mean, this is awful in my lack of understanding, what counsellors actually provide in the service. But from my idea of what they do at the moment is that your taught to give different set answers and you select which one is appropriate to the situation of what the person is telling you, and then that's going to come back why you don't access services and how they can't relate to you really, but that's my own prejudice and lack of understanding really. I'm sure that that's not what they do, but that's how I perceive them.

**R: Where do you think that view comes from?**

P: I really don't know. I guess it's from colleagues and things. I mean when I did my psychiatry module at medical school, and we had a psychotherapist in one lecture and the response from everybody was like, oh my gosh, are you being serious, it's just like digging something up from way way back into somebody's childhood and then say that this is related to something that they did 30 years later, and everybody was like, are you being serious, are you for real, and it was taken as a joke really, so think it may have come from back then because we did a couple of lectures on psychotherapy and psychological help and things like that. It was not very well intended and at the end it was kind of like a joke really, and it was making a big deal out of nothing, that's what I got. I remember thinking, if we all went by what you're saying, we'd all be complete wrecks by now, if

you're saying that such a small thing from the past is having such a big influence on what you're doing now, then you're making a big deal out of nothing. I think as well, that's how we're taught to think as medics – don't make things a big deal, just get on with things.

**R: So what you do know about counselling and psychology, goes against the way doctors think, there's a bit of a clash.**

Yeah, I think medics are a bit more pragmatic, is that the right word? Their approach is more now, here, let's deal with the problem we have now, one at a time, we'll work through them systematically, whereas, psychological services are seen as a bit more fluffy a little bit woolly and not taken very seriously, and I think that originates from that module