



Original Research Article

A STUDY IN MEDICAL STUDENTS TO EVALUATE THEIR REASONS FOR SEEKING PSYCHIATRIC CARE, PERCEIVED BARRIERS TO ACCESS THIS CARE, AND THEIR EXPERIENCES RELATED TO CARE RECEIVED

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ABSTRACT

Background: Medical training itself is quite stressful leading to catastrophic consequences and taking toll on mental health of medical students. **Aim & Objectives:** To evaluate patterns of mental health problems in medical students seeking Psychiatric care, perceived barriers to access to care, and their feedback related to psychiatric consultation.

Materials and Methods: A descriptive, cross-sectional, web-based survey, of medical students who had accessed psychiatric consultation (2018-2023) was conducted. They were contacted telephonically (n=71) and invited to take part in survey. Their Psychiatry consultations details were noted, perceived barriers were assessed through BACE v3 (Barriers to access to care evaluation) scale, and their feedback about consultation, was collected through google form. Their current mental health status was also reviewed through asking them to rate themselves on PHQ-9 (Patient Health Questionnaires-9) and GAD-7 (Generalized Anxiety disorder-7).

Results: The reasons for consultation were anxiety disorders (63%), Depression (21%), Bipolar mood disorder (9%), substance use (5.6%) and Schizophrenia (1.4) and for majority it took >4 months to reach out for help as family (71%) or friends (42%) were not supportive.

67% of students reported recovery from past mental health issues, and 23.9% of students are on treatment. On evaluating perceived barriers, nearly 75% had fear that label of mental health issues may adversely influence their career and 32% of them believed that people will judge them. 91.5% were satisfied with treatment provided and 89.8% appreciated the attitude of treating consultant during their visit to psychiatric OPD. Currently prevalence of depression was 28% (PHQ score \geq 10) and of anxiety was 29.5% (GAD score \geq 10).

Conclusion: Due to perceived barriers related to psychiatry consultation, students took long time to seek help for their mental health issues but they were satisfied and recovered with psychiatry consultation.

Keywords: Medical Students, Mental Health Problems, Perceived Barriers, Psychiatry Consultation.

INTRODUCTION

In recent decades, there has been growing attention paid to psychological distress among medical students. At the start of medical school, medical students have mental health like their nonmedical peers, but students' mental health worsens during medical training.^[1] Medical students face significant

academic, psychological, and existential stressors.^[2] These stressors can lead to catastrophic consequences such as anxiety, depression, impaired academic performance, impaired competency, medical errors, and attrition in Medical Colleges.^[3] Stress level and the extent of emotional disturbances among medical students are high.^[4-6] Mental disorders and distress can result in numerous undesirable personal and

professional consequences including burnout, social isolation, and eventual physician impairment.^[7-9] Mental health issues may persist into adulthood if they remain undetected or are not treated appropriately. Furthermore, undesirable coping mechanisms, such as substance abuse, alcohol consumption, smoking, and harm to self and others, may be observed in medical students with mental and emotional distress.^[10]

The council on medical education reports that medical students are three times more likely to die by suicide than the general public. One of the most significant barriers for medical students and why they may not seek help - is stigma, or "a fear of compromising career progression and the pressures of medical training."^[11]

Fear of stigmatization, i.e., negative attitudes from other people toward mental illness, can lead to low levels of help-seeking for mental health problems. Many students also adopt external social stigma and experience loss of self-esteem and self-efficacy. They were also worried about repercussions and being judged by teachers.^[13,14] Other factors which can have a negative impact on seeking mental health services included concerns of confidentiality, being unaware of one's mental health problems, and lack of experience related to mental health care.^[11,12] There is a positive relationship between social support and help-seeking behaviours; however, the findings were still inconclusive.^[15] (Winter et al., 2017)

The aim of the present study was to assess the patterns of mental health problems among medical students who had previously sought psychiatric help and to evaluate their current mental health status. The study also aimed to identify their perceived barriers in accessing mental health care services and to obtain feedback regarding their psychiatric consultations.

MATERIALS AND METHODS

This study was conducted as a descriptive cross-sectional study. The study population included medical students who had consulted the Department of Psychiatry between 2018 and 2023 for mental health-related issues. A total of 80 students had sought psychiatric consultation during this period. The duration of the study was three months.

Inclusion Criteria

Medical students of our institute who had past psychiatric consultations 2018 -2023.

Exclusion Criteria

Medical students whose contact details (mobile no.) were not available in the records of department consultations, 9 students were excluded.

Study Procedure

Prior to commencement of study, permission was obtained from institution head & the institutional ethics committee. Total 71 students were contacted via mobile phone and invited to participate in the study. Informed consent was obtained from all participants using Google Forms. The data were

collected using semi-structured questionnaires via google forms. The questionnaire was divided into two parts. Part 1 included details of their past psychiatry consultation, their presenting mental health problems, feedback related to their consulting experience, perceived barriers before reaching for help through BACE v3(Barriers to Access to Care Evaluation) scale, time taken to reach out for help and their family reaction.

In part 2 evaluation of their current mental health by applying the PHQ-9 (Patient Health Questionnaires-9) and GAD-7(Generalised Anxiety Disorder-7) scales.

Study Tools

Patient Health Questionnaire (PHQ-9)^[18]: It was developed by Spitzer et al, for diagnosis of depressive disorder. We used self-administered 9-item PHQ. Each question scored on a scale of 0(not at all),1 (several days),2 (more than half the days) and 3(nearly every days). The range of possible score on this questionnaire is 0-27, which is classified as follows: 0-none,1-4 -minimal, 5-9 - mild, 10-14 - moderate, 15-19 -moderately severe and 20-27 - severe depression. As suggested by previous literature we used cut off score 10 or above to define depression in this study. On item 9 score 1 or above measures two week prevalence of suicide ideation.^[18] Generalised Anxiety Disorder (GAD7) Scale^[19]: The GAD-7 was a 7-item self-report scale developed to assess generalised anxiety disorder. Items were rated on a 4-point Likert scale (0= not at all to 3 = nearly every day). It was a valid screening tool in a primary care setting, in clinical practice and research for detecting GAD and its severity.^[19]

Barriers to Access to Care Evaluation (BACE v3) scale^[20]: It was a 30-item measure to assess barriers related to mental health care. The scale rates barriers on a Likert scale of - 0 not at all, 1- Somewhat, 2 - quite a lot, and 3 - a lot, with higher scores indicating a greater barrier. Findings of each barriers were presented as mean score for the item and no barrier at all (% of answering 0) minor barrier (% of answering 1) and major barrier (% of answering 2 & 3).^[20]

RESULTS

During 2018 -2022, total 80 medical students visited the psychiatric OPD for their mental health issues, out of them 9 student's contact details not available in records so total 71 students contacted to participate in this survey and all responded via google form.

Age distribution of the participants:

Majority belong to 21-25 years age group (69%) in which females were (53.5%) more than males (46.5%). [Table 1]. Table 2 describes their clinical details. Their clinical diagnosis were anxiety disorders [63% (45)], Major depressive disorder [21% (14)], Bipolar mood disorder [9% (7)], substance use disorder [5.6% (4)] and Schizophrenia [1.4% (1)]. The time gap from symptom onset to psychiatry consultation ranged from 1month to 2

years. 38.8% (28) of students consulted within a month, 39.7% (28) consulted within 1-6 months, 21.5% (15) took more than 6 months' time for psychiatry consultation. On evaluating impairment on study, 70.4% (50) reported decreased concentration and inability to focus, 49.3% (35) reported reduced interest in studying, 29.6% (21) had

issues of forgetting and 19.7% (14) stopped attending classes. They were provided treatment in form of pharmacotherapy [22.5% (16)], or psychotherapy [29.6% (21)], or both [47.9%] (34). Majority [60.5% (43)] needed follow up treatment and recovered [67.2% (48)].

Table 1: Age distribution of Participants

Age group in years	Male	Female	Total N=71
18-20	6	5	11 (15.5%)
21-25	23	26	49 (69%)
26-30	4	7	11 (15.5)
Total	33	38	71 (100)

Table 2: Clinical variables related to past psychiatry consultation

Variable	N =71 (%)
1) Provisional diagnosis	
Anxiety disorders	45 (63)
Depression	14 (21)
Bipolar mood disorder	7 (9)
Substance use disorder	4 (5.6)
Schizophrenia	1 (1.4)
2) Time taken for psychiatry consultation since symptom onset	
Within 1 month	28 (38.8)
1-3 Months	13 (18.3)
4-6 Months	15 (21.4)
6-12 Months	8 (11.7)
12-24 Months	7 (9.8)
3) Impact on study	
Decreased concentration and Unable to Focus	50 (70.4)
Did not like to study	35 (49.3)
Forgetfulness	21 (29.6)
Stopped going to class/college	14 (19.7)
4) Treatment provided	
Pharmacotherapy	16 (22.5)
Psychotherapy	21 (29.6)
Combined Approach	34 (47.9)
5) Follow up treatment	
	N=43 (60%)
For 1 month	17 (39.5)
For 1-6 months	14 (32.5)
More than 6 months	12 (28)
6) Outcome of treatment	
Recovered	48 (67.2)
On treatment	17 (23.9)
Off treatment	6 (8.9)

The responses of their friends, family, and peers regarding their mental health issues and to receive psychiatric help was shown in Fig 1. As per their experience, most of the times friend encouraged to take psychiatric help [64.8% (46)] while family would believe that there was no such thing as mental illness [40.8% (29)]

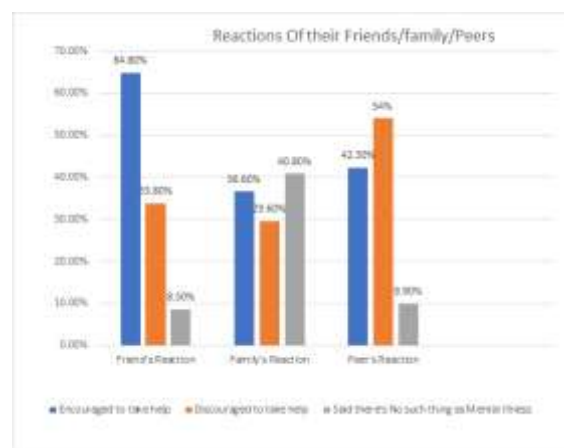


Figure 1: Above Histogram shows the reactions of patient's friends, family and peer's reaction

Table 3: Barriers to access Care Evaluation (BACE) Scale(v3) (N=71)

Questions	Not a barrier (Not at all) (n) row %	Minor barrier (A little) (n) row %	Major barrier (quite a lot to A lot) (n) row %	Mean (SD)
Stigma related barriers				
Concern about what my family might think, say, do or feel	21.2% (14)	39.4% (27)	39.4% (28)	1.02(0.87)
Feeling embarrassed or ashamed	15.5% (11)	33.8% (24)	50.7% (36)	1.26(0.89)
Concern that I might be seen as 'crazy'	19.7% (14)	47.9% (34)	32.4% (23)	0.35(0.58)
Concern that I might be seen as weak for having a mental health problem	14% (10)	43.7% (31)	42.3% (30)	1.38(0.85)
Concern that people might not take me seriously if they found out I was having professional care	28.2% (20)	39.4% (28)	32.4% (32)	1.09(0.88)
Not wanting a mental health problem to be on my medical records	25.4% (18)	38% (27)	36.5% (26)	1.26(1.01)
Concern about what my friends might think, say or do	21.1% (15)	52% (37)	26.7% (19)	1.08(0.75)
Concern that it might harm my chances when applying for job	46.5% (33)	32.4% (23)	21.1% (15)	0.67(0.77)
Concern that people I know might find out	25.4% (18)	36.6% (26)	38% (27)	1.18(0.88)
Attitudinal-related barriers				
Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)	64.8% (46)	29.6% (21)	5.6% (4)	1.54(0.98)
Fear of being put in hospital against my will	56.3% (40)	32.4% (23)	11.3% (8)	0.56(0.73)
Wanting to solve the problem on my own	7% (5)	59.2% (42)	33.8% (24)	1.42(0.73)
Thinking the problem would get better by itself	29.6% (21)	45.1% (32)	25.3% (18)	0.29(0.51)
Thinking that professional care probably would not help	49.3% (35)	35.2% (25)	15.5% (11)	1.18(0.81)
Dislike of talking about my feelings, emotions or thoughts	19.7% (14)	40.8% (29)	39.5% (28)	1.32(0.89)
Professionals from my own ethnic or cultural group not being available	74.7% (53)	22.5% (16)	2.8% (2)	0.28(0.51)
Preferring to get help from family or friends	23.9% (17)	57.7% (41)	18.3% (13)	0.97(0.71)
Thinking I did not have a problem	19.7% (14)	55% (39)	25.3% (18)	1.08(0.73)
Having had previous bad experiences with professional care for mental health	47.9% (34)	39.4% (28)	12.7% (9)	0.64(0.69)
Instrumental-related barriers				
Being unsure where to go to get professional care	31% (22)	50.7% (36)	18.3% (13)	0.88(0.72)
Problems with transport or travelling to appointments	73.3% (52)	23.9% (17)	2.8% (2)	0.77(0.84)
Not being able to afford the financial costs involved	70.5% (50)	23.9% (17)	5.6% (4)	0.45(0.71)
Being too unwell to ask for help	64.8(46)	21.1% (15)	14.1% (10)	0.5(0.77)
Having no one who could help me get professional care	50.70% (36)	43.7% (31)	5.6% (4)	0.56(0.64)
Professionals from my own ethnic or cultural group not being available	74.7% (53)	22.5% (16)	2.8% (2)	0.28(0.51)

Main barrier to seek psychiatric help in medical students were stigma related barriers like being seen as mentally weak [42.3% (30)], concerned about family reaction [39.4% (28)] ,felt ashamed of themselves [50% (36)] and embarrassed [33.8% (24)] for having mental health problems, concerned that people might find them crazy[32.4% (23)] and not take them seriously if they found out about

psychiatric problem and taking professional help[32.4% (28)].Also they wanted to solve problem on their own [33.8% (24)], concerned for medical records of mental illness [54.5% (53)] and not aware about professional resources.

Majority of students perceived good care, and satisfied with treatment provided.

Table 4: Feedback about care received from psychiatry department

1)Feedback of care received by students	Responses %
Excellent	22.60%
Very Good	40.80%
Good	36.60%
2)Attitude of treating psychiatrist perceived by students	
Very Good	23.90%
Good	67.60%

Fair	8.50%
3)Overall Satisfaction Level	
Very Much Satisfied	18.30%
Satisfied	73.20%
Not Satisfied	8.50%

Table 5: 2-week Prevalence of depression, anxiety and suicide ideation

	N (%)
Prevalence of depression in proceeding 2 weeks	20 (28)
Minimal Depression	39(54.9)
Mild Depression	12(16.9)
Moderate Depression	12(16.9)
Moderately severe Depression	6(8.4)
Severe Depression	2(2.8)
Suicide ideation in proceeding 2 weeks	13(18)
Prevalence of Anxiety in proceeding 2 weeks	21(29.5)
Minimal Anxiety	35(49)
Mild Anxiety	15(21)
Moderate Anxiety	12(16.9)
Moderately severe Anxiety	6(8.4)
Severe Anxiety	3(4.22)

2 weeks prevalence of Depression (PHQ-9 score ≥ 10), Suicide ideation (item 9 score ≥ 1) and Anxiety (GAD-7 score ≥ 10) was 20(28) ,13(18) and 21(29.5), as mentioned in Table 5.

DISCUSSION

This study throws light on patterns of mental health problems in medical students seeking psychiatric consultation, their perceived barriers before reaching out for help and experiences related to psychiatry consultation.

In our study, 2 week prevalence of depression, anxiety disorder and suicide ideation was 28% ,29.5% and 18% respectively which was similar to study conducted by Praveen arun et al,^[21] and Bharat Khatri et al.^[22] Suicide ideation was higher than study reported from same institute,^[23] but this may be due to students already struggling with mental health problems. Study from Nepal found prevalence of depression, anxiety, and stress among first-year medical students, 44%, 59.3%, and 45.1% respectively.^[24]

In this study we found that majority of perceived barriers among students were stigma related barriers like most of them are felt judged by people for taking psychiatric help and also didn't want their mental health issues related medical records. Worryingly, students viewed mental illness as a sign of weakness among their peers, evoking social ostracism. This resulted in taking long time for seeking help from mental healthcare services, perpetuating their problems and hampering their learning outcomes. Also feelings of shame and embarrassment regarding mental illness and negative perceptions about its treatment may dissuade young adults from treatment. A Study from India found that stigma, confidentiality issues, lack of awareness about where to seek help and fear of unwanted intervention were more commonly reported as barriers for seeking mental healthcare.^[25] Similar barriers were identified in many other studies.^[26,27] Our study also reported that few of them wanted to deal mental health problem on their own but later on access facilities for care.

Majority were satisfied with their overall consulting experience including attitude of treating professional. The study of Nigerian undergraduate students utilizing mental health facilities, a number (39.6%) of the students agreed that they feel they can get professional help if they had any mental breakdown while 2.9% (13) strongly disagreed that they preferred staying on their own when emotionally disturbed. Overall, the majority (87.5%) of the students showed a positive attitude towards mental health services.^[28] Based on the above findings, we propose several suggestions to improve health services delivery in medical campuses. Firstly, adequate orientation to health issues and existing services, including hospital layout, may help in acquainting new medical students about accessing mental healthcare services in the hospital. Secondly, this knowledge can be periodically refreshed at the beginning of every new academic session to enhance awareness. Thirdly, we observed that stigma and misconceptions related to mental health continue to act as a deterrent, and therefore mental health professionals may help to clear these myths and misconceptions. Fourthly, a separate student clinic located away from the busy outpatient department with satellite centres in the hostels may help to resolve the barriers of lack of time and non-awareness of locations for seeking help and improve ease of use, accessibility and satisfaction with services.

The strength of this study lies in attempting to elicit perceived barriers to seeking mental healthcare services from a medical student's perspective already had past consultation—an issue which is relevant but not adequately addressed. The high response rate as all students responded.

Limitations include the cross-sectional design, web based survey so possibility of respondent bias, single centre sample.

CONCLUSION

This study has shown that the prevalence of depression, anxiety disorder and suicide ideation in medical students are high and a similar trend has been seen in studies done around the globe. Furthermore, our study highlighted barriers of seeking mental health care like stigma, attitude, and instrumental-related barriers.

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