6-2020

Exploration of Physician Attitudes about Self-Care and Personal Mental Health: Possible Barriers to Physician Well Being

Candich Farrar
National Louis University

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Candich Farrar

Florida School of Professional Psychology

National Louis University

Eric Rosen, Ph.D.
Chair

Elizabeth Lane, Ph.D.
Member

A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida
July 2019

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

Candich Farrar

has been approved by the
CRP Committee on July 17, 2019
as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

Examining Committee:

Eric L. Rosen, Ph.D., C.Ht., FPPR

Committee Chair: Eric Rosen, Ph.D.

Elizabeth Lane, PhD

Member: Elizabeth Lane, Ph.D.

Abstract

The present study was designed to examine physicians' mental health, attitudes, and behaviors toward self-care and the utilization of mental health services. As the medical field can be very demanding and exhausting, it is believed that many physicians suffer from mental illnesses such as anxiety and depression. However, it was theorized that many physicians do not engage in adequate self-care regimes or seek support and suppress their symptoms, which may further exacerbate their illnesses. A thorough literature review was performed to explore the following: possible barriers to physicians seeking mental health services to address high rates of mental illnesses, physicians coping styles, and clinical applications of working with physicians given the perceived biases about mental health concerns and seeking services.

DEDICATION

This is dedicated to my husband, Brett, and all of the other hard-working physicians who continuously put others first. Thank you for all of your hard work. We see you and we appreciate you. Take the time to care for and love yourself. Always make yourself a priority – even when it feels like others are not.

TABLE OF CONTENTS

Page

CHAPTER I: INTRODUCTION

Medicine as a field can be a rewarding and lucrative life of service; yet, physicians often experience various personal costs throughout their career. Research shows physicians are at risk of developing mental health concerns throughout their career and suggests physicians are vulnerable to illnesses such as depression (Dyrbye et al., 2006; Ludwig et al., 2015), anxiety (Shanafelt, 2011), and substance abuse (Sotile & Sotile, 2000). As the country and many individuals rely on adequate healthcare to aid in their ailing concerns (Mackenzie et al., 2006), it is important to understand the culture of medicine and its impact on physicians' mental health and self-care tendencies to create more effective clinical strategies to strengthen physician wellness. With physicians working the frontline in the healthcare system, the adage "physician heal thyself," does not seem practical or viable in maintaining mental or physical health, as many physicians appear to be overworked and consistently exposed to traumatic and vulnerable situations within the workforce, leaving little time for them to properly cope and recoup (Vogel, 2018). This research explored the psychology of physicians, specifically examining their mental health in relation to their attitudes and behaviors toward self-care and the utilization of mental health services. A working model of clinical psychotherapy care for physicians is offered based on a thorough literature review and heuristically derived conceptualizations.

Mental Illness: A Fabric of the Human Condition

Mental illness impacts millions of individuals throughout their lifetime (Pedersen & Paves, 2014). Mental illness is defined as a medical condition that may affect one's mood, cognitive abilities, decision making, social capabilities, and overall skills (Crowe et al., 2016). It is estimated that up to 50% of individuals will experience a mental illness within their lifetime, and up to 30% of individuals have suffered from a mental illness within the past year (Mackenzie

et al., 2006; Pedersen & Paves, 2014). The Center for Disease Control estimates that up to 10% of Americans suffer from depression, and up to 15% suffer from various other mental illnesses at any given moment (Gangi et al., 2016). Although nearly half of the population will experience a mental illness at some point in their lifetime, many individuals do not appear to seek mental health services despite supporting evidence showing treatment can effectively decrease symptoms (Barney et al., 2006; Crowe et al., 2016; Mackenzie et al., 2006). Further, past researchers suggest that although some individuals may eventually seek mental health services, they may wait years after the onset of their illness, suggesting treatment may not be as effective (Gangi et al., 2016).

There are several reasons an individual may not seek treatment for mental health concerns. Past studies suggest age (Kessler et al., 2014), gender (Mackenzie et al., 2006), public and perceived stigma (Crowe & Brugha, 2018; Pedersen & Paves, 2014), lack of knowledge pertaining to available treatments (Crowe et al., 2016), and prior experience with mental health services (ten Have et al., 2010) are the most common barriers for individuals seeking mental health treatment. Previous studies indicate older individuals may have more positive attitudes and be more prone to seek services for their mental health illnesses (Kessler et al., 2014). However, they tend to rely on their primary care physicians who may be less likely to focus on effective mental health options as opposed to medical sanctions (Mackenzie et al., 2006). Historically, researchers have also found that women tend to hold more positive attitudes toward seeking mental health services (Calear et al., 2017; Kessler et al., 2014; Mackenzie et al., 2006). Men who obtain a higher level of education may be more apt to seek mental health services (Mackenzie et al., 2006). However, data suggest men of all ages tend to hold more negative views pertaining to mental health than women do (Kessler et al., 2014). Subjective masculine

and feminine roles may play a role in these differences, as men have traditionally been encouraged to suppress their emotions, which is concerning, as men's suicidal completion rates are three times higher than women's (Calear et al., 2017). Similarly, data indicate perceived social support likely impacts an individual's attitude toward seeking mental health services (Kessler et al., 2014), which could impact men's mental health needs, as they may feel like their mental health concerns are not socially supported by traditional masculine roles they are expected to follow (Calear et al., 2017).

Attitude as a Salient Factor in Seeking Mental Health Services

Research suggests attitudes toward seeking help may be the strongest predictor of an individual's intention to pursue mental health services (Mackenzie et al., 2006; ten Have et al., 2010). An individual's attitude toward seeking help includes their beliefs and feelings pertaining to the label attached to an illness, the effectiveness of treatment, as well as availability and affordability of services (Mackenzie et al., 2004; ten Have et al., 2010). Mental health illnesses tend to have an attached stigma that may hinder many individuals from seeking the treatment they truly need, as they do not want to appear "unstable" (Gangi et al., 2016; Pedersen & Paves, 2014). Stigma can be defined as an attribute that something or someone possesses that carries negative connotations (Crowe et al., 2016). Self-stigma (Barney et al., 2006) and public stigma (Pedersen & Paves, 2014; ten Have et al., 2010) are major barriers to individuals seeking mental health treatment. The associated stigma with mental health illnesses often has a negative effect on an individual, as it may cause increased mental health symptoms, social isolation, negative attitudes toward treatment, and noncompliant behaviors within treatment (Crowe et al., 2016; Pedersen & Paves, 2014). In contrast, stigma may be reduced when individuals associate mental illnesses with biological entities, which minimizes their control over and responsibility for the

illness (Gangi et al., 2016). Pairing mental illness with biological causes may be the reason individuals often prefer to seek treatment from their primary care physicians, alluding to the idea that it is more acceptable to seek medical care rather than see a psychiatrist or other mental health professional (Barney et al., 2006).

Work-Life Balance

Among those who are at risk of facing mental illnesses, employed individuals often face professional and personal demands within their day-to-day lives, resulting in these individuals learning how to balance work-life demands to maintain a healthy lifestyle (Simon & Durand-Bush, 2015). Over the past few decades, researchers have begun to focus more on work-life balance, which consists of the quality of an individual's working life and its relation to a broader quality of their overall lifestyle (Guest, 2002). Past research offers the following qualities to define work and life; work typically consists of paid employment, unpaid hours, travel time, and prep time, whereas life consists of family time, leisure time, and free time (Guest, 2002). It is believed that the intensity and pressures of work have steadily been increasing, as consumers have begun to focus on the need for a speedy response and have placed high importance on the quality of customer service and its implications for constant availability of employers (Guest, 2002; Simon & Durand-Bush, 2015). Subsequently, demands from either work or home may become too high or too low, which may cause a feeling of work-life imbalance and negatively impact an individual's lifestyle both personally and professionally if it is not adequately managed (Dorociak et al., 2017; Simon & Durand-Bush, 2015). Consequences of a work-life imbalance may include poor mental and physical health, professional burnout, work-family conflict, marital dissatisfaction, and work dissatisfaction (Dorociak et al., 2017; Guest, 2002; Simon & Durand-Bush, 2015).

Several factors may also affect working individuals' work-life balance and put them at risk of experiencing the consequences of an imbalanced lifestyle. Studies suggest individuals who have families and a household, specifically women in dual-career families, may experience higher rates of burnout and experience a work-life imbalance, as they often come home to work the "second shift," which consists of tending to children and household chores after they have worked a full day at their job (Guest, 2002). Furthermore, individuals who obtain post-secondary degrees are among those who must learn to balance and manage professional and personal demands to avoid high stress and be able to function effectively in the workplace and in their daily lives (Dorociak et al., 2017; Kaliannan et al., 2016). Studies suggest while post-secondary degrees often decrease the risk for burnout and other mental health illnesses post-graduation, physicians are at an increased risk of experiencing an imbalance, burnout, and negative mental health consequences related to their careers compared to the general population (Shanafelt et al., 2012).

Physician work-life imbalance. Physicians are among a unique group of graduates who are likely to experience high demands throughout their work training, creating an increased risk of experiencing a work-life imbalance (Shanafelt et al., 2012). As the medical field is experiencing a global shortage, physicians are at risk of a work-life imbalance as the number of patients seeking care continues to rise (Kaliannan et al., 2016). Throughout their careers, physicians are taught to tailor and dedicate their lives to helping others (Accreditation Council for Graduate Medical Education, 2011; Shanafelt et al., 2012). From medical school to residency and attending status, physicians are often expected to quickly attain and retain a plethora of medical knowledge (Ludwig et al., 2015), work up to 88 hours per week, and be exposed to many ailing patients (Brooks et al., 2011; Gold et al., 2016). While the reward for advancing

within their medical careers and achieving such a lifestyle may include financial gains, reputation, status, and position (Wilson & Cunningham, 2014), these advantages also put physicians at risk of experiencing higher amounts of stress and intense feelings that their personal lives are on hold as they focus on their career and the care of others (Sotile & Sotile, 2000). Subsequently, this heavy workload puts physicians at risk of experiencing an imbalance in their work and personal lives (Kaliannan et al., 2016; Shanafelt et al., 2012).

It is believed that physicians often experience high work demands and long work hours, resulting in over-engagement in work commitments (Wilson & Cunningham, 2014). Consequently, physicians may be at risk of experiencing negative outcomes related to their health and job performance, which may include an inability to separate their work-home lifestyles, continual feelings of arousal and psychological distress from work demands, and increased rates of mental illnesses such as depression and anxiety (Kaliannan et al., 2016; Shimazu et al., 2018). Further, researchers indicate the importance of considering physicians' age and generational upbringing as cultural factors that may impact their ideas pertaining to work-life balance (Kaliannan et al., 2016). For example, Baby Boomer physicians who were born between the 1940s and early 1960s may value their family and personal achievements over their career, whereas Generation X and Generation Y physicians who were born between the late 1960s and the 2000s may prioritize their career over their home life (Kaliannan et al., 2016).

Self-care as a protective factor against work-life imbalances. There are several ways for individuals to manage the demands placed upon them, including engaging in self-care or seeking an unbiased outlet to talk through their stresses (Dorociak et al., 2017; Mills & Chapman, 2016). Self-care, which is the intentional actions an individual takes to maintain and improve their physical, mental, and emotional health (Sanford & Frey, 2018), is an important

factor that allows individuals to manage and process demands within their lives (Dorociak et al., 2017; Kaliannan et al., 2016), as well as recharge mentally and physically (Mills & Chapman, 2016; Sanford & Frey, 2018). Self-care also entails self-reflection and allows individuals the ability to gain a sense of awareness regarding their professional and personal lives (Mills & Chapman, 2016). Self-care allows individuals to maintain a healthy work-life balance and have a better balance of one's work stress, lifestyle goals, healthy habits, personal hobbies, and other meaningful pursuits outside of work (Dorociak et al., 2017; Sanford & Frey, 2018).

Past research indicates physicians have identified a balance between their personal and professional roles as an effective strategy for their self-care routines (Mills, Wand, & Fraser, 2018). Self-care is believed to be beneficial for physicians, as it helps them focus on their wellbeing and relate better to others, including patients (Crowe & Brugha, 2018; Peters et al., 2018). However, studies have shown physicians often show deficiencies in self-care, including inadequate levels of sleep, nutrition, and physical activities (Leão et al., 2017). Global studies suggest physician wellness and self-care regimes tend to be poor due to self-neglect (Wallace, Lemaire, & Ghali, 2009), which may be due to several professional and personal factors, including a lack of time due to long work hours and high work demands (Sonnentag et al., 2010). It is believed that medical training carries overt and covert messages that instill beliefs and behaviors about self-care and attitudes about the exposure of mental health needs that revert medical students, residents, and physicians away from personal care (Crowe & Brugha, 2018; Mills et al., 2018; Peters et al., 2018; Vogel, 2018). Subsequently, many physicians are at an increased risk of experiencing physical and psychological mental illnesses, as they do not appear to engage in adequate care for their overall wellbeing (Leão et al., 2017; Mills & Chapman, 2016; Vogel, 2018).

Demands of Performance, Prowess, and Principle Compete with Self-Care

Medicine is believed to be one of the most stressful fields to enter (Cohen & Patten, 2005; Hillhouse et al., 2000; Shanafelt et al., 2012). Physicians undergo rigorous training for at least 11 years before they become board certified. After obtaining a bachelor's or master's degree, medical professionals undergo several standardized examinations and a rigorous application and interview process. Once accepted into a program, medical students endure four years of medical school and between three to seven years of residency. Additionally, medical professionals have the option to enter competitive specialized fellowship programs, which generally last between one to three years post-residency. Once physicians have graduated from their residency or fellowship program, they can enter the workforce independently (Dyrbye et al., 2006).

Throughout their years of training, physicians are often faced with long work hours and high work demands, which are believed to affect their overall wellbeing (Sonnentag et al., 2010). Past research suggests physicians develop mental health illnesses beginning as early as medical school (Brewin & Firth-Cozens, 1997; Cohen & Patten, 2005). Medical students worldwide have reported high rates of mental health illnesses such as depression and anxiety due to high levels of stress during their training (Dahlin & Runeson, 2007; Dyrbye et al., 2006; Ludwig et al., 2015; Myers & Gabbard, 2008; Sotile & Sotile, 2000). Many medical students have reported experiencing physical and emotional abuse during their training (Cohen & Patten, 2005), often leading to lowered self-esteem and increased rates of depression and anxiety (Dyrbye et al., 2006; Ludwig et al., 2015). Medical students have also reported experiencing a lack of self-care, including an increase in unhealthy sleeping habits, substance use, and lack of adequate diet and

exercise throughout their training due to factors including time restraints and work overload (Ludwig et al., 2015).

Once medical students are accepted into a residency program, their lack of self-care and mental health may continue to decline (Hillhouse et al., 2000). Some believe that residency is the most stressful time in a physician's educational training as they transition from a medical student to a practicing physician (Cranley et al., 2015; Hillhouse et al., 2000; Rashid & Talib, 2015), often working up to 80 hours per week (Accreditation Council for Graduate Medical Education, 2011). Past studies suggest residents feel confident with their wealth of medical knowledge. However, they have indicated they do not feel prepared to engage in the "human aspects" of working with patients (Dossett et al., 2013). Residency entails physicians facing increased responsibility for patient care, uncertainty about treatment options, and inexperience with making quick, critical decisions for ill patients (Cohen & Patten, 2005; Dyrbye et al., 2006; Mills & Chapman, 2016). Similar to medical students, residents report inadequate sleep, fatigue, time constraints, and insufficient social support during their training (Hillhouse et al., 2000). Resident mental health conditions may be exacerbated by feeling stuck due to high amounts of debt, having little time for self-care, feelings of vulnerability, feeling as if their job is in jeopardy, academic and time pressures, and experiencing high levels of work stress, such as making split decisions that could save or cost a life (Dyrbye et al., 2006; Mills & Chapman, 2016; Ross et al., 2006; Sotile & Sotile, 2000).

Unfortunately, once residents can practice independently, their levels of stress do not appear to decrease (Hillhouse et al., 2000). Physicians nationwide have reported high levels of burnout and dissatisfaction with their careers compared to the general public (Kreitzer & Klatt, 2017; Shanafelt et al., 2009; Shanafelt et al., 2012). High levels of physician burnout are

associated with both personal and professional consequences (Kreitzer & Klatt, 2017; Simon & Durand-Bush, 2015). Physicians are at risk of experiencing a decrease in overall physical and emotional wellbeing, dissatisfaction with social and marital relationships, increased suicidal ideation, and problematic substance use (Kreitzer & Klatt, 2017; Simon & Durand-Bush, 2015; Wallace et al., 2009). They are also at risk of being sued due to patient dissatisfaction or making costly medical errors, which may be due to feeling fatigued and overworked (Beresin et al., 2015). Moreover, past research suggests physicians who have been sued for malpractice are at risk of attempting or completing suicide (Gabbard & Menninger, 1988). Physicians nationwide have also reported increased suicidal ideations due to academic and workload distress, sleep deprivation, and experiences of vicarious trauma during their training (Mills & Chapman, 2016; Vogel, 2018).

Physicians have reported several barriers to seeking mental health services including time constraints (Guille et al., 2010), stigma concerns (Myers & Gabbard, 2008), and a fear of being questioned by the licensure board (Dyrbye et al., 2017; Gold et al., 2016). When physicians apply or renew their medical license, approximately 90% of medical licensure applications assess their mental health history and have indicated they believe it is necessary to inquire about and penalize physicians with mental health concerns to protect the healthcare of the public (American Psychiatric Association, 1984; Gold et al., 2016; Hendin et al., 2007; Polfliet, 2008; Schroeder et al., 2009). Thus, due to the lack of time for self-care and the perceived and real risks associated with seeking services, many physicians fail to recognize, report, discuss, or pursue treatment for their mental health concerns (Kishore et al., 2016). Rather than seeking support, many physicians self-medicate or seek consultation from colleagues who tend to have the same views and concerns regarding mental health treatment (Kepper & Baum, 2014;

Schneck, 1998; Sotile & Sotile, 2000; Wilson & Cunningham, 2014), resulting in a vicious cycle of untreated symptoms and illnesses. Sadly, statistics indicate between 300 and 400 U.S. physicians complete suicide every year due to untreated mental health illnesses (Center et al., 2003; Gold et al., 2013).

Promoting Mental Health in a Medical Field

The Accreditation Council for Graduate Medical Education (2011) requires programs to promote physician wellbeing and suggests physicians engage in "alertness management and fatigue mitigation" strategies during their shifts to stay alert and provide the best patient care. Strategies the council suggests physicians should engage in include physicians taking naps, using caffeine, exercising during duty, and using a bright light (Accreditation Council for Graduate Medical Education, 2011). However, past research has indicated the best way to recover from psychological stress occurs during moments when an individual is physically and psychologically detached from their work environment (Sonnentag et al., 2010). Yet, physicians' long work hours and limited downtime do not allow them to engage in self-care and recover day-to-day, resulting in exacerbated negative mental health concerns (Brotheridge & Lee, 2002; Meijman & Mulder, 1998). Although the American Medical Association (2001) has developed a code of medical ethics that indicates physicians have a responsibility to maintain their health and wellness by preventing or treating diseases, including mental illness, to preserve the quality of their work performance, there does not appear to be any evidence that programs, hospitals, or work sites regularly screen for mental illnesses.

Universities in Australia (Mills & Chapman, 2016) and the United Kingdom (Brown, 2008) have begun to implement programs teaching medical personnel about the importance of self-compassion and its impact on physicians' overall wellbeing. However, despite medical

schools', residency programs', and hospitals' efforts to develop programs designed to help physicians who report feeling distressed, it appears that most physicians do not seek services (Dahlin & Runeson, 2007). Studies have suggested physicians do not seek treatment due to time constraints, cost, fear of stigma, and concerns about confidentiality (Chew-Graham et al., 2003; Guille et al., 2010; Myers & Gabbard, 2008; Tyssen et al., 2004). Subsequently, many physicians tend to self-medicate or rely on ineffective coping methods, such as substance use (Schneck, 1998; Sotile & Sotile, 2000; Wilson & Cunningham, 2014).

Statement of the Problem

Throughout their schooling and career, physicians bear distressing events, endure personal stressors, as well as gain exposure to the pain and suffering of numerous patients (Mills & Chapman, 2016). Despite these traumatic experiences, physicians appear to have little time to incorporate self-care, socialize, or take breaks (Kishore et al., 2016; Mills & Chapman, 2016). Thus, many physicians often experience symptoms of illnesses, including depression, anxiety, and substance abuse (Sotile & Sotile, 2000). However, many physicians who do suffer from mental illnesses likely do not seek support and suppress their symptoms, further exacerbating their illnesses (Kepper & Baum, 2014; Schneck, 1998; Sotile & Sotile, 2000; Wilson & Cunningham, 2014). Physicians may resort to unhealthy coping habits such as substance use (Myers & Gabbard, 2008; Sotile & Sotile, 2000) and self-medicating (Guille et al., 2010; Schneck, 1998; Sotile & Sotile, 2000). Consequences for such mental health denial may lead to suicidal ideation (Dyrbye et al., 2008; Enns et al., 2001; Myers & Gabbard, 2008; Sotile & Sotile, 2000), decreased self-esteem (Enns et al., 2001; Myers & Gabbard, 2008), burnout (Kishore et al., 2016; Myers & Gabbard, 2008; Wilson & Cunningham, 2014), and compassion fatigue, (Mills & Chapman, 2016; Wilson & Cunningham, 2014). On a personal level, such a

dynamic of denial of self-care can impact the personal lives of physicians, such as family dynamics, including divorce and mental health of family members (Major et al., 2002; Sotile & Sotile, 2000; Wilson & Cunningham, 2014).

Purpose of the Study

Although past researchers have studied rates of burnout, depression, and anxiety, there has been little focus on possible barriers to physicians engaging in self-care and seeking mental health treatment, which may help decrease the high rates of mental illnesses within this group. Self-care is key to improved mood and reduced anxiety, as well as a good relationship with oneself and others (Dorociak et al., 2017; Mills & Chapman, 2016; Sanford & Frey, 2018). Thus, the purpose of the present study was to review current literature and identify gaps to assess the relationship between physicians' mental health, attitudes, and behaviors toward self-care and the utilization of mental health services. The researcher sought to identify whether there was an association between physicians' mental health and their engagement in self-care tendencies, including seeking out mental health services. This study assessed physicians' mental illnesses, coping tendencies, and whether there were barriers to physicians engaging in adequate self-care that may impact their overall wellbeing and mental health. The study also provided clinical implications for working with physicians and suggestions for reducing possible barriers for physicians receiving adequate care for their mental health concerns.

Definition of Terms

For the purpose of this study, the following definitions were used to describe keywords. Physician is defined as anyone who has obtained a medical degree and practices within the field of medicine. This includes residents, fellows, and attendings. Self-care was defined as any activity that an individual does to take care of their mental, emotional, physical, spiritual,

professional, and social wellbeing. Self-care is different for everyone but may include things such as a nutritious and healthy diet, adequate sleep (recommended 8 hours), exercise (recommended at least 30 minutes per day), regular medical visits (physicals and follow up for preexisting conditions), socializing with others, and partaking in one enjoyable activity per day. Last, mental health was defined as an individual's condition regarding their psychological and emotional wellbeing.

Literature Review Questions

The present study assessed the following four research questions:

1. What aspects of personality and lifestyle are uniquely shared among physicians as a cultural group that may affect their mental wellbeing?
2. In what ways do physicians' attitudes toward self-care relate to the management of mental health concerns?
3. What barriers to seeking mental health services exist for physicians, which impede acknowledgment or receipt of mental health services?
4. Given unique aspects of this career group, what implications exist for the provision of best practices for treating physicians in clinical mental health settings?

Significance of the Study

The current study sought to identify barriers related to physicians' self-care tendencies that may impact their overall wellbeing and mental health. Potential benefits of the current study for the professional community include aiding mental health professionals and medical training programs in how to best assess and handle mental health concerns within this population and reduce the stigma toward receiving services or implementing time for self-care to reduce mental health concerns for physicians. Potential benefits of the present study for physicians include

reducing barriers to physicians receiving mental health services, including identifying barriers, reducing feelings of shame and stigma, and identifying key areas within physician training and lifestyle to implement self-care to reduce mental health conditions.

CHAPTER II: IMPACT OF PHYSICIANS LIFESTYLE ON MENTAL HEALTH

Physician Personality Traits

There have been several theories regarding physician personality styles and whether those individuals who choose to enter the field of medicine have certain characteristics that make them more vulnerable to experience high amounts of stress and mental illnesses (Brewin & Firth-Cozens, 1997; Gabbard & Menninger, 1988; McManus et al., 2004; Sotile & Sotile, 2000). Theorists suggest many physicians exhibit similar traits such as compulsiveness (Sotile & Sotile, 2000), difficulty delegating tasks to colleagues (Myers & Gabbard, 2008; Sotile & Sotile, 2000; Wilson & Cunningham, 2014), neuroticism (McManus et al., 2004), emotional detachment (Sotile & Sotile, 2000), and perfectionism (Myers & Gabbard, 2008; Sotile & Sotile; Wilson & Cunningham, 2014). These traits are believed to affect physicians' overall mood and temperament within the field (Sotile & Sotile, 2000).

Some believe physicians enter the field due to perceived feelings of inadequacy experienced during their childhood (Brewin & Firth-Cozens, 1997; Gabbard & Menninger, 1988). These theorists believe physicians experience "narcissistic wounds" (Sotile & Sotile, 2000) in which they feel they failed their parents (Brewin & Firth-Cozens, 1997; Gabbard & Menninger, 1988). Further, they theorized physicians enter the field to provide their patients with the care and attention they feel they lacked early on (Gabbard & Menninger, 1988) and to gain their parents' approval (Brewin & Firth-Cozens, 1997). Brewin and Firth-Cozens (1997) suggested physicians experience high levels of self-criticism and depression as they yearn to gain their parents' acceptance, which affects their overall mental health throughout their lives and their careers.

Possessing traits such as perfectionism likely helps physicians excel within their career (Enns et al., 2001; Myers & Gabbard, 2008). Physicians tend to be top of their class prior to entering medical school (Enns et al., 2001), and likely were accepted due to their ability to perfect diagnoses and assessments with patients (Myers & Gabbard, 2008). However, those same perfectionistic traits may harm physicians' overall wellbeing throughout their training. For example, once physicians are in training, they likely experience scoring within the average or below average range, as the curriculum becomes heavily stacked (Enns et al., 2001). Subsequently, they may experience a decrease in their self-esteem. They may become vulnerable to depression, burnout, suicidality, and anxiety as they begin to engage in maladaptive perfectionism, which is characterized by harsh self-criticism due to a fear of others' negative perceptions (Enns et al., 2001; Myers & Gabbard, 2008).

Myers and Gabbard (2008) suggested physicians often engage in a compulsive triad consisting of self-doubt, guilty feelings, and an exaggerated sense of responsibility. When physicians enter the field, they often feel pressured, as they experience a loss of social time with friends and family, an overabundance of curriculum material they are expected to learn, quickly making life-or-death decisions, increased amounts of debt, and begin to care for seriously ill patients (Enns et al., 2001). Physicians may begin to feel ashamed and doubt their abilities, as they feel unsure in their capabilities to learn and retain all the new information, as well as make all the correct calls for patient care as they begin to engage in maladaptive perfectionism (Enns et al., 2001). Medical errors often exacerbate all areas of the compulsive triad, which likely leads physicians to experience higher levels of mental health illnesses, such as depression, anxiety, and burnout (Myers & Gabbard, 2008). It is believed that female physicians engage in higher levels

of self-criticism as they strive for perfection within their career and family, which leads to higher rates of mental health illnesses (Brewin & Firth-Cozens, 1997).

The medical field tends to be viewed as a collectivistic culture, as physicians tend to do what is best and put their workplace, colleagues', and patients' needs over their own (Enns et al., 2001; Brewin & Firth-Cozens, 1997). Physicians may be highly motivated to seek the approval of their patients and work staff, which may lead to higher levels of self-criticism, shame, and mental health illnesses if they do not believe they adequately met their expectations (Enns et al., 2001; Brewin & Firth-Cozens, 1997). Moreover, it is suggested that the medical field favors "cognitive mastery" over interpersonal warmth (Gabbard & Menninger, 1988), likely leading many physicians to believe that having an illness is inappropriate as they mask their true needs and exacerbate their symptoms to gain and retain the approval of the medical workforce (Wilson & Cunningham, 2014).

Effects of an Unbalanced Professional and Personal Life

Physicians tend to have a strong work identity, which is often associated with longer work hours and feeling more pressured and responsible while on and off the clock (Kaliannan, Perumal, & Dorasamy, 2016; Major et al., 2002; Shanafelt et al., 2012). Due to the collectivistic nature of the medical field, physicians often may feel an imbalance within their lives as they work more often in an attempt to perfect their medical skills and gain the approval of their patients, colleagues, and workplace (Enns et al., 2001; Brewin & Firth-Cozens, 1997; Wilson & Cunningham, 2014).

Due to physicians' long work hours and strenuous labor, studies suggest their lack of time at home tends to be associated with family conflict and psychological distress for both the individual and members within their family (Kaliannan et al., 2016; Major et al., 2002; Shanafelt

et al., 2012; Sotile & Sotile, 2000). It is believed many physicians tend to escape from these stressors at home by working more, which leads to a never-ending cycle of stress and feelings of imbalance within their lives (Sotile & Sotile, 2000). Research suggests female physicians are significantly more likely to experience burnout and psychological distress related to a professional and personal imbalance, likely due to females taking on more familial responsibilities off shift (Walsh, 2013).

High rates of burnout, depression, substance use, anxiety, and suicidal ideations are believed to be associated with feelings of professional and personal imbalances (Shanafelt, 2011; Shanafelt et al., 2009; Shanafelt et al., 2012). It is believed that one in two physicians are at risk of experiencing burnout, especially those who "work the frontline" and specialize in areas such as emergency medicine, general internal medicine, and family medicine (Shanafelt, Boone, & Tan, 2012). Physicians are also at risk of experiencing compassion fatigue, which is associated with emotional distress (Kadela & Madnawat, 2018; Wilson & Cunningham, 2014). While physicians are working long hours, they tend to be exposed to patient characteristics and trauma, which may affect their stress levels, wellbeing, self-care tendencies, and lead to feelings of a "loss of control" (Myers & Gabbard, 2008; Shapiro et al., 2011; Wilson & Cunningham, 2014). Physicians may experience resurfaced feelings due to an earlier traumatic experience or unresolved grief, which may lead to the physician appearing callous (Myers & Gabbard, 2008). Furthermore, when physicians experience emotional fatigue, they may deplete the resources needed to efficiently cope with their own mental health needs, which may negatively impact their overall wellbeing (Kadela & Madnawat, 2018).

An imbalance in physicians' professional and personal work-life may also negatively impact their work productivity (Schwenk et al., 2008). Physicians who report moderate to severe

depression have indicated they believed their work was negatively impacted up to three times more than their colleagues (Schwenk et al., 2008). Furthermore, physicians experiencing a depressive episode may experience altered judgment for patient care, lethargic feelings and falling behind in work, troubles with decision making and concentrating, ruminations, blaming self for patients' prognosis, and suicidal thoughts (Myers & Gabbard, 2008). Similarly, physicians who experience a disorder such as anxiety may be at risk of medical errors due to tremors, an inability to concentrate, guilty ruminations, or masking the disorder with substances (Myers & Gabbard, 2008).

Physicians who can recognize their mental and physical state incorporate time for their family and friends, set limits on their work hours, and separate work and personal life, which tends to lead to physicians showing more satisfaction within their personal and professional lives (Beresin et al., 2015). Furthermore, physicians have reported they believe they can keep a healthy professional and personal balance when they work for an organization that has family-friendly policies and work with supportive supervisors and colleagues who delegate tasks to reduce pressures within the work environment (Walsh, 2013).

Expected Obligations and Work Ethics

The Accreditation Council for Graduate Medical Education (2011) is responsible for overseeing graduate medical training programs for physicians within the United States. The council directs several residency programs and mandates rules and regulations programs must follow, including areas of competency and resident duty hours.

According to the Accreditation Council for Graduate Medical Education (2011), resident programs are required to include the following competencies in their curriculum: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication

skills, professionalism, systems-based practice, and residents' scholarly activities. Furthermore, the council indicated "programs must be committed to and responsible for promoting patient safety and resident wellbeing in a supportive educational environment" (Accreditation Council for Graduate Medical Education, 2011, p. 54). However, most of the manuscript appears to have little focus on the promotion of resident wellbeing and more focus on patient safety, often making it seem as though the physician's wellbeing is an afterthought.

In 2003, the council restricted residents' duty hours to 80 hours per week, with up to 24-hours of continuous work. At the council's discretion, programs may opt for 88 hours per week (Accreditation Council for Graduate Medical Education, 2011). However, it has been found that many residents work well over 80 hours per week, depending on their rotation (Niederee, 2003). Despite a reported increase in physician wellbeing, some researchers felt the restricted duty hours had negative outcomes, including increased complication rates for high-acuity patients, decreased performance on certification exams, less time for education, and declining patient safety (Ahmed et al., 2014). Regardless of the intended protective barrier for physicians, some individuals appear to disregard the effects the restricted duty hours have on physicians' wellbeing and focus more on patient care and educational aspects.

According to the American Medical Association (2001), physicians have a responsibility to maintain their health and wellness, as the safety and effectiveness of the medical care provided may be compromised if they do not seek appropriate care. The Accreditation Council for Graduate Medical Education (2011) indicated it is the duty of the program to encourage residents to use alertness management strategies such as "strategic napping" to provide the best patient care. The council suggested physicians take naps, use caffeine when sleepy, exercise during duty, and use a bright light (Accreditation Council for Graduate Medical Education, 2011).

However, due to long work shifts, physicians are at risk of becoming impaired and making life-threatening mistakes if they are unable to nap during their shift, as several of their bodies' natural rhythms may be imbalanced including their circadian mechanism, homeostatic mechanism, and sleep inertia (Caldwell et al., 2008). The council listed several alertness management and fatigue mitigation strategies that programs must endorse, including educating physicians to recognize the signs of fatigue and sleep deprivation, educating physicians in alertness management and fatigue mitigation processes, and adopting fatigue mitigation processes to manage negative effects of fatigue on patient care and learning (Accreditation Council for Graduate Medical Education, 2011).

The Code of Medical Ethics provided by the American Medical Association (2001) states physicians should maintain their health and wellness by following healthy lifestyle habits, ensuring that they have a personal physician, and taking appropriate action when their health or wellness is compromised, including engaging in honest assessments of their ability to continue practicing safely and taking appropriate measures to protect patients. However, the lack of guidelines and duty hours specified for attendings and the long 80-hour workweeks set forth for residents do not appear to give physicians adequate time to engage in basic routine needs for self-care (Niederee, 2003). A study performed by Roberts et al. (2000) examined health care needs for physicians during training. Roberts et al. (2000) indicated although 90% of physicians believed they needed to receive health care during training, two-thirds sought informal care from colleagues. Half asked classmates to perform exams for them. Some researchers believe training physicians watch their attendings engage in informal care and unhealthy physical and mental care regimes, resulting in training physicians modeling this behavior and ignoring signs of burnout and fatigue (Brimstone et al., 2007; Mills & Chapman, 2016).

Physicians' Mental Health

High rates of mental illnesses have been increasing among physicians nationwide (Gold et al., 2016; Wilson & Cunningham, 2014). Studies have found physicians in various countries, including England, Denmark, Scotland, and North America, suffer significantly more from drug abuse, alcoholism, depression, suicidal ideation and completion, and psychiatric hospitalizations compared to the general population (Sotile & Sotile, 2000). Data suggest physicians' mental health concerns are nearly three times as high as the general public in some countries (Brooks et al., 2011). Due to the perceived and real barriers to seeking mental health treatment, physicians are reporting high rates of mental health conditions that often go untreated (Brooks et al., 2011; Hope & Henderson, 2014; Sotile & Sotile, 2000). Physicians report experiencing symptoms of mental illnesses as early as medical school training (Dyrbye et al., 2008; Fond et al., 2019; Ludwig et al., 2015; Sotile & Sotile, 2000).

Approximately 40% of female and 27% of male physicians report experiencing pronounced symptoms of anxiety or depression during their training stages, with up to 96% reporting symptoms of psychological distress throughout their medical training (Hope & Henderson, 2014; Myers & Gabbard, 2008; Sotile & Sotile, 2000). Traditionally, women have been shown to experience higher rates of mental illnesses, which puts female physicians at an increased risk of suffering from mental health concerns throughout their training and career (Gold et al., 2016). Ludwig et al. (2015) found that medical students reported increased depression, stress, and substance use, as well as decreased sleep habits, diet, and exercise within their first two years of medical training. Similarly, Fond et al. (2019) found that medical students generally experience increased rates of depression, suicidal ideation, and binge drinking compared to their same-aged peers. Early physicians have reported stressors related to acquiring

an abundance of medical knowledge and experience (Ludwig et al., 2015), balancing their own wellness and professional identity (Sotile & Sotile, 2000), heavy workload and long hours (Brooks et al., 2011; Gold et al., 2016), enduring physical and emotional abuse (Association of American Medical Colleges, 2018; Cook et al., 2014; Sotile & Sotile, 2000), and delayed gratification for their personal life (Sotile & Sotile, 2000). According to the graduate questionnaire obtained by the Association of American Medical Colleges (2018), 42% of medical school graduates reported experiencing adverse behaviors, such as public humiliation, derogatory remarks, and discrimination based on gender, race, sexual orientation, or other personal traits or beliefs throughout their career. Nearly half of training physicians report experiencing mental illnesses such as burnout, anxiety, and depression due to these stressors (Dyrbye et al., 2008; Sen et al., 2010). Common symptoms include emotional exhaustion, depersonalization, decreased feelings of personal accomplishment, and psychological distress from sleep deprivation (Brooks et al., 2011; Wilson & Cunningham, 2014).

It is believed that physicians' stress levels peak during their first year of working post-residency due to a perceived loss of a "safety net" and increased feelings of vulnerability as they face increased risk of malpractice and criticism within their new job (Brewin & Firth-Cozens, 1997; Brooks et al., 2011; Fielden & Peckar, 1999). Approximately half of practicing physicians say they would not choose a medical career again and discourage future generations from entering the field due to the associated stressors that come along with becoming a physician (Association of American Medical Colleges, 2018; Sotile & Sotile, 2000). Researchers suggest that up to 40% of physicians who commit suicide suffered from symptoms of emotional and psychological distress prior to beginning medical training. Up to 60% began to suffer from symptoms of induced stress during their medical training (Sotile & Sotile, 2000). Nationwide

studies suggest approximately one in three physicians are experiencing psychological distress and burnout at any given time, despite their specialty (Kishore et al., 2016).

Although physicians report suffering from mental illnesses throughout their training, over 60% have reported feeling reluctant to seek help, and approximately one-quarter of them do seek professional help (Shanafelt, 2011). Untreated symptoms of the severe mental illnesses physicians may suffer from often lead to suicidal ideations (Dyrbye et al., 2008; Shanafelt, 2011; Zisook et al., 2016). Approximately 300 to 400 physicians in the United States complete suicide every year (Center et al., 2003; Gold et al., 2013; Kishore et al., 2016). It is believed that these numbers may be underreported, as many physician deaths may be mislabeled due to perceived stigma within the medical culture (Vogel, 2018). The high rates of depression and mental illness among physicians are of concern, as both male and female physicians have higher rates of suicidal ideation and completion compared to the general public (Brooks et al., 2011; Gold et al., 2016). Studies have suggested up to 10% of physicians, including medical students, residents, and attendings, are considered high risk for suicide (Zisook et al., 2016, 2016). Data in other countries have revealed that suicide is the second leading cause of death among medical students (Haque, 2018). Studies have found up to 11% of medical students report experiencing suicidal ideations within the past year (Dyrbye et al., 2008), 8.7% of residents and attendings frequently experienced thoughts of self-harming (Zisook et al., 2016, 2016), 6.3% of surgeons experienced suicidal ideations within the past year (Shanafelt, 2011), 2% of physicians have either attempted or made plans within the past two weeks (Zisook et al., 2016, 2016), and 1.6% of students and 2.3% of attendings have previously attempted suicide (Zisook et al., 2016, 2016). Medical students and physicians who have completed suicide were reported to share some common stresses, including feeling severely sanctioned for mistakes, enduring academic stress, failure to

match to residency, bullying, sleep deprivation, and being exposed to vicarious trauma on the job (Vogel, 2018).

Aspects of Personality and Lifestyle Shared Among Physicians as a Cultural Group that Affects their Mental Wellbeing.

Physicians tend to have a strong work identity and share unique personality traits such as perfectionism, compulsiveness, and emotional detachment that allow them to succeed within their careers (Myers & Gabbard, 2008; Sotile & Sotile; Wilson & Cunningham, 2014). However, the constraints and pressures of these personality traits and the typical 80-hour or more workweeks may cause physicians to begin engaging in maladaptive perfectionism, as they are unable to maintain a balanced lifestyle socially, academically, or within their careers (Enns et al., 2001; Myers & Gabbard, 2008; Niederee, 2003). Furthermore, physicians are at risk of experiencing an imbalance in their natural body rhythm (Caldwell et al., 2008), decreased sleep, diet, and exercise habits (Ludwig et al., 2015), and a lack of time to maintain their own wellness and personal identity (Sotile & Sotile, 2000), which may explain the high rates of mental illnesses reported by physicians, including depression, burnout, substance use, anxiety, and suicidal ideation (Shanafelt, 2011; Shanafelt et al., 2009; Shanafelt et al., 2012). Although physicians are reporting high rates of mental illnesses, they often indicate they are reluctant and do not seek treatment due to real and perceived barriers within the cultural society of medical careers (Brooks et al., 2011; Hope & Henderson, 2014; Sotile & Sotile, 2000).

CHAPTER III: PHYSICIANS SELF-CARE TENDENCIES AND BARRIERS TO SEEKING MENTAL HEALTH SERVICES

Physicians Self-Care Tendencies

It has been suggested that medical students and physicians receive inadequate training pertaining to self-care, often resulting in a decrease in their overall wellbeing, as they do not engage in routine self-care regimes (Sanchez-Reilly et al., 2013; Schneider et al., 2014). Although high rates of mental illness among medical students and physicians have been acknowledged for decades, there appears to be little emphasis placed on self-care or mental wellbeing within medical training (Feeney et al., 2016; Mills & Chapman, 2016; Schneider et al., 2014). In 2003 the American Medical Association acknowledged the lack of priority given to physician mental health within the culture of medicine and identified several barriers to seeking treatment. However, there appears to have been little improvement in aiding this disparity (Moutier, 2018). While some institutions have implemented programs focusing on self-care into their curriculum, it appears that most of these programs promote resilience and self-care to prioritize the care of others (Schneider et al., 2014). However, there is little acknowledgment pertaining to the unsafe practice of physicians who continue to neglect their own mental and physical health while caring for patients who tend to be suffering and in pain (Mills & Chapman, 2016). Furthermore, many of the programs that focus on self-care tend to focus on the individual as the sole responsible party for engaging in adequate regimes, suggesting physicians are to blame for their decreased mental health (Vogel, 2018). Sadly, it appears that there is a lack of investment financially and culturally to implement adequate programs teaching the importance of self-care and mental wellbeing into medical training, which likely will continue to lead to increased rates of mental illness among physicians (Peters et al., 2018).

It is believed that physicians learn to model poor self-care behaviors they learn from supervising physicians during their training (Mills & Chapman, 2016; Peters et al., 2018). Several factors seem to influence the perceived deficit in physicians' self-care regimes including lack of time (Myers & Gabbard, 2008; Schneider et al., 2014), lack of encouragement from their work environment (Benkhadra et al., 2016; Vogel, 2018), feeling worried about the process, pressures, and constraints from "hidden curriculum" during training (Peters et al., 2018), and concerns about confidentiality, which may lead to self-prescribing (Schneck, 1998; Sotile & Sotile, 2000). With the stigma related to help-seeking behaviors within the culture of medicine, coupled with the high rates of physician mental health and self-prescribing rights, physicians are at an increased risk of experiencing a fast-paced decline in their self-care regimes and increased risk for suicidal ideation and completion (Moutier, 2018).

Physicians' long work hours tend to interfere with their ability to maintain a healthy diet, adequate sleep, and exercise (Myers & Gabbard, 2008). Physicians do not typically have a set time to eat and tend to work past their scheduled time, leading to a poor diet and inadequate sleep regimes (Myers & Gabbard, 2008; Sotile & Sotile, 2000). Furthermore, physicians may find themselves staying up later at night ruminating about their decisions regarding best practices for their patients' care (Myers & Gabbard, 2008). Due to the high amounts of stress and inability to sleep at night, increasingly, physicians are using prescription medications to help regulate their sleep patterns (Myers & Gabbard, 2008; Sotile & Sotile, 2000). As many physicians are unable to meet basic physiological needs, including adequate food, water, and rest throughout the day, this likely impacts their ability to focus on other needs throughout the day (Gorman, 2010).

Despite physicians having higher rates of mental illnesses, data suggest most physicians do not have their own primary care doctor (Gendel et al., 2012; Haque, 2018; Schneck, 1998).

Physicians indicate they prefer to self-medicate or seek care from a colleague (Schneck, 1998; Sotile & Sotile, 2000). Common barriers to physician healthcare include lack of time (Benkhadra et al., 2016) and loss of privacy (Schneck, 1998). Researchers also suggest many physicians may suffer from "VIP syndrome," which relates to feelings of entitlement and not wanting to be treated like a patient (Schneck, 1998). "VIP syndrome" may include things such as physicians not wanting to wait for care and disagreement on diagnoses or treatment (Schneck, 1998). Thus, rather than seeking care, many physicians continue to work when they should not (Sotile & Sotile, 2000). More than 80% of physicians worldwide have reported they continued to work while they were sick due to a fear of ostracism from their workplace, concerns about continuity of care, and not wanting to let coworkers or patients down (Szymczak et al., 2015).

Physicians tend to devote between 60-80 hours per week to medicine, leaving little time for leisure activities or socializing (Myers & Gabbard, 2008). Physicians often feel fatigued after work, resulting in little interest in socializing with others (Gabbard & Menninger, 1988). Subsequently, physicians' relationships with partners, family, and friends are often affected, which may lead to physicians feeling misunderstood and isolated (Gabbard & Menninger, 1988). Female physicians tend to be at a higher risk, as they typically juggle several roles, including being a physician, mother, wife, and housekeeper (Sotile & Sotile, 2000).

Barriers to Physicians Seeking Mental Health Treatment

Despite medical students and physicians reporting high amounts of mental health concerns, they do not appear to seek treatment for their ailments (Gold et al., 2016). Physicians may likely find it difficult to seek help for numerous reasons. Physicians have reported several barriers to seeking mental health services including time constraints (Guille et al., 2010), concerns regarding stigma (Myers & Gabbard, 2008), fears of being unable to insure themselves

or their family (Gold et al., 2016), and disbelief regarding the effectiveness of psychological treatment (Schwenk et al., 2008). Physicians' reluctance to seek adequate care may lead to pathology being missed, symptoms worsening, and suicidal ideations increasing (Haque, 2018)

The emphasis placed on "cognitive mastery" and the collectivistic nature within the medical culture often lead to physicians ignoring their own wants and needs and implementing those of their workforce over their own (Brewin & Firth-Cozens, 1997; Gabbard & Menninger, 1988). Subsequently, exogenous variables from the medical culture pertaining to mental health concerns and treatment may begin to impede physicians' endogenous beliefs regarding best practice for themselves (Enns et al., 2001). Throughout their training, medical students often indicate they feel pressured to manage their emotions in front of faculty and patients to mask any anxiety or discomfort (Crowe & Brugha, 2018).

Furthermore, medical students have reported feeling reluctant to seek services for any mental health concerns due to a fear of the stigma attached to mental illnesses and the implications it may have on the progression of their careers later in life (Brooks et al., 2011). Due to this stigma, many physicians fail to recognize or report mental illnesses in themselves or colleagues, likely due to the lack of adequate education on mental health and increased feelings of shame and guilt (American Medical Association, 2001; Sotile & Sotile, 2000). It is believed that female physicians may try harder than men to mask their emotions to appear "doctorly" and prove themselves as emotionally competent (Crowe & Brugha, 2018).

Research suggests medicine does not embrace the biopsychosocial model, which leads to neglect of psychosocial issues and physicians' wellbeing, as the medical workplace does not tend to talk about or assess these areas (Shapiro et al., 2011). Moreover, researchers suggest physicians are taught to "detach concern," which allows them to practice sufficiently without

becoming emotionally entangled in their everyday endeavors (Crowe & Brugha, 2018). Due to this, many physicians may adopt the ideation that they can and should push on without help, as they have been trained to rely on high functioning, self-reliant, perfectionistic traits often found within the medical field (Gold et al., 2016). Thus, increasing awareness of the impact psychosocial pressures have on an individual and reducing mental health stigma within the medical field should be initiated within medical school as physicians' mental health concerns may worsen as they progress through their training (Haque, 2018).

Physicians nationwide have indicated they would fear being viewed as weak or incompetent if they were to seek care (Crowe & Brugha, 2018; Myers & Gabbard, 2008; Minh, 2012). Physicians have also reported concerns regarding confidentiality and fear of stigma from the medical field, colleagues, family, and friends (Guille et al., 2010). Physicians have indicated they stray away from seeking mental health services, as they are at risk of being viewed as "impaired" and turned over to the medical board where their competency to care for patients may be questioned, often leading to restrictions or revocation of their license to practice (Minh, 2012; Myers & Gabbard, 2008; Wilson & Cunningham, 2014). In some states, physicians are required to report all mental illnesses and treatment to their state licensing board, often leading to mistreatment of serious mental health concerns that go undiagnosed (Gold et al., 2016).

Licensure Barriers to Seeking Mental Health Services

It has been reported that physicians are unlikely to seek help on their own unless they have been told they would go in front of the medical board, fear they will lose their job, or be pushed by other members (American Medical Association, 2001). Almost 90% of medical licensure applications assess applicants' mental health history (Gold et al., 2016; Polfliet, 2008; Schroeder et al., 2009). Many state licensing boards indicate they believe it is necessary to

inquire about physician mental health to optimize the protection of the public (American Psychiatric Association, 1984; Hendin et al., 2007). However, state medical licensure boards are intended to serve and protect the public through licensure, surveillance, misconduct investigations, and disciplinary actions of physicians, leading many to query whether these questions are necessary (Dyrbye et al., 2017). Questions pertaining to mental health illnesses and treatment are believed to be a major barrier to physicians seeking mental health concerns and may lead to embarrassment and added stress (Dyrbye et al., 2017; Gold et al., 2016).

The majority of states ask broad questions pertaining to physicians' health regarding their physical or mental stature, as well as substance use history (Hendin et al., 2007; Polfliet, 2008; Schroeder et al., 2009). Researchers have found 40 states ask directly about mental illness, 20 inquire about impairment due to mental illness, and 20 question applicants on diagnosis, treatment, and admission to a treatment facility (Hendin et al., 2007). Although Federation of State Medical Boards has advised medical licensure boards not to ask questions pertaining to physicians' history of mental illness due to possible violations of the Americans with Disabilities Act of 1990 (Dyrbye et al., 2017), it is believed that approximately 70% of the applications continue to phrase questions that are impermissible based on the Americans with Disability Act guidelines (Schroeder et al., 2009). Further, researchers found that only 30% of states phrased questions that were congruent with the American Medical Association and the Federation of State Medical Board policies (Dyrbye et al., 2017).

Licensure applications tend to base questions on mental health concerns within the last few months or years. However, some do not give a specific timeframe and can date back to childhood (Hendin et al., 2007; Polfliet, 2008; Schroeder et al., 2009). If physicians check "yes" on any of the boxes, they are at risk of being prompted for more information (Polfliet, 2008).

State licensure boards often require a written explanation; contact information for current and past treating clinicians; detailed letters from treating clinicians regarding diagnosis, treatment, prognosis, and recommendations for treatment and supervision; medical records; self-paid examination by a board-appointed physician; enrollment in a physician health program; acceptance of restrictions to practice; and self-paid inpatient or intensive outpatient treatment with long-term monitoring (Gold et al., 2016; Hendin et al., 2007). More than 30% of state licensure boards indicated that a diagnosis of mental illness is sufficient enough to restrict a physician's ability to practice (Dyrbye et al., 2017).

Subsequently, physicians tend to deny mental health concerns, as they fear their confidentiality may be broken and medical institutions may view them as "impaired," resulting in physicians appearing in front of a medical board, as their license may be revoked due to a question of competency (Myers & Gabbard, 2008). Dyrbye et al. (2017) found that almost 40% of physicians reported feeling reluctant to seek formal care for a mental health concern due to a fear of repercussions to their medical license. Further, it was found that younger male physicians working in private practices were more reluctant to seek help, possibly due to concerns regarding public disclosure of their personal health information (Dyrbye et al., 2017). A similar study performed by Gold et al. (2016) found that of over 2000 participants, fewer than 5% of physicians who had a history of a mental health diagnosis disclosed their treatment on a licensing application. Furthermore, 75% of participants indicated they did not believe the condition posed safety risks to patients, 70% did not think it was relevant to clinical care, 63% did not believe it was the medical boards business, and 75% strongly agreed that medical board questions pertaining to mental health concerns impacted their decision to seek treatment (Gold et al., 2016).

Physician Coping Styles

Physicians endure high demands and experience an imbalance, leading them to be at risk of developing burnout and stress as they attempt to juggle job demands and job skills, a lack of control over work duties, and a discrepancy between resources and expectations of their jobs (Rogers et al., 2016). Throughout their training, physicians endure rigorous labor including long work hours, multi-day exams, the stress of academic and clinical performance, working closely with illnesses and death, and having little time for family, social, or recreational activities (Rogers et al., 2016; Vinothkumar et al., 2016). Further, research indicates that long-term stress may lead to negative physical and emotional wellbeing, poor job performance, poor social interactions, and decreased life satisfaction (Vinothkumar et al., 2016). However, due to real and perceived barriers within the medical field, physicians tend to engage in maladaptive coping methods to deal with these stressors within their professional and personal lives, as they tend to believe having an illness is associated with weakness and vulnerability (Myers & Gabbard, 2008; Schneck, 1998; Shaw et al., 2013; Wilson & Cunningham, 2014). Thus, to avoid being seen as weak or incompetent, physicians tend to avoid or deny their illnesses (Gendel et al., 2012; Guille et al., 2010), self-diagnose (Minh, 2012), minimize their concerns and delay seeking treatment (Guille et al., 2010), or use substances (Sotile & Sotile, 2000). Physicians acknowledged their mental health impacts their work performance and may lead to negative outcomes, further exacerbating their fear of being viewed as incompetent (Guille et al., 2010).

Although most working professionals are at risk of experiencing occupational stress or burnout, the risk is higher for professionals who engage in a helper and client relationship such as medicine (Rogers et al., 2016; Vinothkumar et al., 2016). Thus, it is vital that physicians engage in coping techniques that may help reduce their stressors (Rashid & Talib, 2015).

Researchers have identified two types of coping styles: problem-focused and emotion-focused (Newman & Newman, 2014; Vinothkumar et al., 2016). Research suggests most physicians engage in emotion-focused coping, which includes regulating emotional responses to problems, rather than focusing on managing or altering the problem that is causing the distress (Vinothkumar et al., 2016). It is believed that physicians may intermix emotion-focused coping with the biomedical model to cope, which allows them to block patients' emotional responses and avoid feeling uncomfortable themselves (Shaw et al., 2013).

Due to a fear of being viewed as inept, many physicians have indicated they do not have a regular medical provider. Rather, physicians tend to rely on informal care from colleagues, or they may resort to self-diagnosing and self-prescribing rather than seeking medical or mental health services from an outside source (Gendel et al., 2012; Gold et al., 2016; Minh, 2012; Schwenk et al., 2008). Approximately 85% of physicians have acknowledged they prefer to self-medicate and sign off on their own medical scripts rather than seek care from others (Kepper & Baum, 2014). Although the most commonly prescribed medications physicians self-prescribe are antibiotics, studies have shown some physicians also write their own scripts for medications such as antidepressants, tranquilizers, and hypnotics (Gendel et al., 2012). Further, some physicians have reported they pay for prescriptions using cash to avoid their insurance company gaining knowledge of the medications they use (Gold et al., 2016). Subsequently, physicians underlying diagnoses often go undertreated, as they deny the severity of their symptoms and fail to seek adequate care from an unbiased general practitioner or therapist (Minh, 2012; Schwenk et al., 2008).

Physicians may attempt to avoid or deny their mental health concerns by working more to avoid thinking about or talking to others regarding their wellbeing (Guille et al., 2010). However,

as physicians work more, they are at risk of experiencing more patient illnesses and deaths, which may lead to vicarious trauma of continually breaking bad news to patients and their families (Shaw et al., 2013). Although many physicians describe breaking bad news to patients as a necessary part of their job (Shaw et al., 2013), this continuous exposure likely causes them to repeat the cycle of feeling burned out, depressed, isolated, and so forth, which may cause more negative effects on their overall wellbeing (Guille et al., 2010).

Throughout their training, physicians with high levels of stress have reported increased smoking and caffeine consumption, as well as a decrease in healthy eating, emotional control, physical activity, and sleep patterns (Rogers et al., 2016). Thus, another form of avoidance many physicians tend to engage in is masking their true problems with substance use (Haque, 2018; Sotile & Sotile, 2000). Research suggests physicians' drug dependence is at least 13% higher than the general population, and physicians are five and one-half times more likely to use drugs and two and one-half times more likely to use alcohol (Sotile & Sotile, 2000). As physicians have easy access to medications and other substances, they may quickly resort to these means to cope with their daily stressors (Brooks et al., 2011).

Physicians, especially male physicians, are at an increased risk of continuing to engage in maladaptive coping patterns, as they endure long work hours and high work demands, leaving little opportunity to recover from depletion (Rogers et al., 2016). Subsequently, the medical profession continues to see an increase in mental health concerns among physicians (Sonnentag et al., 2010) and a decrease in overall job satisfaction (Vinothkumar et al., 2016). Studies have found that over 10% of medical students have had serious thoughts of dropping out due to stresses related to academic, personal, professional fit, and mental health concerns (Rogers et al., 2016), while nearly half of physicians who continue into the field later indicate they would not

choose a medical career again for similar reasons (Association of American Medical Colleges, 2018; Sotile & Sotile, 2000).

Impediments to Physician Self-Care Regimes and Wellbeing Within a Medical Culture

Throughout their training and career, physicians devote the majority of their time to medicine, leaving little room for leisurely activities and the ability to maintain healthy levels of essential habits such as sleeping, eating, exercising, or socializing (Myers & Gabbard, 2008). Physicians, specifically females, may feel pressured to fill several roles within their lives, both personally and professionally (Sotile & Sotile, 2000). Subsequently, physicians frequently experience deficits in their ability to engage adequately in self-care regimes. Studies suggest physicians indicate they have difficulty engaging in healthy coping habits to destress from work due to factors such as lacking the time and energy to do so (Myers & Gabbard, 2008) and feeling worried about the pressures and constraints within their work environment (Benkhadra et al., 2016; Peters et al., 2018; Vogel, 2018).

Consequently, this inherent lack of self-care, high rates of mental health concerns, and increasingly demanding jobs leave physicians at an increased risk of experiencing severe pathology (Shanafelt et al., 2012). Yet, physicians indicate they do not seek mental health services, as they fear being stigmatized or viewed as “impaired” and having their competency questioned before their state’s medical board, where they may receive restrictions or revocation of their medical license (Minh, 2012; Myers & Gabbard, 2008; Wilson & Cunningham, 2014). Thus, they often engage in maladaptive coping, such as self-prescribing or denying their symptoms, to conceal the imbalance they feel within their lives, which likely leads to increased mental health symptoms and suicidal ideations (Shaw et al., 2013; Sotile & Sotile, 2000; Wilson & Cunningham, 2014).

CHAPTER IV: CLINICAL IMPLICATIONS

Millions of individuals worldwide are suffering from a mental illness at any given time (Gangi et al., 2016; Pedersen & Paves, 2014). However, despite supporting evidence for treatment, most individuals do not immediately seek mental health services for several reasons (Barney et al., 2006; Crowe et al., 2016; Mackenzie et al., 2006). Individuals suffering from mental health illnesses have described several barriers to accessing care, including gender (Mackenzie et al., 2006), perceived public and self-stigmas (Crowe & Brugha, 2018; Pedersen & Paves, 2014), lack of knowledge pertaining to available treatments (Crowe et al., 2016), and lack of prior experience with mental health services (ten Have et al., 2010). The stigma associated with mental health illnesses is believed to be the largest barrier for individuals seeking treatment (Mackenzie et al., 2006; ten Have et al., 2010). Thus, several individuals have reported they would rather seek mental health services from their primary care physician (Mackenzie et al., 2006), who may treat their mental health symptoms more from a biological standpoint and allow them to feel more accepted by others as they avoid seeking care from a psychiatrist or other mental health professional (Barney et al., 2006).

Physicians Help-Seeking Behaviors

Despite the high reliance on physicians to assess mental health symptoms in others, research suggests physicians are at an increased risk of experiencing high rates of mental illness themselves (Kreitzer & Klatt, 2017). Furthermore, it is believed that physicians also tend to use a biomedical model when they assess their own mental health symptoms, which allows them to manage their stressors from a biological perspective (Shaw et al., 2013). Researchers suggest medicine does not fully embrace the biopsychosocial model, which leads to neglect of psychosocial issues and physicians' wellbeing (Shapiro et al., 2011). Subsequently, for several

decades, physicians nationwide continue to report high rates of untreated symptoms of burnout, depression, anxiety, and other severe mental health illnesses (Shanafelt et al., 2012; Simon & Durand-Bush, 2015; Wallace et al., 2009). Physicians have reported increased symptoms of mental illness beginning as early as medical school (Brewin & Firth-Cozens, 1997; Cohen & Patten, 2005), and their mental health appears to continue to decrease throughout their years of training (Hillhouse et al., 2000). Despite physicians' alarming rates of mental health concerns, they have identified several barriers to engaging in adequate self-care regimes, including seeking mental health services to alleviate their mental health concerns (Guille et al., 2010). Stigma within society and the medical field is believed to play a major role in physicians' avoidance of seeking mental health services (Moutier, 2018).

Paving a Path for Improving Physicians Mental Health and Wellbeing

Similar to many other individuals, physicians nationwide report a reluctance to seek mental health services (Dyrbye et al., 2017). Physicians have indicated they are unwilling to engage in treatment for several reasons, including a fear of being stigmatized and labeled as an unfit provider (Minh, 2012; Wilson & Cunningham, 2014). It is believed that physicians have associated a fear of stigma with medical board licensure application questions, which tends to give the impression that mental illness makes one incapable of efficaciously performing their job (Barney et al., 2006). However, with physicians working in a very demanding and stressful sector that requires them to always be competent, empathetic, and ethical, they are at risk of quickly becoming mentally and physically fatigued if they do not sufficiently tend to their own wellbeing (Kadela & Madnawat, 2018). Thus, it is believed that one of the first steps to providing physicians with adequate care is to reduce stigma and emphasize that the illness does not equate to impairment, both on a personal and structural level (Moutier, 2018).

Stigma reduction techniques. Stigma reduction is a core concept that should be implemented early on within physician training. As physicians progress through their training, they endure emotional and physical strains within the medical culture that most likely will deplete their overall wellbeing (Fong Ha & Longnecker, 2010). Thus, it is essential that they are provided with resources where they believe they can obtain safe and confidential services. Due to the high rates of physicians reporting mental health concerns beginning as early as medical school (Brewin & Firth-Cozens, 1997; Cohen & Patten, 2005), stigma reduction techniques such as routine informal and formal lectures and required hours for continuing medical education credits should be implemented to address subjects such as mental health illnesses and their impacts on an individual's overall wellbeing, available treatments, and time management for self-care.

Educating larger organizations and policymakers on mental health illnesses and positive outcomes of treatment may aid in reducing stigma, allowing physicians to feel supported, and bridging the gap between increasing rates of mental health concerns and declining help-seeking behaviors among this population (Moutier, 2018). Similar to physician training, it may be helpful to provide routine informal and formal lectures to larger organizations that focus on normalizing mental health concerns, discussing the implications of untreated symptoms, and providing information on available resources within the community. Studies comparing suicide rates of the general population and physicians found that physicians were less likely to be receiving treatment for their mental health concerns and more likely to have recently experienced a job-related problem (Moutier, 2018). Thus, it is vital for physicians to feel understood and supported within the medical culture, which includes working within an environment where the hospital management, supervisors, and colleagues understand and acknowledge the hardships they are

faced with, allowing them to accept and take care of themselves and each other (Kadela & Madnawat, 2018; Kaliannan et al., 2016).

Treating Physicians in Clinical Mental Health Settings

Physicians often have an autonomous and dominant position within their career that is accompanied by prestige (Tarkowski et al., 2016). Their educational background and social status may affect the way they identify, interpret, and classify symptoms, including those concerning mental health conditions (Shapiro et al., 2011; Tarkowski et al., 2016). Due to physicians' medical knowledge, they may question the therapist's competence and diagnosis, which affects their willingness to cooperate within treatment (Tarkowski et al., 2016). Moreover, physicians may lack the resources to deal with their own mental health concerns due to the emotional fatigue they may experience on a day-to-day basis working within a highly demanding and stressful environment (Kadela & Madnawat, 2018). Thus, similar to doctor-patient goals, it is essential to create a good interpersonal relationship, facilitate a safe environment where they are comfortable disclosing information, and include them in decision making for their treatment within therapy to account for the multicultural differences between the medical and psychological realms (Fong Ha & Longnecker, 2010).

Recommendations for working with physicians throughout therapy. Physicians often are reluctant to admit to mental health concerns due to several factors, including fear, denial, an irrational ideation that one must be invincible, loss of self-confidence, or an inability to take on the role of a patient (Tarkowski et al., 2016). Thus, it is crucial to begin treatment by normalizing their fears and discussing that mental illnesses do not equate to impairment or weakness (Moutier, 2018). Furthermore, to reduce physicians' fear, at the beginning of treatment, therapists should discuss their confidentiality terms, as well as their competence in working with

this population (Fairburn & Cooper, 2011). It may be helpful to discuss the ways the therapist writes summaries or notes for each session, which may also ease physician patients who may feel vulnerable and unwilling to disclose due to a fear of others obtaining their records. Providing a patient-centered environment allows physicians to feel safe and comfortable, permitting them to feel more at ease about the process (Fong Ha & Longnecker, 2010). Similarly, allowing physicians to feel treated as a partner throughout the therapeutic process, rather than a "patient," may alleviate the fear of being viewed as weak throughout their treatment (Tarkowski et al., 2016).

Physicians may feel misunderstood, as they likely have mastered denying their mental health concerns throughout their training (Minh, 2012; Schwenk et al., 2008). Thus, forming a strong therapeutic alliance helps physicians feel understood and heard. During treatment, it is important to be patient with physicians and understand that their style of communication and vocabulary may differ from the treating therapists, as physicians may seem less empathetic or substitute techniques and procedures for talking, thus, focusing on nonverbal cues may be a more reliable source of how they are truly feeling in session (Fong Ha & Longnecker, 2010). Additionally, although both physicians and therapists are exposed to an abundance of traumatic stories and experiences throughout their careers, one must never compare or assume they understand physicians' suffering, as this may make them feel misunderstood and regress treatment progress (Jaredić et al., 2017). It is crucial to follow the physician's lead within therapy while also setting boundaries that allow them to receive the best course of care. Further, therapists should keep in mind that there is no specific form of therapy that works best for physicians; rather, utilizing relevant techniques and collaborating with the physician may be the most beneficial route for successful treatment.

Implications for Working with Physicians in Clinical Mental Health Settings

Although the majority of the general population indicate they would rather seek mental health services from their primary care physician (Mackenzie et al., 2006), many physicians tend to neglect their own mental health concerns, which may create a barrier to providing adequate treatment (Kreitzer & Klatt, 2017). Many physicians have reported experiencing mental health concerns beginning in medical school (Brewin & Firth-Cozens, 1997; Cohen & Patten, 2005), yet, despite evidence showing treatment is effective, most do not seek help due to a fear of being stigmatized and labeled as an unfit provider (Minh, 2012; Wilson & Cunningham, 2014). Thus, it is believed that utilizing stigma reduction techniques on a personal and structural level within the medical culture may aid in allowing physicians to attend to their mental wellbeing adequately and seek services (Moutier, 2018). Stigma reduction techniques may include routine informal and formal lectures that focus on normalizing mental health concerns, discussing the implications of untreated symptoms, and providing information on available resources within the community, as well as including required hours for continuing medical education credits to address subjects such as mental health illnesses, available treatments, and time management for self-care. Once physicians engage in treatment, therapists must foster a strong therapeutic alliance, provide a safe and confidential environment, and include physicians in decision making to ensure they receive adequate care (Fong Ha & Longnecker, 2010).

CHAPTER V: SUMMARY

Medicine is believed to be one of the most stressful fields to enter (Cohen & Patten, 2005; Hillhouse et al., 2000; Shanafelt et al., 2012). While the reward for advancing within the medical field may include financial gains, reputation, and status (Wilson & Cunningham, 2014), these advantages also put physicians at risk of experiencing high amounts of stress and intense feelings that their personal lives are on hold as they focus on their career and the care of others (Sotile & Sotile, 2000). Physicians undergo rigorous training for over 10 years before they may practice independently (Dyrbye et al., 2006). Throughout their career, physicians endure distressing events, including personal stressors and exposure to the pain and suffering of thousands of patients (Mills & Chapman, 2016). Despite these experiences, physicians appear to have little time to take breaks and incorporate time for self-care to attend to their mental wellbeing properly (Kishore et al., 2016; Mills & Chapman, 2016). Thus, many physicians often experience symptoms of mental health illnesses (Sotile & Sotile, 2000). However, the majority of physicians who do suffer from mental illnesses do not appear to seek out support and suppress their symptoms, further exacerbating their illnesses (Kepper & Baum, 2014; Schneck, 1998; Sotile & Sotile, 2000; Wilson & Cunningham, 2014). As the nation tends to rely on adequate healthcare to aid in their ailing concerns (Mackenzie et al., 2006), it is important to understand the culture of medicine and its impact on physicians' mental health and self-care tendencies to create more effective clinical strategies to strengthen physician wellness.

This study sought to explore the relationship between physicians' mental health, attitudes, and behaviors toward self-care and the utilization of mental health services. The study assessed physicians' mental health concerns, coping tendencies, and whether there are barriers to

physicians engaging in adequate self-care, which may impact their overall wellbeing and mental health. The following literature review questions were generated to shed light on this topic.

Literature Review Question 1: What Aspects of Personality and Lifestyle are Uniquely Shared among Physicians as a Cultural Group that may Affect their Mental Wellbeing?

Theorists suggest physicians exhibit similar traits that affect their overall mood and mental wellbeing within the field of medicine (Sotile & Sotile, 2000). It is believed that many physicians possess traits such as compulsiveness (Sotile & Sotile, 2000), neuroticism (McManus et al., 2004), emotional detachment (Sotile & Sotile, 2000), and perfectionism (Myers & Gabbard, 2008; Sotile & Sotile; Wilson & Cunningham, 2014). Theorists also suggest throughout their training, physicians may engage in a compulsive triad of self-doubt, guilty feelings, and an exaggerated sense of responsibility (Myers & Gabbard, 2008). As the medical field tends to be viewed as a collectivistic culture, physicians who have a strong work identity often put their workplace, colleagues', and patients' needs over their own (Enns et al., 2001; Brewin & Firth-Cozens, 1997). Subsequently, physicians tend to work more to perfect their medical skills and gain the approval of their patients, colleagues, and workplace (Enns et al., 2001; Brewin & Firth-Cozens, 1997; Wilson & Cunningham, 2014). While many of these shared traits likely help physicians excel within their careers, they could also harm their overall wellbeing, as the medical field favors "cognitive mastery," resulting in physicians beginning to engage in maladaptive perfectionism due to the ideation that they should perfect their skills and not make any medical errors (Enns et al., 2001; Gabbard & Menninger, 1988; Myers & Gabbard, 2008). Furthermore, physicians may doubt their abilities due to ambivalent feelings in their capability to learn and retain new information and care for all their patients (Enns et al., 2001). When physicians begin to engage in the compulsive triad, they are at risk of experiencing higher

levels of mental health illnesses, such as depression, anxiety, and burnout (Myers & Gabbard, 2008).

High rates of mental illnesses have been increasing among physicians nationwide (Gold et al., 2016; Wilson & Cunningham, 2014). Data suggest physicians' mental health concerns are nearly three times as high as the general public (Brooks et al., 2011). Due to physicians working over 80 hours per week, they often endure professional and personal imbalances, resulting in them becoming at risk of experiencing high rates of burnout, depression, substance use, anxiety, and suicidal ideations (Shanafelt et al., 2009; Shanafelt, 2011; Shanafelt et al., 2012). They are also at risk of experiencing compassion fatigue due to the high amounts of emotional distress they bear throughout their career, which may result in them depleting the resources needed to cope efficiently with their own mental health needs (Kadela & Madnawat, 2018; Wilson & Cunningham, 2014). Physicians report experiencing symptoms of mental illnesses as early as medical school as they attempt to perfect their skills and retain an abundance of new academic material (Dyrbye et al., 2008; Fond et al., 2019; Ludwig et al., 2015; Sotile & Sotile, 2000). Data suggest approximately 40% of female physicians and 27% of male physicians experience pronounced symptoms of anxiety or depression during their training stages, with up to 96% reporting symptoms of psychological distress (Hope & Henderson, 2014; Myers & Gabbard, 2008; Sotile & Sotile, 2000). Sadly, although physicians report suffering from mental illnesses throughout their training, over 60% have reported feeling reluctant to seek help (Shanafelt, 2011). Nearly 400 physicians complete suicide every year in the United States, which may be due to the high rates of mental illnesses and lack of treatment within this population (Center et al., 2003; Gold et al., 2013; Kishore et al., 2016).

More information on generational differences, specialty and training type, gender, and ethnicity factors may help identify further factors that may either aid or harm physicians' mental wellbeing throughout their career.

Literature Review Question 2: In What Ways do Physicians' Attitudes toward Self-care Relate to the Management of Mental Health Concerns?

While high rates of mental illness among physicians have been acknowledged for decades, there appears to be little emphasis placed on self-care or mental wellbeing within medical training (Feeney et al., 2016; Mills & Chapman, 2016; Schneider et al., 2014). Many of the ethical guidelines and programs within the medical field that focus on self-care tend to emphasize the individual as the sole responsible party for engaging in adequate regimes, suggesting physicians are to blame for their decreased mental health rather than the medical culture as a whole (Vogel, 2018). Consequently, it is believed that physicians receive inadequate training pertaining to self-care, often resulting in them suppressing their true needs and incurring a decrease in their overall mental wellbeing (Sanchez-Reilly et al., 2013; Schneider et al., 2014).

Throughout their training, physicians endure rigorous labor including long work hours, multi-day exams, the stress of academic and clinical performance, working closely with illnesses and death, and having little time for family, social, or recreational activities (Rogers et al., 2016; Vinothkumar et al., 2016). Despite these hardships, physicians have identified several barriers to engaging in adequate self-care regimes including lack of time (Myers & Gabbard, 2008; Schneider et al., 2014), lack of encouragement from their work environment (Benkhadra et al., 2016; Vogel, 2018), high curriculum demands (Peters et al., 2018), and concerns about confidentiality (Schneck, 1998; Sotile & Sotile, 2000). Furthermore, physicians' long work hours tend to interfere with their ability to maintain a healthy diet, adequate sleep, and exercise (Myers

& Gabbard, 2008). Physicians may also feel misunderstood and isolated when they experience a loss of social support, as they often feel fatigued after work and have little interest in socializing with others (Gabbard & Menninger, 1988). Due to the lack of self-care, physicians are at an increased risk of experiencing burnout and other mental health concerns (Shanafelt et al., 2012). Despite these concerns, most physicians report they do not seek services from either a mental health professional or an unbiased primary care doctor; rather, they prefer to self-medicate or seek care from a colleague (Gendel et al., 2012; Schneck, 1998; Sotile & Sotile, 2000).

As physicians often have difficulty engaging in healthy coping habits to destress from their demanding work environment due to factors such as lacking the time and energy to do so (Myers & Gabbard, 2008) and feeling worried about the pressures and constraints (Benkhadra et al., 2016; Peters et al., 2018; Vogel, 2018), they continue to experience high rates of mental health concerns (Shanafelt et al., 2012). Physicians often engage in maladaptive coping methods to deal with their daily stressors, which likely leads to increased mental health concerns (Guille et al., 2010; Rogers et al., 2016; Vinothkumar et al., 2016). Physicians may avoid or deny their illnesses (Gendel et al., 2012; Guille et al., 2010), self-diagnose or self-prescribe (Minh, 2012), minimize their concerns and delay seeking treatment (Guille et al., 2010), or use substances (Sotile & Sotile, 2000).

Information pertaining to physicians' training background, specialty type, familial status, and work environment may help understand barriers to engaging in adequate self-care, including time constraints both inside and outside of work.

Literature Review Question 3: What Barriers to Seeking Mental Health Services Exist for Physicians, which Impede Acknowledgment or Receipt of Mental Health Services?

Throughout their training, physicians have indicated they feel pressured to manage their emotions in front of faculty and patients beginning as early as medical school due to a fear of the stigma attached to mental illness and the implications it may have on the progression of their careers (Brooks et al., 2011; Crowe & Brugha, 2018). Due to this attached stigma, it is believed that many physicians believe they can and should ignore their concerns without help, as they have been trained to rely on high functioning, self-reliant, perfectionistic traits often found within the medical field (Gold et al., 2016).

Physicians have also indicated a major barrier to seeking mental health services is the ideation that they may be viewed as "impaired" and turned over to the medical board where their competency to care for patients may be questioned, leading to restrictions or revocation of their license to practice (Minh, 2012; Myers & Gabbard, 2008; Wilson & Cunningham, 2014). It was found that almost 90% of medical licensure applications assess physicians' mental health (Gold et al., 2016; Polfliet, 2008; Schroeder et al., 2009). If physicians check "yes" on any of the boxes, they are at risk of being prompted for more information, as more than 30% of state licensure boards believe that a diagnosis of mental illness is sufficient enough to restrict a physician's ability to practice (Dyrbye et al., 2017; Polfliet, 2008). Subsequently, this is believed to be a major barrier to physicians seeking mental health services, as they may feel embarrassed to admit to "weaknesses" (Dyrbye et al., 2017; Gold et al., 2016).

Physicians have also identified barriers such as time constraints (Guille et al., 2010), a fear of being unable to obtain adequate medical insurance (Gold et al., 2016), and disbelief regarding the effectiveness of psychological treatment (Schwenk et al., 2008). Despite high rates

of mental illness and a lack of time for self-care, many physicians may feel unable to leave the medical field due to high amounts of debt and the perceived inability to care for their families. These ideations likely lead to further feelings of being incompetent and shameful of their abilities within a highly demanding job (Enns et al., 2001). Furthermore, the collectivistic nature and emphasis on "cognitive mastery" within the medical culture may lead to exogenous variables from the medical field pertaining to mental health concerns and treatment obstructing physicians' endogenous beliefs regarding best practice for themselves (Enns et al., 2001). Unfortunately, physicians' inability and reluctance to seek services may lead to severe pathology going untreated, as well as increased risk for suicidal ideations (Haque, 2018). Figure 1 was created by the author to outline the impact that physicians' neglect of self-care and extraneous barriers to mental health services have on their overall mental health wellbeing.

Figure 1. Impact of barriers to physician's mental health wellbeing.

It may also be beneficial in learning more about physicians' preferences in terms of degree status, facility type, and distance from home or work in terms of seeking services to assist in ensuring they obtain proper information to gain access to services that best fit their needs.

Literature Review Question 4: Given Unique Aspects of this Career Group, what Implications Exist for the Provision of Best Practices for Treating Physicians in Clinical Mental Health Settings?

Millions of physicians worldwide are suffering from a mental health illness (Gangi et al., 2016; Pedersen & Paves, 2014). However, despite supporting evidence for treatment, most individuals do not immediately seek mental health services for several reasons (Barney et al., 2006; Crowe et al., 2016; Mackenzie et al., 2006). It is believed that physicians associate a fear of stigma with medical board licensure application questions, which tends to give the impression that mental illness makes one incapable of performing their job effectively (Barney et al., 2006). With physicians working in a very demanding and stressful sector that requires them to always be competent, they are at risk of quickly becoming mentally and physically fatigued if they do not tend to their own wellbeing sufficiently (Kadela & Madnawat, 2018).

Thus, it is believed that utilizing stigma reduction techniques on a personal and structural level within the medical culture would allow physicians to attend to their mental wellbeing adequately, including gaining time for self-care regimes and seeking mental health services as needed (Moutier, 2018). Reducing mental health stigma within the medical field should be initiated within medical school, as physicians' mental health concerns may worsen as they progress through their careers (Haque, 2018). Although programs in other countries, such as Australia (Mills & Chapman, 2016) and the United Kingdom (Brown, 2008), have begun to implement programs teaching medical personnel the importance of self-compassion and its impact on physicians' overall wellbeing, most programs do not seem to enforce or follow up on participation. Thus, it is believed that most physicians do not engage in or seek services within these programs due to the perceived barriers associated with these topics within the medical field (Dahlin & Runeson, 2007). Therefore, these programs should be mandatory and made part of

their curriculum within medical school, residency, and continuing education post-graduation. Educating larger medical organizations may also aid in reducing stigma, allowing physicians to feel supported and bridging the gap between increasing rates of mental health concerns and declining help-seeking behaviors among this population (Moutier, 2018). Resourceful topics may include mental health illnesses and their impacts on an individual's overall wellbeing, available treatments, and time management for self-care.

Although the concerns of stigma are worldwide, they appear to severely impact physicians within the medical field. It is key to reduce this stigma and allow physicians to feel they have a safe, confidential space to seek services. The following figure was created by the author to depict a hierarchy of recommendations for therapists to adopt to provide a positive experience for physicians who do seek services.

It is essential to create a good interpersonal relationship and facilitate a safe environment where physicians are comfortable disclosing information. Including physicians in decision making for their treatment helps them feel less like a patient and more like a partner, as well as account for the multicultural differences between the medical and psychological realms (Fong Ha & Longnecker, 2010). It is also recommended that therapists outline their credentials in working with this population, as well as their routines regarding writing session notes and breaking confidentiality. Due to several factors such as physicians' fear, denial, irrational ideations that one must be invincible, loss of self-confidence, and an inability to take on the role of a patient (Tarkowski et al., 2016), it is crucial to begin treatment by normalizing their fears and discussing that mental illnesses do not equate to impairment or weakness (Moutier, 2018). Further, therapists need to be patient with physicians and understand that their view of mental health and style of communication may differ from the treating therapists, thus, focusing on

nonverbal cues and listening for key details may be a more reliable source of how they are truly feeling (Fong Ha & Longnecker, 2010).

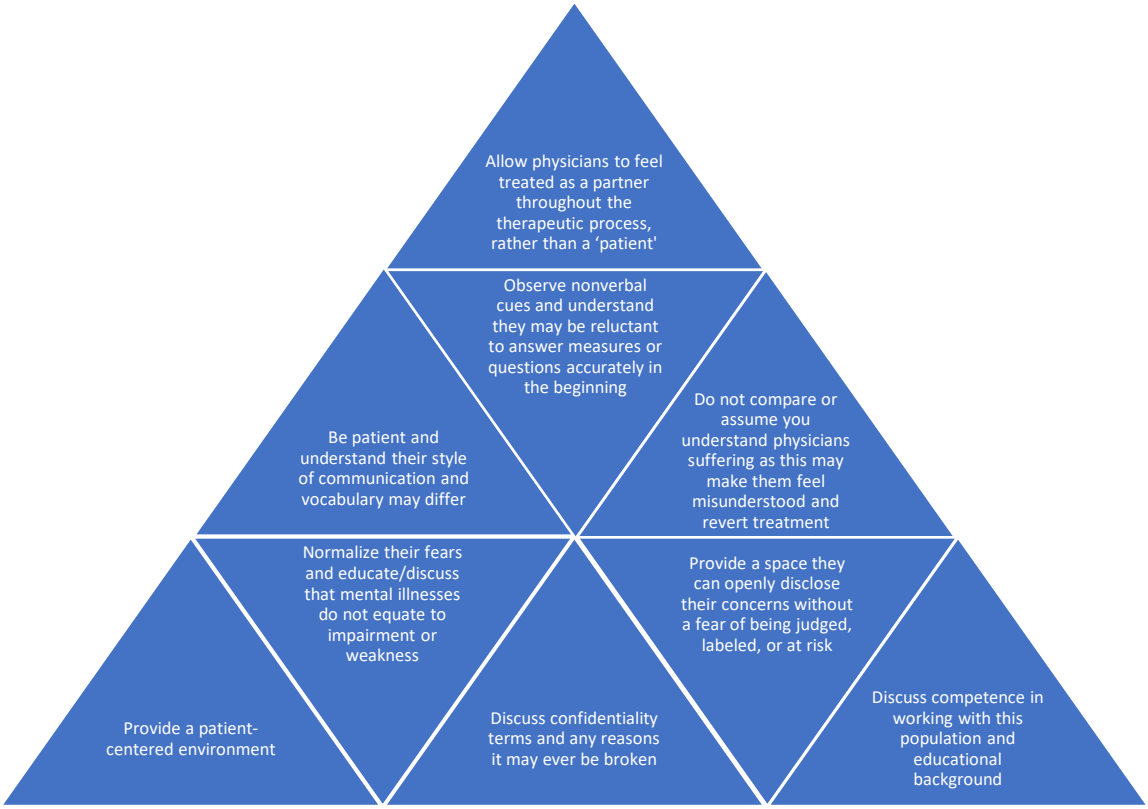

Figure 2. Hierarchy of recommendations to aid therapists to successfully work with physicians.

Providing resources for physicians who are not in one's direct network may help allow physicians to feel they can obtain confidential services. Further, working with state medical licensure boards and implementing strict rules and regulations on the type of questions they can ask should be considered. As mentioned, approximately 70% of the applications use questions that are impermissible based on the Americans with Disabilities Act guidelines (Schroeder et al., 2009). It seems as though many of these licensing applications place more emphasis on physicians' mental health than other important aspects, including their expertise and skills to perform the job. The fear and stigma associated with medical board licensure applications give

the impression that mental illness makes one incapable of successfully thriving; however, research has supporting evidence showing proper treatment for mental health illnesses can effectively decrease symptoms (Barney et al., 2006; Crowe et al., 2016). Despite evidence supporting treatment, physicians continue to be affected by the associated stigma, leading them to believe they must deny or avoid their symptoms, as they are not acceptable. However, the denial of these mental health concerns continues to lead to increasing rates of physician suicide (Center et al., 2003; Gold et al., 2013).

Limitations

Due to the real and perceived stigma associated with mental health illnesses within the medical field, it is believed that most of the available statistics may include underreported rates of physician mental health and self-seeking behaviors. Although there are varying rates of mental illnesses within this population being reported, the overall numbers tend to be alarming and may be higher than expected. Similar to the barriers associated with seeking care, physicians may be reluctant to report their symptoms and illnesses due to a fear that their workplace may find out. It may be difficult to gauge an accurate statistic for mental health concerns among this population; however, the current rates are alarming and should aid in reduction techniques moving forward.

Regarding self-care, there is limited research on physician's self-care regimes, which may be due to the lack thereof or an inability to measure those differences adequately. Because self-care looks different for everyone, it may be a difficult concept to define and measure. Thus, there is a need for continued research in this area, as physicians' mental wellbeing continues to decline with time. Utilizing or creating standardized self-care measures, coupled with mental health screeners, may assuage this gap.

Similarly, there is limited research that measures multicultural considerations among this population. Studies that consider things such as diversity, ethnicity, gender, specialty, training type, and work environment may help differentiate whether mental health concerns and a lack of self-care are shared among certain groups. Continued research looking specifically at targeted factors within this population will be beneficial in providing the best care possible to decrease the continued high rates of mental health concerns among physicians.

Recommendations for Future Research

It would be beneficial to complete an empirical study assessing possible associations between physician's mental health, self-care tendencies, and the utilization of mental health services. Standardized questions from measures such as the *DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure* (American Psychiatric Association, 2013), *Self-Care Questionnaire* (The Institute for Functional Medicine, 2016), and *Inventory of Attitudes Toward Seeking Mental Health* (Mackenzie et al., 2004) may help obtain relevant information to assess physicians' mental health and self-care practices, including seeking mental health services. See Appendix A for the author's suggested survey combining these measures.

The *DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure* (American Psychiatric Association, 2013) includes questions designed to inquire how often the individual has been bothered by the specific symptom during the past two weeks and is used as a mental health screener to identify areas that may have a significant impact on the individual's treatment and prognosis. This information may help assess physicians' mental health concerns and the severity of their symptoms. The *Self-Care Questionnaire* (The Institute for Functional Medicine, 2016) is designed to assess participants' self-care tendencies and contains four subscales: physical wellbeing, mental/emotional/spiritual wellbeing, professional life/work/career, and social

life/family/relationships. This may aid in assessing the frequency of physicians engaging in self-care tendencies. Last, the *Inventory of Attitudes Toward Seeking Mental Health Services* scale assesses participants' attitudes toward seeking professional psychological services and measures their psychological openness, help-seeking propensity, and indifference to stigma. This information may help assess hypotheses regarding physicians' beliefs and feelings toward seeking professional care for their mental health concerns.

It would also be advantageous to implement mandatory self-care programs in medical schools, residencies, and work settings that would allow physicians to receive adequate training and time to implement such techniques. As the medical realm often "emphasizes" the importance of engaging in alertness strategies, allowing physicians to adequately eat, relax, and take time throughout the day may be beneficial to their mental wellbeing and work performance. It would be beneficial to utilize a longitudinal study on the effectiveness of such a program across several programs. It may be helpful to measure whether participants who receive self-care training and program implementation throughout their career fare better in terms of mental health concerns compared to those who do not receive such training.

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Appendix: Sample Measure for Physician Study on Mental Health Concerns and Self-Care

Demographics
Age:

Gender
- Male
- Female

Ethnicity
- Black or African American
- Caucasian
- Asian
- American Indian or Alaska Native
- Hispanic
- Native Hawaiian or Other Pacific Islander
- Other:

Marital Status
- Married
- Committed Relationship
- Divorced
- Single
- Widowed

Training Experience
Type of Training
- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- The Doctorate of Medicine and of Philosophy (MD–PhD)

Current stage of training
- Resident
- Fellow
- Attending
- Specialty Type

Years in practice/training (post-medical school):

Mental Health
Have you ever been diagnosed with a mental health condition?
- Yes
- No

If so, when did it begin?
- o Childhood
- o Adolescence
- o Undergrad
- o Medical School
- o Residency
- o Fellowship
- o After graduation
- o Other:

Have you ever battled with an undiagnosed mental health condition?
- o Yes
- o No

If so, when did it begin?
- o Childhood
- o Adolescence
- o Undergrad
- o Medical School
- o Residency
- o Fellowship
- o After graduation
- o Other:

Current Mental Health Symptoms
The questions below ask about things that might have bothered you over the past two weeks.

For each item indicate how often you have felt bothered by each problem during the past TWO (2) weeks: none - not at all (0), slight - rare, less than a day or two (1), mild - several days (2), moderate - more than half the days (3), or severe - nearly every day (4).

Little interest or pleasure in doing things?
0 1 2 3 4

Feeling down, depressed, or hopeless?
0 1 2 3 4

Feeling more irritated, grouchy, or angry than usual?
0 1 2 3 4

Feeling nervous, anxious, frightened, worried, or on edge?
0 1 2 3 4

Feeling panic of being frightened?
0 1 2 3 4

Avoiding situations that make you anxious?
0 1 2 3 4

Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?
0 1 2 3 4

Thoughts of actually hurting yourself?
0 1 2 3 4

Problems with sleep that affected your sleep quality overall?
0 1 2 3 4

Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?
0 1 2 3 4

Unpleasant thoughts, urges, or images that repeatedly enter your mind?
0 1 2 3 4

Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?
0 1 2 3 4

Not knowing who you really are or what you want out of your life?
0 1 2 3 4

Not feeling close to other people or enjoying your relationships with them?
0 1 2 3 4

Drinking at least 4 drinks of any kind of alcohol in a single day?
0 1 2 3 4

Smoking any cigarettes, cigar, or pipe, or using snuff or chewing tobacco?
0 1 2 3 4

Using any of the following medicines ON YOUR OWN, that is, without a prescribing doctors' prescription, in greater amounts or longer than prescribed (e.g., painkillers, stimulants, sedatives or tranquilizers, or drugs like marijuana, cocaine or crack, club drugs (ecstasy), hallucinogens, heroin, inhalants or solvents, or methamphetamine)?
0 1 2 3 4

Views and Behaviors Regarding Self-care

Self-care is defined as any activity that an individual does in order to take care of their mental, emotional, physical, spiritual, professional, and social wellbeing.

For each item indicate whether you engage in the following activities: never (0), rarely (1), sometimes (2), regularly (3), or always (4).

Do you feel like you engage in an adequate amount of self-care?

- o Yes
- o No

Physical Wellbeing

How often do you:

Drink enough water?

0 1 2 3 4

Exercise for more than 20 minutes?

0 1 2 3 4

Sleep at least 7 hours per night?

0 1 2 3 4

Make time to relax or nap?

0 1 2 3 4

Engage in stress-reducing activities (excluding TV or screen time)?

0 1 2 3 4

Feel nourished, healthy, and strong?

0 1 2 3 4

Mental/Emotional/Spiritual Wellbeing

How often do you:

Make time to participate in things you enjoy?

0 1 2 3 4

Feel understood and valued by those who are close to you?

0 1 2 3 4

Feel gratitude on a daily basis?

0 1 2 3 4

Find meaning in life even during difficult times?
0 1 2 3 4

Take an interest in or find joy in the world around you?
0 1 2 3 4

Have hope that things will get better?
0 1 2 3 4

Professional Life/Work/Career
Hold a work position in an area of your interest?
0 1 2 3 4

Find a sense of meaning and enjoyment in your work?
0 1 2 3 4

Feel supported at work or in your professional life?
0 1 2 3 4
Have someone you can rely on if you need help or guidance?
0 1 2 3 4

Set limits at work, whether it be with clients or tasks?
0 1 2 3 4

Disengage and leave pressures behind at the end of the day?
0 1 2 3 4

Social Life/Family/Relationships
How often do you:

Have a dependable person who listens to you?
0 1 2 3 4

Have supportive family and friends close by?
0 1 2 3 4

Feel like your close relationships are loving and supportive?
0 1 2 3 4

Do something fun with family or friends at least once a week?
0 1 2 3 4

Feel like your personal life brings balance to your professional life?
0 1 2 3 4

Feel comfortable asking for help when you need it?
0 1 2 3 4

Views of Treatment
Have you ever sought services for a mental health condition?
- o Yes
- o No

If so, from whom?
- o Primary care doctor
- o Psychiatrist
- o Psychologist
- o Counselor
- o Friends/Family
- o Anonymous hotline
- o Other:

Inventory of Attitudes Toward Seeking Mental Health Services
The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, family physicians). The term psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, mental troubles, and personal difficulties.

For each item, indicate whether you disagree (0), somewhat disagree (1), neutral (2), somewhat agree (3), or agree (4).

There are certain problems which should not be discussed outside of one's immediate family.
0 1 2 3 4

I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.
0 1 2 3 4

I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
0 1 2 3 4

Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
0 1 2 3 4

If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
0 1 2 3 4

Having been mentally ill carriers with it a burden of shame.
0 1 2 3 4

It is probably best not to know everything about oneself.
0 1 2 3 4

If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
0 1 2 3 4

People should work out their own problems, getting professional help should be a last resort.
0 1 2 3 4

If I were to experience psychological problems, I could get professional help if I wanted to.
0 1 2 3 4

Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.
0 1 2 3 4

Psychological problems, like many things, tend to work out by themselves.
0 1 2 3 4

It would be relatively easy for me to find the time to see a professional for psychological problems.
0 1 2 3 4

There are experiences in my life I would not discuss with anyone.
0 1 2 3 4

I would want to get professional help if I were worried or upset for a long period of time.
0 1 2 3 4

I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.
0 1 2 3 4

Having been diagnosed with a mental disorder is a blot on a person's life.
0 1 2 3 4

There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.
0 1 2 3 4

If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

0 1 2 3 4

I would feel uneasy going to a professional because of what some people would think.

0 1 2 3 4

People with strong characters can get over psychological problems by themselves and would have little need for professional help.

0 1 2 3 4

I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

0 1 2 3 4

Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."

0 1 2 3 4

I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

0 1 2 3 4

Possible Barriers to Treatment

Do you feel like there are any specific barriers to seeking mental health services (e.g., difficulty with licensure, stigma)?

- o Yes
- o No

If so, please select the items below that you feel are barriers to seeking mental health services.

- o Lack of time
- o Cost concerns
- o Lack of convenient access
- o Confidentiality concerns
- o Fear of being brought in front of the medical board
- o Stigma concerns
- o Fear of being viewed as "impaired" or "incompetent"
- o Fear of license being revoked

Please briefly describe any other barriers to seeking mental health services.

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