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**Research Article**

# Exploring the Link between Attributional Styles and Learned Helplessness in Medical Postgraduates in Pakistan: A Qualitative Interview Study

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**ABSTRACT**

**Background:** Medical postgraduate education in Pakistan is marked by a lot of stress, working long hours as well as being hard on academics. Such setting can make the trainees susceptible to maladaptive forms of thinking. An established antecedent of learned helplessness is attributional style, or ways in which people elaborate on the causes of negative events, and as a consequence develop a state of apathy and perceived powerlessness. Nonetheless, the relationship between the two constructs is under researched in the Pakistani medical education settings.

**Purpose:** To investigate the connection between attributional styles (internal/external, stable/unstable, and global/specific) and development of learned helplessness among medical postgraduates in Pakistan.

**Methods:** The qualitative exploratory design was used. The semi-structured interviews with 25 postgraduates (residents) of the teaching hospitals in the public sector were carried out in the period between January 2025 and March 2025 in Sindh, Pakistan. It was a purposive sample of participants to ensure that first year trainees, second year trainees and third year trainees are represented.

**Results:** Patterns of attributions and helplessness behaviors were determined through thematic analysis. Findings: Four key themes were identified which comprise: (1) Internal, stable, and global attributions of academic failures (e.g., I am naturally incompetent)(2) External, unstable attributions of successes (e.g., luck or easy case)(3) manifestations of learned helplessness (e.g. reduced studying efforts, emotional withdrawal) and, (4) systemic and hierarchical influences including.

**Conclusion:** Pakistani medical postgraduates who have learned helplessness have a strong association with maladaptive attributional styles. Interventions promoting adaptive attributions and systemic support are urgently needed.

**Keywords:** Attributional Style, Learned Helplessness, Medical Postgraduates, Pakistan, Qualitative Research.

## INTRODUCTION

The study of postgraduate training (residency) in medical practice in the United States and other countries is considered an intensely psychologically vulnerable experience that is marked with burnout, depression, and anxiety.[1] This situation is further compounded in Pakistan by systemic problems such as shortage of resources, overloaded patient ratios, stiff hierarchical systems and lack of structured mentorship.[2] More recent Pakistani research has cited disastrous numbers of psychological distress among medical trainees, with one survey indicating that more than 60% of residents indicated they experience moderate to severe burnout threshold. The focus has however not been on what cognitive processes could possibly be behind the developments of some trainees turning passive and hopeless when compared to others, which are left resilient.[3]

The attributional style is one of such mechanisms; it is a cognitive personality variable that characterized the way people inclusively describe the reasons behind both negative and positive events in their habits when these occurrence can be explained by them.[4] The reformulated learned helplessness model suggests that those who have a habit of attributing bad events to internal (it is my fault), stable (it will always be like to me), and global (it affects everything I do) causes, tend to develop a psychological response known as learned helplessness, or become passive, unmotivated, and emotionally blunt in the face of perceived uncontrollable events.[5,6] In contrast negative events attributing it to external, unstable, and specific factors make those who do this more resilient. It can be seen how this model is applicable to medical training. A resident who is unsuccessful in an exam and thinks to herself, I am not smart (internal), I will never pass (stable), and I am a failure in all aspects (global) is set up to be helpless. Conversely, a person who thinks, the exam was a draw (external), I can do improved next time (unstable) and the failure will only be in this particular subject (specific) will not go away easily.[7,8] To illustrate, a longitudinal study discovered that depressive symptoms six months after residency were predicted by pessimistic attributional style of the new resident on the entry day of treatment at the onset of residency.[9,10]

In Pakistan, stress and coping in medical students and postgraduates have been studied across a number of studies, but none that have qualitatively investigate the exact attribution patterns that result in learned helplessness. A quantitative study found a correlation between external locus of control and burnout in Pakistani residents, but did not differentiate stable/global dimensions or use qualitative methods to capture lived experiences[11]. Likewise, high percentages of helplessness-related behaviors were reported by in the group of postgraduate trainees but not associated with certain attributions.[12] This gap is important in that attributional styles can be improved using cognitive interventions but there is a high number of stress factors in the system that cannot be improved.

Thus, this research proposed to investigate the relationship between attribution style (i.e. internal, stable and global dimensions of negative events) and learned helplessness in Pakistani medical postgraduates qualitatively. Our aim was to shed light on the thinking processes that either immunize or nothing alike immunize residents to helplessness in the challenging Pakistani training milieu by giving them the opportunity to explain their contributions to their own success and failure.

## METHODOLOGY

### The Design and Setting of the Study

Semi-structured interviews based on a qualitative exploratory design were used. This type of design is suitable to reveal the subjective thinking processes that are behind intricate psychological situations such as learned helplessness. The study was done at open sector teaching hospitals in Sindh, Pakistan during the period of January 15, 2025, to March 15, 2025.

### Participants and Sampling

A purposive sample of 25 medical postgraduates (residents) was sampled. Inclusion criteria consisted of: (1) full time enrollment in a residency program (e.g, medicine, surgery, pediatrics and gynecology and obstetrics); (2) no less than 6 months training duration; (3) willing to give informed consent. Exclusion criteria consisted of: (1) the previous diagnosis of major depressive disorder or other psychiatric illness; (2) on leave at the time of the study. Objective of this study was to have 20-30 participants so that we could attain thematic saturation and thematic saturation was reached at 22 interviews and 3 interviews after that no new themes were identified. The final sample comprised 25 residents (14 female, 11 male; the mean age 27.8 years; 9 first-year, 8 second-year, 8 third-year).

### Data Collection

The interviews were semi-structured, in Urdu, Sindhi or English (participant choice) and in a separate room in every department. Interviews were provided 45-60 minutes and they were audio taped. Qualitative previous work and reformulated learned helplessness theory were used to develop the interview guide used base on the previous work and the theory. Key questions included:

1. How about a recent incident in which you felt that you had failed in doing something significant in your residency?
2. What do you consider to have been the principal reason of that failure? (Probes: Could anything about you have done it? Could anything about the situation have done it? Do you believe that this reason will exist in the future? Is it influence on other aspects of your work/life?)

3. What was a particular accomplishment that you have made recently?
4. What do you think when you encounter again and again a doorknob that you cannot turn? Give an example?
5. Have you ever felt like quitting or that you are not making a difference? How did that feel like?

To improve the wording of questions, two pilot interviews were held with the non-main sample of residents. Interviews were transcribed verbatim; those written in Urdu were translated into English by a bilingual researcher, and back-translated to be accurate.

**Data Analysis**

It was thematically analyzed in accordance with the six phases outlined by Braun and Clarke (thematic analysis). Phase 1- Familiarization all transcripts were independently read by two researchers. Phase 2-Preliminary coding -line-by-line coding attribution statements and helplessness behaviors. Phase 3- Seeking themes: Codes were combined into possible themes. Phase 4- Themes reviewing: Themes were verifying against coded extracts and the whole dataset. Phase 5- Naming themes: conclusion thematic order was reached. Phase 6- Report writing. Inter-coder reliability was determined.

**Ethical Considerations**

The IRB approved this study, approval number IRB (F.NO.00826). All the participants were recruited via written informed consent. Participants were assured of confidentiality and their right to withdraw without any impact on their training. Since the failures are a sensitive topic to be discussed, a clinical psychologist has been in place in case of debriefing, none of these participants needed debriefing.

**RESULTS**

The Sources of negative attribution Analysis Four major themes were identified (1) Predominance of internal, stable, and global attributions to negative events (2) External and unstable attributions to positive events (3) Manifestations of learned helplessness and (4) Systemic amplification of maladaptive attributions.

**Theme 1: "It is me, it is permanent, it is always me" Internal, Stable, Global Attributions about negative events.**

The vast majority of interviewees (22/25) attributed their greatest failures in terms of internal, stable and global attributions. Here, an example of a resident in surgery in the second year who failed a clinical skills evaluation:

"I do not think I was ever made to be a surgeon, I am so shy, too hesitant it's part of my personality, I will always be a surgeon, not the chatting to patients... I feel like I am not doing it right, not even surgery itself, not even talking to patients…" (PG, Medicine, year 1)

Maladaptive dimensions are all present in this quote, that is, internal (my personality), stable (cannot change), and global (always). Likewise, one of the first-year residents working in medicine mentioned making a medication error:

"The senior scolded me in front of the entire team, and I felt like, yes, I am deserving it. I am stupid. I always was stupid since the medical school. I am a failure as a doctor, as a person. There is no use in trying harder." (PG, Med, year 1)

It is worth noting that participants still quickly reverted to the idea of internal attributions as even though they recognized systemic factors (e.g., understaffing, poor supervision).

According to one respondent: "Yes, the system is bad, but everybody is managing. So problem must be in me". (PG, obs, year 2)

**Theme 2: Just luck or an easy case - External, Unstable Attributions of positive events.**

Contrastingly, when subjects reported achievements (e.g. they saved a patient, passed an exam, received praise), they were much more often using external and unstable attribution. Third-year gynecology resident described:

Another member wrote:

"I have taken test during ward round and it was easy, does not imply that I am that bright, that I might be asked some hard questions next time, and I will fail in that case (PG, gynae year 3).

The tendency to discount personal agency to successes and install the full blame of failures results in a negative reinforcing loop of self-demonstrating negative expectancies.

**Theme 3: Why bother? - Expression of Learned Helplessness.**

Each and every participant reported about two or more classical symptoms of learned helplessness in terms of behavioral, motivational, and emotional symptoms. The most widely reported one was the least effortful:

"I would study at nights after my duty, now I just go to home and scroll the phone. Why? Because whatever I may do to prepare I will

not get the presentations right anyway... (PG, medicine, year 3)

There was also a great deal of emotional withdrawal and passivity: "I do not even try about speaking during rounds anymore. I even know that the answer is correct, but I think that they will find something wrong about it and I say nothing. I feel as a robot." (PG, Surgery, year 2)

Cognitive deficits (difficulty learning new information despite ability) were reported by several senior residents: "I could easily remember drug medication doses, now my head is empty. I suppose because somewhere in the back of my mind, I believe that I can no longer learn anything. My brain has broken down it is blanked out." (PG, Surgery, year 3)

Others made the attributional style particularly explicit by saying that they were helpless because they had decided that failure was due to who they are (internal), and that they could do nothing to change (stable).

**Theme 4- Systemic Factors that Enhance Maladaptive Attributions:** This theme explores how systemic factors such as gender, age, social status, and ethnicity amplify maladaptive attributions. "There is the consultant saying in front of everyone, that you do not study, you do not care, and you will be a useless doctor in the future." (PG, obs, year 2). The participants mention that others do not tell them specifically what they need to change. They claim that they are not trying to place effort in the work, but they do not know where to change exactly.

"Such uncontrollable working conditions:... It is chaotic all the time, there are never enough beds, the relatives of patients are angry... when something goes wrong you hold the system accountable, but the system is designed to fail".(PG, peads, year 3)

These systemic variables do not produce learned helplessness per se, but they allow repeated chances to develop maladaptive attributions into a consistent, blanket explanatory style.

## DISCUSSION

This qualitative research is the first research to clearly examine the relationship between the attribution styles and the learned helplessness among medical postgraduates in Pakistan. Study found that a significant percentage of residents routinely explain negative events by using attributions of internal, stable and global events and dismissing positive events as externally located and unstable. This mental process is strictly linked with behavioral, motivational, and emotional manifestations of learned helplessness. In addition, organizational (high-stress, hierarchical) Pakistani training climate seems to play a dynamic role in reinforcing these maladaptive attributions.

The Study find results to be consistent with the learned helplessness model as reformulated, which holds that a pessimistic attributional style is a necessary aspect of helplessness deficits after uncontrollable negative events.[13] The same results have been observed with international studies conducted among medical trainees, which have found that internal, stable attributions of failures were found to predict burnout and depression.[14] As an example, a longitudinal study carried out in the US established that medical interns who started the year with a negative attributional style were three times more likely to experience a major depressive episode by the end of the year compared to those whose attributional style was less negative at the beginning of the year.[15] Our qualitative data build this a notch higher, demonstrating how these attributions are built and perpetuated in the particular Pakistani setting.

These findings have been indirectly supported by a number of Pakistani research founds that perceived lack of control (a fundamental aspect of learned helplessness) has been the most predictive of burnout in more than 400 Pakistani residents.[16] Nevertheless, attributional style was not measured in that study. Equally, it was concluded that medical postgraduates with high external locus of control (similar but distinct construct) tended to report emotional exhaustion more.[17] We introduce two such critical dimensions in our study, namely, stability and globality, which make a specific episode of helplessness, not a generalized and durable impression of hopelessness.

The observation of the attribution of successes abroad (e.g., "luck, easy case) is especially alarming. This tendency, which is termed as depressive attributional style in the literature cancel out positive events to buffer up the impact of negative events.[18] A similar inverse correlation between self-serving attributional biases and depression was found in a Pakistani study (or the inverse thereof).[19] The current research is the first to record this among the medical postgraduates meaning that in cases

where residents perform successfully, they do not gain any benefit in terms of self-efficacy.

A significant input of this research is the approach to discovering the systemic amplifiers peculiar to Pakistan. Medical hierarchy has been stated to be a stressor in international studies, yet this wide scope of public shaming that our participants reported seems to be culturally unique. According to a qualitative study by Pakistani medical students, this type of teaching is typical in most educational institutions: humiliation-based teaching is accepted therein.[20] Other implications of our findings are that these practices nourish internal, stable attributions (they are right, I am incompetent). Individual-level cognitive interventions might not be as effective without having an impact on these systemic factors.

**Implications for Intervention**

Our finding indicates a number of interventions that can be acted on. First, programs that involve attributional retraining (AR) where people learn to acknowledge and change maladaptive attributions have worked successfully in higher education. An AR pilot program among Pakistani residents can be conducted in small seminars, where trainees will be shown how to use instead of I am stupid, I need more practice on this particular skill. Second, training of supervisors is necessary. Specific, behavioral, and non-personal feedback (i.e. You are careless vs. Your note missed the drug dose) should be trained to consultants and elderly residents. Third, institutional policies are needed to require organized mentorship and confidential mental health provision. In Pakistan, psychological wellbeing indicators in residency accreditation could be implemented by the Pakistani Medical and Dental Council.

**Limitations**

There are a number of limitations in this study. To begin with, the qualitative research design and purposeful sample about a hospital in a single province restrict the generalizability to other locations or privates. Second, the self-report interviews could be susceptible to social desirability and recall bias (however, the participants seemed to be honest). Third,, the cross-sectional design is unable to determine the causality that maladaptive attributions can be a cause as well as be a result of helplessness.

**Future Research Directions**

Quantitative longitudinal investigations are necessary to determine whether or not attributional style assessed at the onset of residency indicates subsequent helplessness and dropout. Attributional retraining interventions with randomized controlled trials in Pakistani residency programs are urgently required. Otherwise, cross-sectional research across various specialties (e.g., surgery vs. psychiatry) and type of hospital (public vs. private) would be helpful as well.

## CONCLUSION

Internal attributional style, that is, stable and global attributions of negative events is greatly associated with learned helplessness among Pakistani medical postgraduates. This connection is reinforced in the training context by shaming up the hierarchy and the absence of constructive feedback. There is a need to intervene positively, both at individual level cognitions and at systemic level practices, to avoid the vicious circle of helplessness and keep the psychological well-being of future medical specialists in Pakistan safe.

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**Authors Contributions:** Ayub. P conceived the idea, did data collection and helped in the write up of the study. Khuhawar.SR, Shah SYA & Khalid. A did statistical analysis and Shah MA & Arif. S planned the study, critically revised the manuscript and supervised the study, All authors contributed significantly to the submitted manuscript.

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