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# Context guides illness-identity: A qualitative analysis of Dutch university students' non-help-seeking behavior

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***Abstract:*** The purpose of this article is to develop a context-based and identity-centered perspective on help-seeking. Recent approaches have indicated the inability of conventional models of help-seeking to account for the non-utilization of health care services in situations for which services, resources and information are adequately provided. We address this non-utilization from a perspective that explores the interactions between notions of health, illness, and identity formation, especially in highly transitional situations in which people are confused about their identity and sense of belonging. More specifically, we explore the non-utilization of health care services by Dutch university students. The results of 36 in-depth interviews show that the help-seeking behaviors of university students are closely associated with questions about identity, forms of agency, and styles of self-presentation, and are deeply influenced by the uncertain social and cultural context in which students are inserted. For example, being a 'normal' student was often regarded as more important than solving health problems, and stress was repeatedly portrayed as a constant and inevitable condition of everyday student life, giving a common language to express the burdens of the shared student experience. Some students even romanticized health problems. Eventually students with serious health problems avoided accessing health services.

***Keywords:*** Help-seeking behavior, under-utilization, identity, student health

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## INTRODUCTION

The question of why people who suffer from mental, physical or social problems, even if severe, do not seek help presents academic professionals with a challenge. Several major theoretical approaches, derived from a wide range of disciplines, have been adopted to explain the under-utilization of care. These models focus on individual attitudes, values, and beliefs about seeking help, pathways that lead to health care utilization, and the accessibility and affordability of services.

Psychological models, such as the Health Belief Model and the Theory of Reasoned Action, are the most widely used. These models address people's decisions to seek care based on how they perceive their susceptibility to and the severity of diseases (1), or measure people's intent to seek help by investigating attitudes towards behavior, subjective norms, and perceived control (2). Over the years, various efforts have been made to refine these models, usually by

including a cultural sensitivity toward help-seeking. This approach has resulted in the development of various decision-tree models that aim to predict the range of illness decisions made by particular groups of patients (3).

The major theoretical approach that most medical sociologists employ when studying health care utilization, is the Ron Andersen (4) social behavioral model of health services use. This model investigates the end-point of health care utilization, giving attention to issues related to the accessibility and affordability of care. Medical sociologists have also studied the illness pathways that lead to actual service utilization (5,6). These pathway approaches address the steps people make before they reach health services, for example by focusing on how individuals engage with family and friends, information, beliefs, and services. The models describe several interlinking steps, such as individual assessment and reassessment of symptoms, definition and redefinition, presenting and discussing symptoms with others, lay referrals, and information seeking.

In recent years, both psychological and sociological approaches for studying health care utilization have been increasingly criticized. Psychological models assumptively select the individual help seeker as the unit of analysis and are accused of over-emphasizing the cognitively determined nature of help-seeking (7). These models aim to predict and explain help-seeking behavior from a deliberate, reflective and utilitarian perspective and consequently portray individuals as 'naturally' inclined to seek care for health problems.

Pathway models, on the other hand, have been said to focus too closely on the interaction of the individual with health services. MacKian, Bedri, and Lovel (8) noted that this approach directs too much attention to endpoint utilization, thereby presenting help-seeking behavior as an unfolding process of treatment. The authors instead suggested that help-seeking behavior should be approached as '*a complex and ongoing process that cannot adequately be conceptualized by measuring dislocated actions aimed at a specific end point*' (8:141). This idea is reflected in the underdeveloped research on individuals and groups who actively resist seeking help in situations where services, resources, and information are adequately provided.

Contemporary research on help-seeking behavior departs from these conventional approaches and instead focuses on more dynamic and relational aspects of help-seeking. Here, seeking help is viewed as part of the broader context in which it occurs (9). Viewed from a contextual perspective, help-seeking is a dynamic process that is not restricted to the domain of health but also involves the individual, family, community and health services (10). This requires shifting the focus from individuals to social collectives and the social meanings underlying the utilization of health care. O'Brien, Hunt, and Hart (11) addressed popular stereotypes about male reluctance to seek help and have shown that powerful aspects of identity and collective representations influence help-seeking attitudes and behaviors. The authors note that the idea that communities of men are less inclined to seek help owes much to the widespread endorsement of a 'hegemonic' view that men 'should' be reluctant to seek help.

Exploring the relationship between help-seeking behaviors and aspects of identity offers an opportunity to gain insight by approaching the subject from a different angle (12). To date little empirical work has been done in this direction. Drawing from the material of a qualitative study that investigated the non-utilization of health care services by Dutch university

students, we aim to further develop this identity-centered perspective of help-seeking.

## Health and help-seeking behavior of Dutch university students

Research performed by the Student Health Services of the University of Amsterdam indicates that Dutch university students report more mental and physical health problems than their non-studying peers (13,14). This group of students experiences a lower quality of life and overall health status. The most frequent symptoms suffered by these students include fatigue, anxiety, irritation, sleeping and eating disorders, difficulties concentrating, headache, stress, depression, and recurring suicidal thoughts. Health problems are also closely related to academic achievement. Disappointing academic results may reinforce the experienced health problems, creating a vicious circle in which health problems and academic problems negatively influence each other. The University specifically offers a broad range of easily accessible health services, such as student medical support and student psychologists. These services are located in the center of the student district in the city, and the service is covered by health insurance. Moreover, our research indicates that a large group of students does not seek professional help for health problems. This becomes clear from the discrepancy between student-reported health complaints in field studies and documented treatment records. This finding contradicts expectations that suggest that being younger and having a high level of education increases health service utilization.

Various European and North American studies also indicate that students are increasingly suffering from health-related problems but do not utilize professional health services (15,16). To explain why students do not seek help for reported problems, scholars generally cite their perceptions (or misperceptions) of students about their health functioning and negative attitudes toward health. Perceived health problems have been found to be related to self-reliance and self-disclosure, stigma and embarrassment, emotional openness, difficulty in discussing health problems, and lack of trust in mental health professionals (17). Moreover, inactive problem solving, inward-oriented attitudes, or lack of control are held to negatively influence student help-seeking (18). The majority of these studies aim to differentiate and define core characteristics and personality traits of students to distinguish categories of students on the basis of pre-established psychological profiles.

Other studies have used the pathways approach to investigate the under-utilization of health care services. Significant others like family members and friends have been found to positively influence help-seeking behavior. Students also appear to seek help and advice on a wide range of topics and concerns from informal sources before they seek professional care (19). The literature also indicates that students show a strong tendency towards self-treatment. For example, medical students are known to treat and diagnose themselves by self-testing their urine or pressuring colleagues to prescribe drugs for them.

The literature thus offers a useful overview of students' perceptions and behavioral responses to their health, but has to a lesser degree explored how their health experiences are mediated by the everyday practical university environment, their social relatedness, and their general outlook on life, which is reflected in the relative lack of empirical interest in the group of students who do not use health services. This is remarkable considering that the broader context of university life threatens core aspects of personal and social identity (20). Compared with non-studying adoles-

cents, the transition to university brings about abrupt changes in many aspects of students' lives in a relatively short period of time. Typically, this includes changes in living arrangements, occupying new social roles, developing personal interests and desires, and exploring new styles and forms of self-representation. Moreover, students' help-seeking behavior is likely to comprise more than just individual interactions with health and health services; it reflects everyday worldly concerns, like effectively managing difficult social situations and creating a sense of belonging. To show this, the rest of this article aims to contextualize the help-seeking behavior of Dutch university students.

## METHODS

The literature on help-seeking is largely quantitative, the data often originating from health service intake interviews, surveys, and questionnaires. As a result, the analyzed data is generated from people who are already committed to seeking help from a care provider or have successfully found other pathways to care. Few empirical studies have focused explicitly on people who do not seek help for reported health problems (11).

This study used qualitative methods to explore the group of students who did not seek help. Thirty-six students from the University of Amsterdam were interviewed. We defined non-help-seekers as students who reported health problems but had not visited a general practitioner/family physician (GP), or other health care professionals, or had long periods of non-help-seeking. In total 27 students fit this definition. In an attempt to capture diversity, we interviewed students of both genders and of different ages. Twenty-two students were between the ages of 18 and 26 years. Five students were in their late 20s or early 30s. Because previous research has relied on interviews with medical students, we chose students from a range of disciplinary backgrounds such as medicine, psychology, communication science, physics, economics, and law.

It was a formidable task to locate students who did not seek help. Students were recruited with flyers and posters spread throughout student housing complexes, bars, and other student meeting places. The posters asked if the students had ever experienced anxiety, fatigue, or high levels of stress, sleeping or eating problems, felt lonely or unhappy, or if they knew other students who fit this description. The symptoms reported by students in previous quantitative studies functioned as guiding criteria in the design of the various media we used. Students could sign up on a specially designed website or were approached by mail or on social networking chat sites like *Hyves* and *Facebook*. Student advisers and counselors helped to locate students with academic delay. In addition, participant observation was used to recruit students, observe group processes, and contextualize the stories and experiences presented verbally in the interviews. The findings presented in this study are largely based on the interviews.

The interview periods ranged from 2-3 hours and were recorded on a digital mp3 recorder. They covered a wide range of topics and took place at the student health services, in local bars, or at locations selected by the students. Students were invited to reflect on specific illness experiences and responses, but were also asked to describe their thoughts about university life more broadly. The interview transcripts were analyzed for content and thematically indexed. The indexing process involved identifying key themes from the transcripts and formulating a series of categories, from which dominant themes were constructed that described a variety of

health problem experiences. Repeat interviews were held with 14 students to explore whether their perceptions and behaviors had changed over time.

Students' were given the opportunity to discuss their lives in an unstructured way to increase the possibility that they would fully address their health problems in their own terms and in relation to university life more broadly. This approach was used because the goal of the interviews was to assess the students' accounts of their health and place them in context, not to document statements that justified or rationalized why they did not comply with professional notions about help-seeking. Four main themes emerged from the interviews showing the relationship between contextual factors, the formation of illness identity, and help-seeking behavior. In the following paragraphs we will discuss the following themes: the concealment of problems, using problems to define a sense of belonging with other student, the feeling of being trapped between different life worlds, and the romantization of problems.

## RESULTS

### Concealment and disclosure of problems

A major theme in the accounts of the students involved concealing parts of their lives and personalities that did not correspond with their idealized image of the successful and capable student. In many ways, the university context promotes a strong sense of individualism among students that is distinctively future-oriented, and students are expected to become competent, independent, and hard working individuals. The students (total of six) told us that they highly valued these qualities but found it very difficult to live up to these expectations and norms. Brian described how the difficulties he experienced coping with academic work, such as planning and organizing tasks, profoundly affected the image he had of himself:

> *Before I went to university I had always thought of myself as a successful and capable person. In high school I used to be very good at everything. That is what you base your self-image on. It is terrible when this image collapses; it is as if you have to base your right to existence and feelings of self-worth on something completely different* (Brian 24 years).

Mary also described her disappointment when she could no longer live up to academic standards:

> *I just wanted to be successful in everything I did, or if necessary just to be able to complete university in a normal way. You know you have academic potential, else you wouldn't be here, but you want the whole picture to be right, you don't want to be inferior. If you don't succeed you feel as if you are failing, compared with the standard, the norm* (Mary 22 years).

The students described how they did everything within their power to conceal their health problems from others by acting in a socially approved and acceptable manner. They sustained and maintained an image of what they thought was a successful and 'normal' student. For example, John explained how he concealed his health problems for over seven years by behaving in accordance with what he thought other students and family members expected of him:

> *At parties, or when visiting my family, I always made a case of looking decent and recounting a good story about student life. Most people thought of me as a success story, nice to be with, witty. Even when I didn't do my best, if I was moody and sitting alone in the corner, they still thought of me that way. Girls particularly seemed to enjoy this image. I always had girlfriends, until*

> *they found out what a dark and unhappy person I really was* (John 27 years).

Another student increased his engagement in university life as a strategy to hide problems from others and manage his public identity. He explained how he preserved the image of a 'typical' student by working overtime at his student job, socializing, drinking heavily, and hanging around at the university library, even though he never actually took exams or wrote papers. In all four cases, the public image of a successful student stood in sharp contrast to the students' private behavior, covering up a deep abyss of loneliness and emotional problems.

The interviews suggest that students create expectations and understandings that do not promote help-seeking. Three students commented that they found it increasingly difficult to gain distance from the public image they had intentionally constructed for significant others and inadvertently began to reinforce this image, as John found out when he finally decided to reach out for help after seven years of hiding his problems:

> *Because I always went through so much trouble to pretend to lead an exciting student life, and had a funny way of telling this, people found it hard to judge whether I was being serious or not. It literally took years for me to create an image of myself as a patient* (John 27 years).

Moreover, the immediate social and cultural context of university life, which highly values individualism, autonomy, and responsibility, influenced expectations and perceptions of what is considered a 'normal' student trajectory. Being a 'normal' student was often regarded as more important than solving health problems. This specific interweaving of notions of health and identity influenced students' social functioning, as they concealed health problems from others in several ways (e.g., by maximizing engagement in 'normal' students activities) and made them less inclined to seek professional help.

**'My problems make me part of the group'**

Another important theme in the interviews was the recurrent portrayal of stress as a constant, inevitable, and ubiquitous condition of everyday student life. University students experience high levels of stress, which can result in feelings of hopelessness, depression, and a lower quality of life (18). Despite the knowledge that stress negatively impacts students' health status, many students are likely to consider symptoms of stress as part of the daily routine of university life.

Eight students recognized, or could relate to, high levels of stress as part of daily student life. They told us that stress was a condition you accepted and endured as a student, despite the discomfort it caused. These students viewed the manifestations of stress as part of their particular phase of life, often considering stress as a wide-spread student experience. Remarks such as the following appeared in many of the interviews: '*You just have to learn to deal with stress, it is a part of studying*', '*I have always experienced some kind of stress. Yet, I have always felt as if it was something passing*', and '*You learn not to be weighty about stress because you notice that it is something normal… It is probably part of this phase of life*'. When asked to describe what they precisely meant by stress, students had varying definitions; some conceptualized stress in physical terms, whereas others described it as a psychological or social condition. Difficult exams, upcoming deadlines, problems with housing, worries about the future, loss of friends, and the insecurity of living in a new environment were all potential causes of student distress identified in the interviews.

High levels of stress reported by students are commonly held to result from inadequate coping with transitional issues, such as high academic demands, problems with time management, or shifting social networks. In contrast to this belief, our research showed that stressful events appeared to give students a common language in which they could express the hardships of their shared experience. For example, several students made a significant link between stressful encounters, such as making social commitments, financial pressures, achieving academic goals, or having problems with romantic relationships, and the compensation found in intellectual challenges and freedom. Being stressed was what made their experience unique compared with other groups of young adults, or as Toine put it:

> *Studying is extremely stressful. You constantly have to perform all sorts of new and difficult tasks. I don't think that other adolescents of our age have to go through the same stresses. It is something that only we as students go through. On the other hand, stress is also valuable. Putting up with stress is what makes us different from other young people who live their lives the easy way* (Toine 23 years).

In this sense, discussing stress helped students to define their identity in contrast to other groups of adolescents. Several students often bragged about high levels of stress and appeared to recognize stress as an indicator of their student identity, as Mark remarked:

> *I am a big stress eater. I can do many different things at the same time. Even though I find studying very stressful, I don't think twice about it. I just deal with it. It pushes me to realize my academic and intellectual potential* (Mark 21 years).

Even though many students claimed that stress was something they never discussed with fellow students, participant observation showed that these students often discussed the demanding and stressful nature of academic life with others. Discussions about stress were repeated in social interactions: during lunch breaks, in hallways, or at social get-togethers, and conversations were spiced with references to lack of time, upcoming deadlines, and frustration about housing, or a shortage of money. Students continuously weighed their circumstances in relation to what other students were saying. As a result the constant references to stress created ambiguous expectations, worries, and doubts. Therefore, the stress discourse circulating throughout the university made it very difficult for students to determine to what extent their stress was pushing them to perform beyond their academic capacity or continue with unwanted social or extracurricular activities, as Marcel describes:

> *I felt like everybody around me was doing all these fun things which made me decide to do the same, to tackle things, for instance by doing all kinds of extracurricular activities alongside my student career. Eventually this made me pick up way more than I could eventually handle* (Brian 23 years).

Defining health problems as part of student life thus set up broad collective ideas and expectations about university life that impeded concentration, completion of work, and other skills necessary for student learning. Still, students did not acknowledge the need for professional help because the convergence of health problems and group identity shaped their collective understandings of health. Students found it meaningful to discuss the stressful nature of university life as a way to share the

challenges they encountered in the new student environment and in the process, create a sense of belonging and engagement with other students.

**Trapped between different lifeworlds**

The third theme that emerged from the interviews was not being able to negotiate university life and other social areas, such as family, religion, culture, and social relationships. This group of students made connections between the student experience and finding a balance among their different life worlds: university, family, and friends. Uncertainties about choosing between and identifying with these different social groups made it difficult for them to create coherent identities and establish group affiliations.

Students described the transition from home to a university in terms of being trapped between different social worlds and voiced doubts about who they were and to which social groups they belonged. Five students discussed how their transition to university had created a situation in which they could no longer relate to older forms of identification, but said they could not integrate into the student environment either. Maria, one of these students, describes how she moved from her small village in the south of Holland to the capital, Amsterdam, to get away from her Protestant upbringing, leaving behind family and friends who did not agree with her decision. In the beginning she experienced the move toward independence as liberating, however, problems arose when she lost her connection with family and friends and could not 'fit in' with her new life either:

> *I imagined Amsterdam to be the city where I could finally discover the world. Although I had only been there once, people spoke of the city as Sodom and Gomorrah, a place where everything was possible. In my first weeks at university I did everything that God prohibited, extensive drinking, constant partying, smoking weed. I met many students, yet contacts never seemed to evolve into genuine friendships. ... They somehow had a different culture; unlike me, they were so concerned with appearance and back-ground. I felt as if I didn't belong with those people. On the other hand, I realised that I had said farewell to my old life as well. Many of my former friends didn't want to speak with me anymore* (Maria 23 years).

Not being able to bridge two worlds may give rise to identity problems as a result of which the initial feelings of emancipation and independence can become over-shadowed by feelings of melancholy and despair, as Maria again describes:

> *After a while I collapsed and became ill. Mentally I was completely drained and felt depressed… I was very lonely and searched for people who had gone through the same thing, but never found anybody. I really felt that nobody could understand my situation or background; people just didn't have a clue. Discussing my problems with them made me feel sadder… Eventually I decided that the best thing to do was solve my own problems* (Maria 23 years).

The total absence of stable, supportive relationships did not encourage Maria to seek care: as she became increasingly more isolated and cut off from others, family, friends, and fellow students. Instead she developed an attitude of perseverance that resulted in the avoidance of healthcare services.

Simone, another student, describes how she was constantly being dragged back and forth between academic obligations, familial expectations, and her personal desire for independence and autonomy. She

continually sought inclusion in various social worlds. To meet the expectations of family and friends and appear ‘normal’, she joined a sorority, moved into a girls-only student residence, and actively participated in student life, for instance by going to the same nightclubs and bars as her fellow students did. On weekends, she explored and developed her personal interests and desires, often visiting alternative house parties where she used drugs and came in contact with people from outside the university. Having to incorporate such disparate experiences into a desired identity eventually made her feel as if she did not belong to either world, as she describes:

> *I really feel as if I am stuck between two worlds: on the one side there is student life and the fraternity and on the other the alternative scene and those parties. I am always in-between worlds, in the middle. That is such a contrast. It really troubles me* (Simone 24 years).

Being stuck with differing loyalties and expectations can make it increasingly challenging to discuss difficult personal matters, as Simone’s case makes clear:

> *At a certain point I really needed to talk to someone. I tried to tell some friends from university, but they didn’t get it. They really didn’t like me hanging around at these alternative parties, which made discussing the subject off limits. ... I also had a couple of friends in the alternative scene, but could not discuss my problems with them either as we have totally different lives* (Simone 24 years).

Parents and other family members also found it difficult to recognize her problems, either because they held another perspective about the nature and legitimacy of health problems or they were unfamiliar with the life of a student attending a university, as Simone again describes:

> *My older brother always has another perspective on things telling me that my life as a student is not so difficult. He thinks that I don’t have any real problems because I am still in university. He tells me that I don’t have a mortgage, kids, or obligations, so really I don’t have it all that bad* (Simone 24 years).

When confused about their identity and constantly confronted with the question of how to integrate different forms of social identification, students may become equally confused about the status of their health problems, which can discourage them from seeking help for problems. Because Simone was always occupied with the formation and management of her identity, she understood her health problems in the light of the identity crisis she suffered. She was constantly concerned about the outcome of her health behavior on her identity. The knowledge that her family trivialized her health problems, for example, made her anxious that seeking help would disappoint them and cause a break with her family. In this sense, her health behavior had become interwoven with confused feelings of belonging, personal loyalties, and attachment, which resulted in the avoidance of health care services.

**‘Splendid isolation’ and the romantization of health problems**

The fourth theme illustrates how students use health problems to contrast and distinguish themselves from their peer group. Some students had difficulty participating in university life and establishing relationships with fellow students, which resulted in social isolation and physical, psychological, and emotional distress. Despite the negative effects on

their health, these students were likely to discuss their isolation and solitude in a positive and meaningful way, for instance through portraying health problems as intrinsic qualities that made them feel as a more complex person and so created a sense of exclusivity.

For David (and for four other students) participating in student life caused many problems. When David decided to move to Amsterdam to study medicine, he lost contact with most of his high school friends. Because he still lived at home and felt economically and culturally out of place at the medical faculty, he did not make new friends at the university. Nevertheless, when asked about his socially isolated position, he responded by telling us that it was his own choice not to participate in student life. He emphasized that he was isolated because he was a driven student with a slight tendency towards nihilism, who read many books, wasn't interested in partying. David saw the profession of a doctor as a profession rather than something that was passed on through bloodlines, and so he skillfully carved out an image of himself as a romantic loner.

David's recurring descriptions of his fellow students demonstrate how he compared and contrasted himself with other students, thus defining himself as an outsider, free from social constraints, but at the same time isolated and prone to melancholy:

> *You have several kinds of students: those that are super serious and ambitious, those drive me crazy, students who ask the most annoying questions, those that act hysterically about everything and of course you have the snobs* (David 24 years).

David used his loneliness and malaise to define and distinguish himself in relation to other students as a strategy of self-preservation; it forged and sustained forms of splendid isolation placing him on a separate level from other students, which made it possible to manage and resist the difficult social expectation encountered in his university. David describes this as follows:

> *I don't care about being different. It makes me feel stronger and care less. When people judge me it feels less like an assault. I don't think I could ever be an insider* (David 24 years).

Once they become accustomed to seeing their health problems as indistinguishable and precious parts of themselves, students can find it increasingly difficult to commit to seeking help. Over his long student career, Frederic had become more and more isolated from other students, up until the point that he spent most of his days lonely and miserable at home. Similar to David, Fredrik claimed his isolation was a deliberate choice, often stating that he was a loner because of his profoundly unique perspective on life:

> *These days students don't talk about the meaning of life anymore. Nobody takes the trouble to look up to the sky and simply observe a bird or stops and wonder at other simple everyday situations. I appear to be the only one* (Fredrik 33 years).

After studying for over 10 years, the pressure of being an outsider became unbearable for Frederik. Although he had no confidence in health professionals, an acquaintance pressured him into visiting a student psychologist. After the first appointment, Fredrik decided that the counselor could not help him with his problems, as he put it:

> *I didn't have any use for someone who just looks into my eyes and asks me if I feel sad. He certainly appeared to be an experienced*

*psychologist, but if that was all he could come up with! I could have had a more profound conversation with my mother. Eventually, I only went this one time consultation and the next one through email* (Fredrik 33 years).

Seeking help had forced him into a discomforting situation that sharply contrasted with the unique and exclusive image he had constructed of himself over the years. Frederik's social isolation and ancillary symptoms, such as anxiety, stress, and depression were interwoven with making sense of and managing demanding social expectations and situations. Moreover, sustaining the notion of an outsider, someone who was concerned with the profound and existential dimensions of life, had become more important than finding ways to overcome solitude and isolation and greatly influenced Frederik's unwillingness to seek (or commit to) professional help.

**DISCUSSION**

The results of this research suggest that students establish complex interactions between identity and notions of health and illness, and that this is related to the highly relational context of university life where there is a lot of confusion around identity. Exploring the formation of health related identities, Fox and Ward (21) argue that the health and illness practices of individuals and groups of individuals reflect cultural dimensions, social expectations and constraints, and often deviate from, or are diametrically opposed to, conventional medical models of health and illness. Our results suggest that the way people construct health-related identities also influences how they seek professional help for health problems. By describing four different ways in which university life, identity and notions of health and illness are related, we have shown that student's health related identities make them reluctant to seek professional help for health problems.

The first case illustrated that students constructed a health related identity that reflected dominant social values and expectations, in which the need for competence, independence, and academic individualism was highly valued. Health had complex meanings for students; good health was valued as the expression of 'good studentship', while the absence of 'good health' was associated with the loss of a fundamental identity as a student and often resulted in what Radley (22) has described as the active denial of health problems. Hence, our analysis suggests that the construction of a health identity based on opposing and resisting illness sets up expectations and understandings that do not facilitate professional help-seeking.

Secondly, we have shown that students may construct a health identity that forges and sustains their identification with their peer group. When confusion about social position and identity is the dominant theme, health problems may become associated with establishing and maintaining a sense of belonging. For example, students did not necessarily perceive the manifestation of stress as an individual or essentially unhealthy condition. In various instances, stress was socially located and used to define and articulate a shared social condition. In contrast to dominant ideas in the literature that high levels of stress are an important trigger for help-seeking, stress was a 'diffuse and invisible "force"', somehow mediating between individuals (and their mental and physical states), and the social environment in which they live and work' (23). Student's experiences of stress were part of a complex interpretative process and encouraged solidarity and feelings of camaraderie which is congruent with Van Maanen and Barley's (24) conclusion that constant talking and

complaining about the stressfulness of work can encourage solidarity and cohesion between professional groups. In demanding and challenging life phases such as time in a university, health problems become connected to mechanisms of social inclusion that are counter-productive to seeking help.

The third theme described how a lack of identity or attachment to others served to discourage seeking professional care. The transition to university made some students feel as if they were trapped between different social worlds, while in the process of shaping their conception of themselves and others. Students who were confused about their identity avoided health services. In this situation, students placed health beyond the control of the individual, into multiple familial and social relationships, which resulted in a decreased sense of confidence in other people and feelings of being isolated.

The final theme illustrated that some students may attach positive meanings to health problems, often constructing forms of 'splendid isolation', in which a negative health experience becomes a mark of exclusiveness, uniqueness, and moral worth. This is especially the case if students cannot fully participate in student life. The findings show that students highly valued their health problems, irrespective of increasing isolation and loneliness, because they appropriated health problems to resist the social expectations placed on them in university. This particular relationship between health and identity was proactively forged and sustained by the explicit opposition to other social groups. Notions of health were often used to distance themselves from the wider student community. This approach did not facilitate professional help-seeking. These students found that managing the isolation encountered in university and having a positive identity were more important than finding ways to overcome solitude and isolation.

**CONCLUSIONS**

Our research findings have several implications for theories about help-seeking. Although interest is growing in more contextual and interpretative aspects of help-seeking, traditional models still influence much of the research being done on this topic. Existing approaches tend to focus on perceptual 'barriers' that influence people's decisions to seek care or portray individuals as innate help seekers who are constantly moving from one stage of help-seeking to the next (12).

Our research findings instead suggest that the under-utilization of health services cannot be adequately understood by focusing only on the mental aspects of individual behavior (8) or of whole populations (11). Whether someone seeks help depends as much on their place in society and how this place is mediated by prevailing ideologies and social-structural circumstances (9), as it does on mental processes. Seeking help is not simply a cognitively determined process. Therefore researchers should be careful when approaching health behavior that does not follow medical notions as resulting from 'distorted perceptions', 'disabling factors', or 'barriers' that need to be overcome.

To consider the utilization of health services as an unfolding process structured by social networks and information seeking also has shortcomings. People do not constantly appraise and reappraise their health status and functioning, nor are they always oriented toward medical institutions. In some cases, people may even avoid certain pathways altogether. Rather, health behavior emerges in the immediate and everyday social and cultural context and often serves strategic purposes, such as managing uncertainty, making sense of

difficult social situations, and negotiating priorities. Research should take these aspects of help-seeking into account, instead of focusing solely on the steps that lead up to service utilization.

To move the debate about help-seeking into new and more fruitful areas, we suggest addressing the relationship between health and identity formation in people's immediate daily social and cultural context. This seems to be a particularly insightful approach in transitional situations where people are confused about their identity and sense of belonging. During transitory and uncertain life phases, individuals have to redefine and rearticulate who they are, and what their place in society is, which may open a window of opportunity to study help-seeking behavior from an identity-centered perspective.

Our results have implications for policy and practice as they stress the importance of looking beyond current major theoretical frameworks used to account for help-seeking. That existing models give prominence to individual aspects of help-seeking over social and cultural aspects may encourage misinterpretations because it fails to recognize that people often have priorities other than becoming healthy, such as for instance, making sense of their lives or managing uncertainty, and that their subsequent behavior can therefore be counterproductive to health. Consequently, people who persistently do not seek help may be labeled as unmotivated, lethargic, or even 'irrational' actors who behave in irresponsible and reckless ways. Yet, educating people about health issues and improving their knowledge may not be enough to encourage them to seek professional care. This seems to be the case particularly in situations in which health problems are intertwined with changes in identity and a sense of belonging. Health service providers should therefore develop alternative ways in which people can access care facilities without having to jeopardize their identity.

Some limitations of this study are addressed here. Our study had a unique sample, based on the situation of Dutch university students. Whether our conclusions also apply to the experiences of students in other countries, such as America or England or to other broad social groups, remains to be seen. Differences in health complaints reported by students from various nationalities suggest important cultural and social differences in the way aspects of identity influence help-seeking behaviors (16). Nevertheless, there is no reason to think that an identity-centered approach will not offer useful insights in other contextual situations where people persistently avoid healthcare services, especially if these situations raise questions about identity and belonging.

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