

PEER RESPONSES TO PSYCHOLOGICALLY DISTRESSED TERTIARY STUDENTS

**THE DETECTION OF DISTRESS AND THE HELPING
BEHAVIOURS OF STUDENT COLLEAGUES FROM MEDICINE,
COMPARED TO PSYCHOLOGY, LAW AND MECHANICAL
ENGINEERING STUDENTS**

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Dedicated to my mother
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Candidate's Declaration

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Catherine Leahy, 1 June, 2009

TABLE OF CONTENTS

LIST OF TABLES	7
LIST OF FIGURES	11
ABSTRACT	14
PERSONAL INFORMATION	16
ACKNOWLEDGEMENTS.....	18
ABBREVIATIONS	20
General	20
Statistical	21
STYLISTIC FEATURES ADOPTED FOR THIS THESIS.....	22
CHAPTER 1: OVERVIEW	23
Introduction	23
Aim.....	24
Significance	25
Chapter Map.....	26
CHAPTER 2: REVIEW OF LITERATURE.....	27
<i>Overview.....</i>	<i>27</i>
<i>Definitions of Distress in the Literature</i>	<i>29</i>
<i>Evidence of Distress</i>	<i>32</i>
Rates of Distress and Mood Disorder.....	32
Rates of Treatment	33
Rates of Suicide.....	34
Rates of Fatigue and Burnout.....	35
Rates of Distress By Gender.....	35
Rates of Distress for Medical and Non-Medical Students.....	36
Conclusion	37
<i>Distress and its Manifestations.....</i>	<i>37</i>
<i>Solutions</i>	<i>40</i>
Controlling for Distress	40
Management of Distress	44
Attitudes to Mental Health Issues.....	45
Patterns of Help Seeking	48
Prediction of Distress in Individuals.....	53
Formal Support Services and Student Training Programs	54
Peer Support	57
Peer Support Programs.....	58
Helping Behaviour	59
Application to Medicine.....	63

<i>Summary</i>	66
<i>Research Questions</i>	69
Distress Levels	69
Detection of Collegial Distress.....	70
Helping Behaviours.....	70
Methodology Comparison.....	71
CHAPTER 3: METHODOLOGICAL FRAMEWORK	73
<i>Overview</i>	74
<i>Definition of Distress</i>	75
<i>Measurement Instruments</i>	76
Demographic Data	76
Measure of Psychological Distress.....	77
Retrospective Helping Behaviour Instrument	79
Hypothetical Helping Behaviour Instrument.....	81
Exploration of the Causes of Distress	88
<i>Study Designs and Ethical Considerations</i>	88
Study I.....	92
Study Design.....	93
Ethical Considerations	95
Study II.....	96
Ethical Considerations	97
Study III	97
Ethical Considerations	99
<i>Development of Student Support Material: Tips for Dealing with Distress</i>	100
<i>Questionnaire and Website Production</i>	101
Questionnaires, Information Sheets and Consent Forms.....	101
Study I – Web-site development	102
CHAPTER 4: PILOT STUDIES	103
<i>Pilot Investigation: Study I</i>	103
Process	104
Characteristics of Sample.....	104
Questionnaire Adjustments	104
Procedural Adjustments	105
<i>Pilot Investigation: Study III</i>	106
Method	107
Characteristics of Sample.....	107
Responses to the Hypothetical Helping Behaviour Instrument - Pilot.....	108
Discussion of Study III Pilot	112
CHAPTER 5: METHOD.....	113
<i>Research Setting</i>	113
The University of Adelaide	113
Medical Course	113
Engineering Course.....	114

Law Course	115
Psychology Course	115
Reasons for Discipline Choice.....	116
<i>Participants, Procedures and Safeguards</i>	116
Participants	116
Procedure for Study I.....	119
Procedures for Study II and Study III.....	120
<i>Data Entry and Storage</i>	121
<i>Data Analysis</i>	121
Quantitative Data.....	122
Qualitative Data.....	123
Analysis Tools: Measure of Psychological Distress	124
Analysis Tools: Hypothetical Helping Behaviour Instrument	124
Analysis Tools: Retrospective Helping Behaviour Instrument	125
Analysis Tools: Methodology Comparison	125
<i>Student Feedback</i>	125
CHAPTER 6: CHARACTERISTICS OF THE TERTIARY STUDENT SAMPLE	127
<i>Response rates</i>	127
<i>Characteristics of Participants</i>	129
<i>Sample Representativeness</i>	130
<i>Characteristics of Non-responders</i>	133
CHAPTER 7: DISTRESS LEVELS AMONG TERTIARY STUDENTS	135
<i>Context and Objectives</i>	136
<i>Characteristics of Sample</i>	137
<i>Comparison of K10 Frequency Data with Population Normative Data</i>	140
<i>Comparison of K10 Mean Scores</i>	145
<i>Tertiary Students' Self Reported Diagnosis or Treatment for Mental Health Problems</i>	152
<i>Tertiary Students' Perceptions of their Distress Level</i>	155
<i>Tertiary Students' Concern about their Perceived Distress Level</i>	159
<i>Distress Symptoms among the Tertiary Student Sample</i>	162
<i>Chapter Summary</i>	164
CHAPTER 8: DISTRESS LEVELS SPECIFIC TO THE MEDICAL STUDENT SAMPLE..	167
<i>Characteristics of Sample</i>	167
<i>Distress Levels in the Medical Student Sample</i>	169
<i>Comparison of K10 Mean Scores within Medicine</i>	171
<i>Year Level Comparison of Medical Students' Perception of their Distress Level</i>	176
<i>Chapter Summary</i>	178
CHAPTER 9: PERCEPTIONS OF COLLEAGUES' DISTRESS LEVELS	179
<i>Context and Objectives</i>	180
<i>Response Summary</i>	181

<i>Characteristics of Sample</i>	182
<i>Modified Version of the K10</i>	184
<i>Association between Raters' and Ratees' K10 Scores</i>	186
<i>Comparison of Raters' and Ratees' Overall Perception of Distress</i>	193
<i>Distress Levels of Groups: Comments</i>	195
Theme 1: Specific Individual Functioning.....	195
Theme 2: General Group Functioning	199
Theme 3: Difficulty in Determining Distress and Functioning	205
Comparison of Student Groups.....	206
Distress Levels of Groups: Summary of Comments	207
<i>Chapter Summary</i>	209
CHAPTER 10: EXPLORATION OF HELPING BEHAVIOURS PROVIDED IN A HYPOTHETICAL SITUATION	211
<i>Context and Objectives</i>	212
<i>Characteristics of Sample</i>	213
<i>Description of Responses to the Hypothetical Helping Behaviour Instrument</i>	215
<i>Number of Helping Options Selected</i>	217
<i>Coding Responses into Helping Types</i>	221
<i>Quality of Helping Options</i>	224
<i>Chapter Summary</i>	236
CHAPTER 11: EXPLORATION OF RETROSPECTIVE HELPING BEHAVIOURS PROVIDED TO COLLEAGUES	239
<i>Context and Objectives</i>	240
<i>Characteristics of Sample</i>	241
<i>Analysis of Quantitative Data</i>	242
Perception of the Number of Distressed Colleagues	244
Frequency of Consideration to Help and Actual Help.....	248
Confidence to Help	253
Who Was Helped	258
<i>Analysis of Qualitative Data</i>	261
Reasons for Helping.....	263
Theme 1: Benefit to the Distressed Colleague	263
Theme 2: Benefits for the Helper/Participant.....	265
Comparison of Student Groups.....	268
Summary of Reasons for Helping	269
Types of Help Provided.....	270
Theme 1: Social Support.....	270
Theme 2: Therapeutic Assistance	273
Theme 3: Academic Assistance	275
Comparison of Student Groups.....	278
Summary of Types of Assistance.....	281
Discussion of Themes Derived From Responses	281
Outcomes from the Provision of Help.....	284

Theme 1: Positive Outcomes.....	284
Theme 2: Negative Outcomes	286
Theme 3: Uncertain Outcomes	286
Comparison of Student Groups	287
Summary of the Outcomes from Assistance	288
Reasons for Not Helping	289
Theme 1: Outside the Friendship Role	289
Theme 2: Lack of Resources	293
Theme 3: Benefit from Withholding Help.....	294
Comparison of Student Groups	295
Summary of Reasons for Not Helping a Colleague.....	296
Concerns Regarding Helping or Intervening	298
Theme 1: Benefit Doubt	298
Theme 2: Lack of Resources	300
Theme 3: Ramifications for the Helper	301
Comparison of Student Groups	303
Summary of Concerns about Helping Colleagues	305
<i>Chapter Summary</i>	308
CHAPTER 12: COMPARISON OF WEB-BASED AND PAPER-BASED METHODOLOGIES	311
.....	
<i>Context and Objectives</i>	312
<i>K10 Distress Levels: Comparison of Web-Based and Paper-Based Methodologies</i>	313
<i>Retrospective Helping Behaviour Instrument: Comparison of Web-Based and Paper-Based Methodologies</i>	314
<i>Chapter Summary</i>	317
CHAPTER 13: DISCUSSION.....	319
<i>Tertiary Students' Distress</i>	319
<i>The Detection of Collegial Distress by the Tertiary Students</i>	327
<i>Hypothetical and Retrospective Helping Behaviours Provided to Distressed Tertiary Student Colleagues</i>	331
<i>Delivery Method Comparisons for Studies of Psychological Distress and Helping Behaviours</i>	343
<i>Research Questions Answered</i>	345
Distress Levels	345
Detection of Collegial Distress.....	346
Helping Behaviours.....	347
Methodology Comparisons	350
<i>Research Limitations</i>	351
<i>Recommendations from this Research</i>	352
<i>Recommendations for Further Research</i>	355
<i>Conclusion</i>	355
REFERENCE LIST	357

APPENDIXES	373
<i>Appendix A: Study I Website Questionnaire on Distress among Tertiary Students.....</i>	<i>373</i>
<i>Appendix B: Study III Questionnaire.....</i>	<i>382</i>
<i>Appendix C: Study II Questionnaire.....</i>	<i>384</i>
<i>Appendix D: Information Sheet and Consent Form for Study I.....</i>	<i>386</i>
<i>Appendix E: Information Sheet and Consent Form for Studies II and III</i>	<i>390</i>
<i>Appendix F: Sample Student Feedback Webpage</i>	<i>393</i>
<i>Appendix G: Additional Data on the Helping Types from the HHBI</i>	<i>395</i>
<i>Appendix H: Qualitative Data Participant Codes – Retrospective Helping Behaviours.....</i>	<i>397</i>
<i>Appendix I: Process to Ensure Data Confidentiality in Study I</i>	<i>401</i>

LIST OF TABLES

<i>Table 1. Measures used by a Selection of Researchers in Distress and Distress-Related Studies.....</i>	30
<i>Table 2. A Selection of Other Psychological Attributes Examined in Members of the Medical Profession with Examples of those Researching in these Areas.....</i>	31
<i>Table 3. Socio-Demographic Variables Collected from Participants and Participating Disciplines</i>	76
<i>Table 4. Kessler Measure of Psychological Distress – Scoring Methods</i>	78
<i>Table 5. Questions Comprising the Kessler Measure of Psychological Distress and the Modified Questions Used In Study I.</i>	78
<i>Table 6. Questions used to Explore Retrospective Helping Behaviours towards Colleagues, the Response Options and Purpose behind the Questions.....</i>	80
<i>Table 7. Subject Variations in the Vignette Component of Study III.....</i>	82
<i>Table 8. Original Vignette by Kelly et al. (2006) and the Modified Version used in Study III.....</i>	82
<i>Table 9. The Variable Components of the Vignette used in Study III, Reflecting the Subject Variations Outlined in Table 7.....</i>	84
<i>Table 10. Helping Types Identified by Kelly et al. (2006) with Examples</i>	86
<i>Table 11. Helping Styles from Kelly et al. (2006).....</i>	86
<i>Table 12. Predefined Responses for the Study III Vignette</i>	87
<i>Table 13. Research Questions Grouped into 4 Main Categories (Distress Levels, Detection of Collegial Distress, Helping Behaviours, Methodology Comparison) and the Studies and Measures Designed to Address Them.....</i>	90
<i>Table 14. Vignette Type Variations used in the Study III Pilot</i>	106
<i>Table 15. Number of Responses by Vignette Type in the Study III Pilot</i>	110
<i>Table 16. Comparison of Helping Types between the Vignette Variations in the Study III Pilot.....</i>	112
<i>Table 17. The Participating Cohorts and the Studies Assigned to Them</i>	118
<i>Table 18. Student Access Rates for Feedback Web Pages by Discipline and Year Level</i>	126
<i>Table 19. Response Rates by Discipline and Year Level.....</i>	128
<i>Table 20. Characteristics (Age, Sex, Status) of Students Participating in the Research Studies in 2007</i>	131
<i>Table 21. Characteristics (Age, Sex, Status) of Students Enrolled at the University of Adelaide in 2007 and the National Medical Student Cohort for 2007</i>	132
<i>Table 22. Characteristics (Age, Sex, Status) for Non-Responders in Research Study I.....</i>	134
<i>Table 23. Characteristics of the Tertiary Students Completing the K10.....</i>	138

Table 24. Kessler Measure of Psychological Distress – Scoring Methods	140
Table 25. Participants (%) in Each of the Four K10 Distress Level Categories (Low, Moderate, High, Very High) Reported by Sex and Including South Australian Population Data for Comparison.....	141
Table 26. K10 Summary Score Means for the Tertiary Student Sample as a Function of the Students’ Characteristics (Sex, Status, Primary Language, Location) and Discipline	146
Table 27. K10 Summary Score Means and Standard Deviations for Males and Females by Discipline	148
Table 28. K10 Summary Score Means for Year Level 3 Students from the Participating Disciplines (Medicine, Psychology, Law, Mechanical Engineering) Including Measures of Effect Size for Discipline Comparison.....	151
Table 29. K10 Summary Score Means (+ SD) by Discipline between those Students Reporting Diagnosis or Treatment for Mental Health Problems and those Who Did Not.....	153
Table 30. Percentage of Students Reporting Diagnosis or Treatment for a Mental Health Problem as a Function of the Students’ Characteristics (Sex, Status, Primary Language)	155
Table 31. Comparison of Perceived Distress Ratings and K10 Ranked Score (3 Levels) for All Participants Reported by Discipline	158
Table 32. Medicine, Law and Mechanical Engineering Students’ Level of Concern Regarding Perception of their Own Distress	160
Table 33. Frequency of Low or High Concern for those Participants Classified as Psychologically Distressed (as determined by the K10) Reported as a Function of the Participants’ Characteristics (Sex, Status, Primary Language, Mental Health Treatment Status)	161
Table 34. Percentage of Tertiary Participants Exhibiting the Severe Spectrum of Responses (i.e. Symptom Experienced ‘Most’ to ‘All’ of the Time) Reported by Discipline, and Compared with South Australian Population Normative Data Responses	163
Table 35. Characteristics of the Medical Student Sample Completing the K10	168
Table 36. Comparison of Medical Student K10 Summary Score Means as a Function of the Students’ Characteristics (Sex, Status, Primary Language, Mental Health Treatment Status) and Year Level.....	173
Table 37. K10 Summary Score Means (+SD) for Male and Female Medical Students from Each Year Level.....	175
Table 38. Response Data for Raters and Ratees Participating in the Collegial Distress Component of Study I, Reported by Discipline and Year Level.....	182
Table 39. Socio-Demographic Characteristics (Sex, Status and Age) of Participants (Raters) and those Colleagues they Rated for Distress (Ratees).....	183
Table 40. Participants’ Ratings of Colleagues’ Distress for Each of the 10 Questions from the Modified K10 (N = 1881 Matched and Unmatched Ratings).....	185

<i>Table 41. Comparison of K10 Distress Means between Matched Raters and Ratees Reported as a Function of the Participants' Characteristics (Sex, Student Status, Mental Health Treatment Status, and Psychological Distress Classification)</i>	<i>188</i>
<i>Table 42. Comparison of K10 Distress Means for Matched Raters and Ratees for Year Level 3 Students from Medicine, Law and Mechanical Engineering</i>	<i>191</i>
<i>Table 43. Comparison of K10 Distress Means for Matched Raters and Ratees from Year 1, 3 and 5 in the Discipline of Medicine.....</i>	<i>192</i>
<i>Table 44. Socio-Demographic Characteristics (Age, Sex, Student Status, Primary Language) for the Tertiary Student Sample Participating in Study III</i>	<i>214</i>
<i>Table 45. Predefined Responses to the Vignette from Study III and the Classification of these Responses into Helping Types.....</i>	<i>216</i>
<i>Table 46. Mean Number of Responses for the Tertiary Student Sample Completing the Hypothetical Helping Behaviour Instrument Reported as a Function of Student Characteristic (Sex, Status, Primary Language, Mental Health Treatment Status, Psychological Distress Classification), Discipline and Vignette Subject Discipline</i>	<i>219</i>
<i>Table 47. Description of Additional Text Responses from the Hypothetical Helping Behaviour Instrument Classified into Helping Type Categories.....</i>	<i>222</i>
<i>Table 48. Tertiary Student Helper Styles, Showing Helping Techniques that Constitute that Style and the Percentage of Students Employing that Style</i>	<i>227</i>
<i>Table 49. Characteristics of Participants Completing the Retrospective Helping Behaviour Instrument</i>	<i>241</i>
<i>Table 50. Questions Yielding Quantitative Data from the Retrospective Helping Behaviour Instrument</i>	<i>243</i>
<i>Table 51. Comparison of the Perception of the Proportion of Distressed Colleagues According to the Participants' Sex, Student Status, Psychological Distress Classification and Mental Health Treatment Status.....</i>	<i>245</i>
<i>Table 52. Frequency of Participants' Consideration to Help Distressed Colleagues and Participants' Self-Reported Actual Help, Reported by Sex, Student Status, Psychological Distress Classification and Mental Health Treatment Status.....</i>	<i>250</i>
<i>Table 53. Comparison of Participants' Confidence to Help Distressed Colleagues as a Function of the Participants' Sex, Student Status, Psychological Distress Classification and Mental Health Treatment Status.....</i>	<i>255</i>
<i>Table 54. The Five Text Questions Comprising the Qualitative Component of the Retrospective Helping Behaviour Instrument, Including Number of Responders, Length of Response and Range, for Each Question.....</i>	<i>261</i>
<i>Table 55. The Five Text Response Questions (a component of the Retrospective Helping Behaviour Instrument) Identifying Categories and Themes for Each Question</i>	<i>262</i>

<i>Table 56. Sample Sizes of Student Groups Participating in the Retrospective Helping Behaviour</i>	
<i>Instrument</i>	<i>315</i>
<i>Table 57. Average Length of Qualitative Responses from the Retrospective Helping Behaviour</i>	
<i>Instrument: Comparison of Year Levels in Medicine</i>	<i>316</i>
<i>Table 58. Proportion of Participants Responding to the HHBI by Helping Type, as a Function of the</i>	
<i>Socio-Demographic Characteristics (Sex, Status, Primary Language, Discipline, Vignette</i>	
<i>Type, Mental Health Treatment Status, Psychological Distress Classification)</i>	<i>395</i>

LIST OF FIGURES

Figure 1. Organisation of Published Knowledge on Distress within the Medical Profession.	28
Figure 2. Organisation of Published Material on the Management of Distress.	44
Figure 3. Outline of the Three Research Studies and the Measurement Instruments Selected for Each.	89
Figure 4. Conceptual Diagram of the Research Design for Study I.	93
Figure 5. Conceptual Diagram of the Research Design for Study III.	98
Figure 6. Helping Type Preferences Comparing Participants who Received the Depression Vignette (n = 42) and Participants who Received the Suicide Vignette (n = 41).	111
Figure 7. Comparison of K10 Distress Levels (Low, Moderate, High, Very High) for Tertiary Students (N = 955) and Age-Matched Population Normative Data (N = 1515).	143
Figure 8. Percentage of Tertiary Students Classified With or Without Psychological Distress, Reported by Discipline and Comparative Age-Matched Population Data.	144
Figure 9. K10 Mean Summary Scores (+ SE) for Males and Females as a Function of Discipline.	147
Figure 10. K10 Mean Summary Scores (+ SE) for Males and Females by Discipline.	150
Figure 11. Proportion of Students with Psychological Distress (as Determined by the K10) and the Proportion of Students Reporting Treatment or Diagnosis for a Mental Health Problem Reported by Discipline.	154
Figure 12. Tertiary Students Perceived Distress Level Compared to their K10 Ranked Distress Level, for all Students (a), Medicine (b), Psychology (c), Law (d) and Mechanical Engineering (e).	157
Figure 13. Tertiary Student Concern Regarding Perceived Distress, for those Classified with and without Psychological Distress (as determined by the K10) N = 336.	160
Figure 14. Comparison of K10 Distress Levels (Low, Moderate, High, Very High) for Medical Students (N = 471) and Age-Matched Population Normative Data (N = 1515).	169
Figure 15. Comparison of Medical Students (%) Classified With and Without Psychological Distress, by Year Level with Age-Matched Population Data.	170
Figure 16. K10 Mean Summary Scores (+ SE) for Medical Students Reported by Year Level.	174
Figure 17. K10 Mean Summary Scores (+ SE) for Male and Female Medical Students Reported by Year Level.	176
Figure 18. Medical Students' Perceived Distress Level and their K10 Ranked Distress Level, for all Medical Students (a), Year 1 (b), Year 2 (c), Year 3 (d), Year 4 (e), Year 5 (f), Year 6 (g).	177

<i>Figure 19. K10 Distress Means for Matched Raters and Ratees Reported as a Function of Ratees' Characteristics (Self-Reported Treatment for a Mental Health Problem [a], Classification as Psychologically Distressed [b], Sex [c] and Student Status [d]).</i>	189
<i>Figure 20. K10 Distress Means for Matched Raters and Ratees Reported as a Function of Raters' Characteristics (Self-Reported Treatment for a Mental Health Problem [a], Classification as Psychologically Distressed [b], Sex [c] and Student Status [d]).</i>	190
<i>Figure 21. Comparison of Raters' Overall Perception of their Colleagues' Distress and the Ratees' Overall Perception of their Own Distress (Number of Matched Pairs = 1265).</i>	194
<i>Figure 22. Participants' Responses (%) Regarding their Group's Overall Distress Level Classified into Three Themes and Reported by Discipline (Medicine, Law, Mechanical Engineering).</i>	207
<i>Figure 23. Mean Number of Responses (+ SE) for the Four Condition Groups (Medicine versus Medicine [A], Medicine versus Non-Medicine [B], Non-Medicine versus Non-Medicine [C], Non-Medicine versus Medicine [D]).</i>	220
<i>Figure 24. Helping Types and the Percentage of Students Selecting that Helping Type (Includes Coded Text Responses) N = 572.</i>	223
<i>Figure 25. Helping Style Classifications (Informed by Cluster Analysis).</i>	225
<i>Figure 26. Proportion of Participants Classified into the Four Helping Styles.</i>	228
<i>Figure 27. Participants (%) Favouring Each Helper Style Reported by Sex (a), Student Status (b) and Language Spoken at Home (c).</i>	230
<i>Figure 28. Comparison of Participants' Helping Style Preferences Reported by Discipline.</i>	232
<i>Figure 29. Participants (%) Favouring Each Helper Style Reported by Discipline Type (a), Medical Student Helpee Preferences (b) Non-Medical Student Helpee Preferences (c).</i>	233
<i>Figure 30. Comparison of Helper Styles Patterns Reported for Each Year Level (Year 2 Medicine N = 65, Year 3 Psychology N = 83, Year 4 Medicine N = 60, Year 5 Medicine N = 74) from the Health Discipline Sample.</i>	235
<i>Figure 31. Proportion of Distressed Colleagues in Undergraduate Programs (Medicine, Law and Mechanical Engineering) as Perceived by the Student Participants (N = 395).</i>	244
<i>Figure 32. Perceived Proportion of Distressed Colleagues by Year 3 Student Participants in Medicine, Mechanical Engineering and Law (N = 208).</i>	246
<i>Figure 33. Perceived Proportion of Distressed Colleagues by Medical Student Participants from Year 1, 3 and 5/6 (N = 278).</i>	247
<i>Figure 34. Proportion of Participants who Considered Helping Distressed Colleagues and the Proportion who Provided Actual Help.</i>	249
<i>Figure 35. Frequency of Year 3 Participants' (Medicine, Law and Mechanical Engineering) Consideration to Help Distressed Colleagues Compared to the Frequency of Participants' Self-Reported Actual Help.</i>	251

<i>Figure 36. Proportion of Year 1, 3 and 5/6 Medical Participants Considering Helping Distressed Colleagues (a) and the Proportion Reporting the Provision of Actual Help (b).</i>	252
<i>Figure 37. Participants' Self-Reported Levels of Confidence to Help Distressed Colleagues in their Undergraduate Programs (N = 393).</i>	254
<i>Figure 38. Participants' (Year 3 Level Medicine, Law and Mechanical Engineering) Self-Reported Levels of Confidence (Low/High) to Help Distressed Colleagues.</i>	256
<i>Figure 39. Medical Student Participants' Self-Reported Levels of Confidence to Help Distressed Colleagues as a Function of Year Level.</i>	257
<i>Figure 40. Frequency of Helping Close Friends, Small Group Members, and Other Students from the Participants' Disciplines (N = 374).</i>	258
<i>Figure 41. Colleagues Helped the Most (a) and Least (b) by Year 3 Participants from Medicine, Law and Mechanical Engineering.</i>	260
<i>Figure 42. Reasons for Helping Distressed Colleagues: Proportion of Participants' Responses in Each Theme by Discipline.</i>	268
<i>Figure 43. Types of Assistance Provided to Colleagues in Distress: Proportion of Participants' Responses in Each Theme by Discipline.</i>	279
<i>Figure 44. Types of Assistance Provided to Colleagues in Distress: Proportion of Participants' Responses in Each Theme by Sex.</i>	280
<i>Figure 45. Responses on the Outcomes of the Assistance Provided to Colleagues in Distress: Proportion of Participants' Responses in Each Theme by Discipline.</i>	287
<i>Figure 46. Reasons for Not Helping a Colleague: Proportion of Participants' Responses in Each Theme by Discipline.</i>	296
<i>Figure 47. Concerns about Helping a Colleague: Proportion of Participants' Responses in Each Theme by Discipline.</i>	304
<i>Figure 48. Identification of Theme Similarity between the two Questions Obtaining Data on i) Reasons for Not Helping and ii) Concerns about Helping.</i>	305
<i>Figure 49. Data Organisation Chart For Study I.</i>	403

ABSTRACT

Medical students experience elevated levels of psychological distress and they are reluctant to seek professional help for mental health problems. They are also reticent to notify authorities about colleagues experiencing psychological distress. Yet, young people are more likely to seek help from peers than from any other source and we know very little about the help that these peers provide to their distressed colleagues. The current research explored medical students' approaches to colleagues experiencing psychological distress: firstly, to determine whether they notice the distress of colleagues; secondly, to explore what determines consideration to intervene and help colleagues; and thirdly, the range of helping behaviours provided. Comparisons were made with students from other professional tertiary disciplines.

Students from all six years of an undergraduate medical course were compared with convenience samples from Psychology, Law and Mechanical Engineering at The University of Adelaide. Students were recruited for one of three studies which employed a variety of measures, including the Kessler Measure of Psychological Distress (K10), a Retrospective Helping Behaviour Instrument (RHBI) and a Hypothetical Helping Behaviour Instrument (HHBI).

Psychological distress (as determined by the K10) among the disciplines surveyed (N = 949) was 4.4 times that of age-matched population normative data. Despite this high rate of distress, students consistently rated the distress of their colleagues as significantly lower than the colleagues' own self ratings. All disciplines were equally inaccurate in detecting the distress of their colleagues.

Analysis of hypothetical helping behaviours, in response to a vignette, indicated that medical students offered more help to non-medical students than they did to fellow medical students; however, the quality of help delivered to fellow medical students was superior. Non-medical students offered more help to medical students than they did to students from their own discipline, but the quality of help they offered did not change between the two disciplines.

Analysis of the mixed method RHBI indicated that discipline had an effect on the types of help provided to distressed colleagues, the reasons for and for not helping a colleague, and general helping concerns. Three main types of help were provided: social support, academic assistance and therapeutic assistance. Medical students from Year 3 onwards offered a diverse array of helping behaviours, whilst law and mechanical engineering students primarily offered academic support. Help was considered more frequently than it was actually given and reasons for and against providing help were associated with belief or doubt about the benefit of helping, positive or detrimental effects for the helper, the closeness or lack of friendship with the helpee, and confidence to help.

This research has improved our understanding of the mechanisms that produce helping behaviour. It has also provided a rich inventory of the type of help offered by the medical students and by other tertiary students. This knowledge is crucial in the development of effective approaches to assisting distressed students, particularly in regards to the theoretical and practical development of peer support programmes. Peer support programmes take into account young peoples' preferences to speak to peers. Peer support programmes that build on the students' existing behaviours and resources (those behaviours identified in this research) have an increased chance of acceptance and validity. Such programmes may offer a viable adjunct to formal support services and, more importantly, may have far reaching effects in breaking down the stigma of mental health problems within professions such as Medicine.

PERSONAL INFORMATION

My first contact with the world of medical education began during my Psychology Honours year when I undertook a project exploring medical students' attitudes and reasons for studying Medicine. After completing my honours project I began to work in a Medical Education Unit administering the curriculum for the last three years of the medical course. I was not at that time an academic staff member, nor am I medically-trained and it is because of these two reasons that I believe some of the students chose to speak to me about many issues including the mental health of themselves and their colleagues. In more recent times I have also witnessed several young doctors struggling with mental health problems and was astonished at the stigma still surrounding mental health in the profession and the effect it had on these doctors.

The idea to research the mental health of medical students was suggested to me by a friend and medical education expert (who later became my principal supervisor). Given my interests it was such a logical suggestion that I was amazed I had not thought of it myself. It built on my experience working with the medical students and my observations of some of the issues around mental health. I was very fortunate to receive a *beyondblue* scholarship for the course of my doctoral studies, and the association with them gave my project added respect. Every discipline or school I approached was more than happy to have their students be a part of the research.

As the research unfolded the data collected from the non-medical disciplines gained importance so that in the end I found the research was more about tertiary students with an emphasis on medical students, rather than all about medical students with some secondary comparisons with other disciplines. The findings from my research have confirmed some of my ideas, at other times they have surprised me and raised many more questions. I have at times laughed at many of the student responses, at other times I have been appalled at what some of them have had to deal with, and I have been truly amazed at the help provided by some individuals to distressed colleagues. Above all, I believe that this research has shown that the students have a vast array of helping behaviours. Finding effective ways of fostering these attributes could help many psychologically distressed students. These attributes, carried

through to professional practice, have the potential to change the climate within a profession to one of care and acceptance, rather than fear, judgement and stigma.

As part of this doctoral study, all the study designs, questionnaire designs, supporting documentation, and the delivery processes were conceived by me. All data entry (with some additional verification by staff of the University of Adelaide), database design and programming, website computer programming, and data analysis were undertaken by me.

Catherine Leahy

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ABBREVIATIONS

General

CES-D	Centre for Epidemiological Studies Depression Scale
GHQ	General Health Questionnaire
HHBI	Hypothetical Helping Behaviour Instrument
ICT	Information Communication Technology
K10	Kessler Measure of Psychological Distress
MBBS	Bachelor of Medicine, Bachelor Surgery
Mech. Eng. or M. Eng.	Mechanical Engineering
Med	Medicine
MMPD	Modified Measure of Psychological Distress
MPD	Measure of Psychological Distress
PBL	Problem Based Learning
RHBI	Retrospective Helping Behaviour Instrument
SF-36	Short Form Health Survey (36 questions)
TER	Tertiary Entrance Ranking
UMAT	Undergraduate Medicine and Health Sciences, Admission Test

Statistical

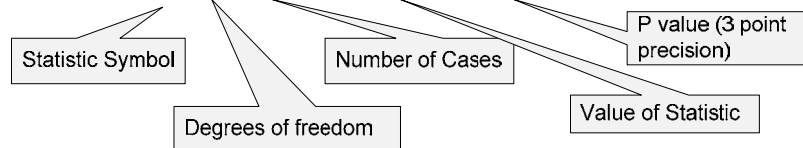
H	Kruskal-Wallis Statistic
χ^2	Chi Square Statistic
CI	Confidence Interval (95%)
d	Cohen's Effect Size with Hedges Bias correction
df	Degrees of Freedom
M	Mean
$Mdiff$	Mean of the Difference
r_s	Spearman's rho Statistic
SD	Standard Deviation
SE	Standard Error of the Mean
U	Mann-Whitney U Statistic
z	Z Statistic for Comparison of Proportions Between Independent Populations

STYLISTIC FEATURES ADOPTED FOR THIS THESIS

The American Psychological Association Publication Manual was used as a style guide for this thesis (American Psychological Association, 2001). The following is a list of the main stylistic features adopted from the manual.

- All *p* values are reported exactly to 3-point precision unless this is inadequate in which case $p < .001$ is used instead of $p = .000027$.
- Inferential statistics are reported in the text in the following format

“The differences between the sexes was statistically significant with more females (58%) than males (42%) indicating they were psychologically distressed, $\chi^2(1, N = 312) = 7.39, p = .007$.”



- Table and figure captions use italic font.
- Reference list uses hanging indentation.
- In the reference list, for works with more than six authors only the first six are written followed by “et al.”
- Effect size estimates are reported, where possible, for all comparisons of mean scores. Effect sizes are reported to 2 point precision.
- Confidence intervals are reported, where possible, for all comparisons of frequency data.
- Within the text, frequency data are reported rounded to the whole integer.
- Non-significant *p* values are not reported in the text but are contained within the tables, unless a case is being made that the null hypothesis is close to being confirmed, in which case the non-significant *p* value is reported in the text.

Throughout the text references are made to previous sections of this thesis. All references to other sections of the thesis are named, bolded and italicized within the text. The three studies are identified by Roman Numerals within the text (I, II, III).