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**Between patient-hood and trust: Interlocking doctor-patient relationship among  
mental health care users in Kedah and Pulau Pinang**Nur Zafifa Kamarunzaman<sup>a,\*</sup>, Nor Hafizah Selamat<sup>a,b</sup><sup>a</sup>Centre for Research on Women and Gender (KANITA)<sup>b</sup>School of Social Sciences

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\*Corresponding Email: [nurzafifa125@gmail.com](mailto:nurzafifa125@gmail.com)**Abstract**

The article aims at exploring the trust establishment among patients with depression during their journey to psychiatric patient-hood. This study was undertaken in government hospital involving 29 psychiatric outpatient users in Kedah and Pulau Pinang respectively. Phenomenology study and gender lens employed to scrutinize on the patients' lived experiences in mental health care, at the same time magnifying the gender differences in perceiving the service. Semi-structured in-depth interview and non-participant observation were the tools used in data collection. The data then explicated with the aid of a qualitative data analysis tool, Atlas.ti., version 7.5. Through the findings, the study identified "Trust" appears critical in the accounts of the patients in shaping the doctor-patient relationship; with at least five interlocking sub-themes describing the health professional's characteristic while giving the service. The sub-themes include doctor's integrity, concern, competencies, empathy, and autonomy enabler. There are no gender differences detected in most of the sub-themes, except for doctor's competency, and integrity. Barriers in language and communicating with patients cultural believe potentially moving away from the patients' interest elsewhere for help seeking or diminishing the client's compliance. The findings are consistent with previous studies whereby language and lacking in a cultural competence garner gender stereotype in treatment giving. Thus, trust in this context becomes the enabling or disabling factor for the patient to stay on in the treatment.

**Keyword:** *Trust, Doctor-patient relationship, Compliance, Psychiatric users, Depression*

**1. Introduction**

Depression is a common disease in a modern society. The World Health Organization (WHO) predicted depression as one of the top-ranked global disease burdens worldwide by the year 2030 (WHO, 2010), and the statistic recorded in Malaysia also supplements the overall increment. In the country, psychiatric morbidity was marked by 10.7 percent in 1997, and in 2002, depression alone stood at 2.6 percent and the overall morbidity reached 9 percent in 2011 (Abdul Kadir et al., 2011). The recently released statistic by the National Health and Morbidity Survey records 29.2 percent or 4.2 million of adults suspected of having mental health

problems (Institute of Public Health, 2015). Notwithstanding, a new trend has emerged from help seeking pattern in the country. In 2015, at least 40.6 percent of Malaysians were seeking treatment in health care for acute illness, and majority of the decisions were made within themselves (Institute of Public Health, 2015). This new pattern implies the development of not only the confidence in health care but also the trust on the services provided. However, does this progress reflect in psychiatric patients' confidence towards the mental health care?

In relation to the above, accepting treatment courses and aids from health professionals mean transforming self into patient hood. In such a way, trust becomes the foundation to the doctor-patient relationship and plays a pivotal role to engage the patient into continuous treatment in health care (Borba et al., 2012). Skirbekk et al. (2011, p. 2) define trust as "patient's implicit willingness to accept the physician's judgment in matters of concern to the patient". Hence, trust is an element that is embedded in the social relationship and negotiated implicitly, particularly by authorising the doctors to exercise the judgment in treatment. In other words, trust is interpersonal; it relates to caring the sick and vulnerable (Ormon et al., 2014). A few scholars have concluded that trust in psychiatrist would shape the treatment given according to the patient's preference because active participation is involved in the relationship (Carpenter-Song, 2009). Similarly, Adams et al. (2015) posit that a doctor's communication style is able to break the disparity of depression treatment. Respect and partnership were concluded as the critical elements to establish a trusting relationship (Adams et al., 2015). In another study of a person with HIV, Dawson-Rose et al. (2016) discovered that respect and partnership (1) provide the space to be heard, (2) acknowledge the patient's experiences and bodies, and (3) encourage the sharing of knowledge and experiences of HIV. Given these points, trust is fluid in nature; it grows in temporality as long as the negotiating process happens between the health professionals and patients.

In mental health issue realm, most of the patients prefer to keep their illness in private domain because the disease can potentially damage personal and family status (Al-Krenawi et al., 2001; Basu, 2012). As mentioned by Goffmann (1963), once a person is associated with mental institutions or other mental affiliation, moral labelling usually follows, tainting them with mental problem stigma. This stigma hampers their daily productivity because the label is likely to confiscate their rights to citizenship, such as housing, employment, and treatment (Crabtree & Chong, 1999). In one study undertaken in a psychiatric clinic, Koekkoek et al. (2011) discovered that health professionals were inclined to label mental health patients as

“difficult,” and the former were prone to provide ill-services to the patients. Similar findings were noted by Minas et al. (2011), who discovered that stigmatising attitudes hampered a productive relationship between a doctor and a patient. Other studies have identified that psychiatric patients suffered from a series of abusive relationship by the professional health team, spouse, family members, friends, and society (Corrigan et al., 2014; Drew et al., 2011; El Enany et al., 2013; Kilian et al., 2003; Lasalvia et al., 2013). Hence, the objective of this article is to explore the trust establishment among patients with depression during their journey to psychiatric patient-hood. Because depression is perceived as a gendered phenomenon (Conrad, 2005; Ussher, 1991, 2011), the analysis aimed to examine gender differences of how men and women patients conceptualised trust establishment.

## 2. Literature Review

### 2.1 *Gender Perspective in Depression Studies*

Women who experience depression symptoms throughout their life course often regard the disease as “myth” and will be resolved on its own (Barn, 2008; Basu, 2012; Raphael et al., 2012). Often time, depression is perceived as a gendered phenomenon suffered by women mostly in a difficult situation (Conrad, 2005; Ussher, 2011). Feminists view women who live in oppressive settings as dominated by patriarchal power (Busfield, 1988). As Ussher (1991) perceives, mental illness is given a misogynist label and is socially constructed to keep the women status lower in the social hierarchy (Ussher, 1991).

In one of the feminist arguments, Garland-Thomson (2002) contends that both men and women diagnosed with mental illness would be veiled by a disability status, which is manifested in the construction of everyday language about the body. The “abnormal” or the “sick” self is then perceived as a docile body needing disciplining through the politics of medicalisation (Foucault, 1991). The stigma of mental illness stems patients as unpredictable, dangerous, and violent (Corrigan et al., 2011). Prejudices, stereotyping, and discrimination originating from the stigma often hamper the recovery process (Corrigan & Shapiro, 2010), and numerous studies have identified that men were also afflicted by the stigma. Men diagnosed with mental health issue are often perceived as having femininity qualities and abject bodies (Garland-Thomson, 2001). Such social pressure of aligning self with masculine hegemony has resulted in depressive men who are used to be confused, feeling powerlessness, and fragmented (Olliffe et al., 2013; Wong et al., 2012).

## *2.2 Doctor-Patient Relationship*

Amber Haque (2005) postulates that from service user and medical field's perspective, mental health care suffers poor image. Pertaining to medical field's perspective, Haque draws the unpopular choice of psychiatry as a subspecialty, which in fact, becomes the last resort for a medical student who is unable to join a more challenging medical field, viz., surgery, or neuroscience. In a similar vein, clinic socialisation with established norms was found to facilitate the shaping of internship or housemen's attitude. The subculture of GROG (get rid of patients) has interplayed as the relevant norms to survive in the medical field especially during junior years and the culture is further reinforced during the senior time (Mizrahi, 1985). The GROG paradigm is intertwined with a few factors: services cost, availability of technological medicine, whether the diagnosis is an interesting case to attend, rewards gained (intrinsic or extrinsic), and norms of efficiency. Norms of efficiency, in particular, is the critical point of an intern's performance evaluation; at this point his or her capability to reduce the treatment time is judged.

In another study, the practice of shifting patients to another physician was found to potentially breed human conflicts in medical care (Caldicott, 2007). Known as "turfing," the decision involves shifting uninteresting and challenging patients to junior doctors that will overburden them with unchallenging and routinize task. The junior doctors reported to be resented on the task overburden and in turn, are disbursed to the patients who are subject to stereotypes, such as name-calling and receiving degraded services as protest manifestation. Carr et al. (2004) identify that poor communication among service providers for schizophrenia patients invited integration issues during the crises. The finding unravels that although mental health staff and general practitioners agreed on the overlapping roles, the information distortion obviously revealed the new developed techniques and medication. This situation caused unsynchronised treatment provided across the treatment timeline.

As for the perspective of service users, Carpenter-Song (2009) found that Euro-Americans tend to engage in services to gain deeper understanding of the illness, whereas African Americans stay ambiguous and prefer a talk therapy from the physician. In this sense, the promise of explanation from the doctor is regarded as a feeling of control and power by the patients; however, it actually removes the patient's personal agency from their experiences of depression. Mental health nurses also play a significant role in supporting the patients.

Chambers et al. (2010) state that nurses' attitudes are likely influenced by the gender and the position they hold, as well as by the cultural, social, and institutional practices of the nursing profession. Nurses with positive attitudes are able to promote patient's independence, empower them to take control, be proactive in decision-making, and inspire hope and openness to other alternative treatments. Borba et al. (2012) indicate that trust in treatment fosters compliance and bridging to the right care. They particular noted that patients who trust their physician had expressed having a sense of meaning to live and were less likely to be admitted to the emergency room.

On the contrary, Crabtree (2003) uncovered that psychiatric ward staff displayed vulnerabilities in managing psychiatric patients and the former tend to prevent open and friendly relations. The staff accounts also illustrated that not only strong prejudices were held by the staff towards the service users but also stigma domination had influenced the professional judgement. Additionally, abused women seeking for psychiatric treatment were subjected to caring and uncaring treatment (Ormon et al., 2014). In uncaring treatment, these women suffer from being misinterpreted and from abusive experiences perceived as a secondary issue, leading them towards trust issues. Caring treatment, on the other hand, promotes self-confidence, which their experiences acknowledged and active listening took place. Simultaneously, trust is built across time with an added dynamic social interaction (Dawson-Rose et al., 2016). Trust is also used as a tool to prevent uncertainties within the medical judgement domain. Drawing from gynaecology field, Diamond-Brown (2016) emphasises the compatibility between doctor's philosophy and skills with patients' preference, which cultivates choices and build a trusting relationship. Similarly, this findings had challenged the idea of the evidence-based medicine (EBM) in which a standard approach is used to solve uncertainties in most medical models.

### *2.3 Conceptual framework*

The study adopted a social justice framework of health equity. A health equity approach is interested in the achievement and capability to obtain health, which includes the right processes in getting and providing the health care (Sen, 2002). It focuses on the wholesome of justice from the resources, the distribution, and the effect towards a diverse social setting. The combination of social, economic, and political apparatuses are set as the stratifiers of individual socio-economic standing and are determined by how the recipients are exposed to material,

psychosocial, biological, and behavioural circumstances, which later define the type of health care perceived by the beneficiaries (Solar & Irwin, 2010).

### 3. Methodology

The study adopted the phenomenology approach to explore the meaning of mental health care usage (Moustakas, 1994). In this method, patients who were attending governmental outpatient psychiatric clinic in Kedah and Pulau Pinang were selected for recruitment because their narratives represented the first-hand accounts for a particular phenomenon (Creswell, 2013). Twenty-nine service users were recruited based on three main inclusive criteria: (1) eighteen years old and above, (2) diagnosed with depression, and (3) has sought outpatient psychiatric clinic for at least twelve months. Two states in North Peninsular Malaysia were chosen, namely Kedah and Pulau Pinang, due to the increasing number of patients with depression in these states as recorded by the Malaysian Morbidity Health Survey (Abdul Kadir et al., 2011). Data were gathered through in-depth interviews with the informants. The semi-structured interviews, which were audio-taped, were adopted to explore the themes hidden under the accounts of doctor-patient relationship as the patients have experienced. The data were explicated using Atlas.ti, a qualitative data software. During the data collection, the study gained the ethical clearance from the Ministry of Health Malaysia (MOH) and the university's research board (IRB).

According to the demographic profiling, majority of informants were among Malays (20 Malay, 3 Chinese, 4 Indian, 2 Others) aged between 24 until 60 years old. Gender represents 21 female and eight male informants. There were five major groups of occupations employed by the patients: homemakers (24%), self-employed (24%), government sector (21%), private sector (24%), and pensioner (6.9%).

### 4. Findings

Majority of the informants expressed that the doctor's traits play a critical role in their continuous psychiatric treatment. Five subthemes emerged in terms of the physician's traits: competencies, integrity, concern, empathy, and enabling autonomy.

#### Competencies

The informants appeared to have wide descriptions of a physician's competencies in order to gauge them into a trusting relationship. One of the areas was the medicine given by

the doctor. According to the informants, the objective of seeking hospital treatment was to understand the differences of substantial experience they had and to get rid of the symptoms particularly by medicine taking. Hence, a physician's competencies are partly measured by the advice and the suitability of the medicine given to eliminate the depressive symptoms.

However, a few female informants mentioned that language barrier and cultural dissonant existed in the attended treatment. Some perceived the depressive experience as a personal matter, thus talking about it with an opposite gender physician invited a sense of uncomfortableness and embarrassment. Although different gender disclosure can potentially distort the communication flow in the treatment, the physician is inclined to mixing medical jargon with different languages (for example, mixing English language in the conversation to a non-native speaker), resulting in confusion at the informant's end. This will hamper the rapport and support to be established. Dina elaborated her feeling when consulting a physician of opposite gender and different ethnicity:

*I like to see a female doctor, and even better if the doctor is a Malay. Not that I don't like Chinese or Indian doctors, but the way they say things are a bit "weird." I can't recognize what they were saying. As for the male doctor, well, I am a shy person, especially when I need to be alone with a non-mahram doctor during the session, it just not right!*

(Dina, 48, Female, Homemaker)

#### 4.1 Integrity

Integrity in this context is defined as the degree of confidence in the doctor's code of conduct that leaves the patient feeling that his or her rights are safeguarded across the treatment. The data revealed that the informants perceived their physician as trustworthy and upholding of high morality especially in helping them to resolve their depressive symptoms. They also stated that accepting a patient as a person in a psychotherapy can significantly build their confidence in the physician.

Gender differences in this subtheme reveal that compared to the male informants, the female informants were more trusting of their doctor. The female informants particularly felt that they were being heard, were able to sense making of the depressive experience, and thus felt a sense of belongingness in the intervention. On the other hand, the male informants gave mixed accounts; they believed that the turfing exercises have made them confused. In particular

they were confused on the information input from various doctors and were sceptical on the confidentiality of the personal information shared. One informant, Ahmad, has been actively applying information filter to his psychiatrist and counsellor. He felt that his rights as a patient was violated because he deemed the expression he made to his psychiatrist and counsellor was not to be shared and should remain private.

#### *4.2 Concern*

A basic empathetic gesture of a health care provider is being concerned to the patients. Most of the informants, regardless of gender, considered this core element of attention as essential to building a trusting relationship with their care provider. Although many studies have concluded the stigmatising treatment given by the doctors to mental health patients (Crabtree, 2003; Koekkoek et al., 2011; Minas et al., 2011), the present study intends to challenge this notion. Majority of the homemakers interviewed in this study were bound to the caring tasks of family members, they are either sick or children. At the same time, various studies have suggested that the caretakers of mental health patients have a fair share of stigma, exposing themselves for prejudice and discrimination from the public (Crabtree & Chong, 1999; Hight et al., 2005; Kim, 2015). If this is not the case, women who are burdened with caretaking and at the same time help to earn family income would be working double shift in a day (Busfield, 1988). These people often are those living a stressful and depressive lifestyle.

Nevertheless, a concerned and observable doctor would grasp the social environment in his or her consultation clinic, especially when a patient is accompanied by a stressful caretaker. Maria, a mother and a caretaker for her ADHD son, is also a tailor and living with her substance abuser husband. She has succumbed to the pressure by bursting into tears after her child's psychiatrist asked how she was doing. This situation is regarded as a breakthrough to getting the treatment, and then the next time she knew, she was a patient of the same clinic with her child. In this case, the doctor was concerned for her well-being, and she detected that Maria was in a depression while unleashing her stress. Without having to follow the regular registration procedure that needed her at least six weeks for an appointment, she obtained her first treatment the same day with her son's appointment.

Many informants, male or female, opposed the turfing exercise that the act was seen as building an impersonal relationship. However, the exercise also allowed them to explore a suitable physician for their treatment. Majority of the male informants expressed their



preference to be treated by a female physician rather than by a male doctor. Male doctors were seen as objective and dehumanising the treatment, and the informants hardly found a common ground that has led to a trustful relationship.

#### 4.3 Empathy

Empathy is a therapeutic gesture that fosters a sense of belonging to cope with the misery a patient experienced (Ryrie & Norman, 2004). In the present study, the informants felt that they were being listened to with full interest by the doctors during the psychotherapy. This was also an important turning point for most informants where they found hope of helping hands in the treatment. In fact, the informants appreciated physicians who go beyond their depressive symptoms, for example, those who asked on financial hardship, marital problems, or workplace problems where the root of depressive symptoms grew. This was clearly implied by an analysis of a female informant's response concerning her doctor's empathy on her current state of marital distress:

*At the earlier stage, I came to see my doctor; I was crying non-stop. He asked whether I've taken my medication. I nodded. He asked me again why I continue crying. I said I was sad. Suddenly, he punched his desk very hard that took me in shock! He said why did I ruined my life grieving for my unfaithful husband? I felt like I was slapped. He was right! Only then I realized and stopped crying....*

(Azfa, 45, Female, Businesswoman)

#### 4.4 Enabling Autonomy

The findings also unravel that the physicians who attend to psychiatric cases were able to promote agency in the informants. The principle of patient's autonomy has gained a wide acceptance particularly in the western society as a social justice for patients to determine their future, through decision making in the treatment and partnership in service revamp, among others (Koyanagi & Bazelon, 2007; Schaefer, 1998). Most of the informants enjoyed the constant feedback on the newly medication or treatment interventions, which has helped in giving life strategies and in supporting them to reduce medicine intake. The neutrality stands depicted by the doctors is therapeutic in nature because the informants allowed taking charge in their treatment. Correspondingly, Bishop et al. (2007) maintain that the neutrality stand adopted by doctors is regarded as an ethical conduct because they avoid regulating the decision

made by the patients and indirectly empower them. Fatin, 44, divorcee, homemaker, and care provider for her mother expressed that her psychiatrist was happy and supportive of her decision when she decided to take off the pills from the treatment after eighteen months of consultation. Another similar account from a male informant implies that the knowledge imparted by the doctor is crucial for him to comprehend what was happening as the depressive episode strikes. This also increases his confidence towards the treatment.

## 5. Discussion and Conclusion

This paper explores the trust establishment among patients with depression upon their embarkation to patient hood. At least five subthemes of trust were identified from the data. The subthemes are doctor's competencies, integrity, concern, empathy, and enabling autonomy. Each informant pointed out the vitality of active social interaction in the central cushioning of each subtheme. The findings eventually are consistent with those found by Mechanic and Meyer (2000), who concluded that trust as conceptualised by patients with serious illness involved interpersonal competence, caring, concern and empathy with high listening skill, having technical competence, and the agent who fight for the patient's right in health care. The findings indicated that doctor's competencies towards the psychiatric knowledge and latest encounters in the field were among the top listed by the informants. The acceptance for taking the treatment involved the process of normalisation of medical discourse for depression, which is partly contributed by the mass media which discusses the issue openly and hosts confession of numerous public figures (Kangas, 2004). Although the informants did not disclose openly about their illness due to stigma, they freely shared their experience in the interventions. Besides, doctors were evaluated from their gesture of care, empathy, and enabling autonomy. In this matter, concern and empathy were regarded as the basic care in the treatment. These elements also define that the patients are treated as human beings, which eventually shaped their sense of belongingness. The therapeutic effect of these elements was described by the informants as having a sense of serenity when the appointment is approaching, feeling calm while in the psychiatric clinic, and after seeing the doctor's signage. On the other hand, an enabling autonomy signifies empowerment by undertaking responsibility for the decision made. However, the neutrality stands challenged by Skirbekk et al. (2011), who found that a trusting relationship requires the physician to stand for the patient's right especially when dealing with health bureaucracy. In this sense, adapting a neutrality stand should be limited to

a certain point, where a patient should gain her agency in determining the beyond (Mechanic & Meyer, 2000). However, when dealing with intra-agency which requires administrative know-how, guidance and support from the doctors are necessary. It engenders the trust because it fosters an open relationship. The patients usually found their sense of belongingness in the treatment by having a common ground of understanding.

Gender differences detected in doctor's competencies and integrity have highlighted the language barriers and cultural dissonant among the female informants. Trust also vanishes when the doctor's integrity is revoked through untrustworthy encounter. In this context, some female informants felt uncomfortable consulting the opposite gender, and most male informants' revealed preference for the female physician. In this realm, male physicians are likely to abide with the medical role in providing the medical needs, but performing this role alone would draw a limited mandates of trust. According to Skirbekk et al. (2011), limited mandates of trust inhibit openness to authorise the doctors to undertake their medical judgment on the patients. In this regard, male doctors would have certain degree of expectation for both genders to get better, and this was emphasised more on the male informants by inserting the values of masculine hegemony in the treatment (Oliffe et al., 2013; Wong et al., 2012). Besides, female doctors were perceived as having more mandates of trust because they go beyond their role expectations as physicians by touching some areas of informants' psychosocial problems. This is characterised as more empathetic than the practice of male doctors. The female doctors were often regarded as having nuance experience with the female informants, but the male informants in particular have stereotyped the gender roles of caring displayed by the female physician. Besides, patients who have doctors who act beyond the normal role expectation knew their doctors as a person, despite being treated as a person.

In a nutshell, trust is enacted and gained through series of attempts of social interaction between the doctor and the patient. Therefore, trust is a negotiated process to a certain degree. Patients are always testing the negotiating opportunities with their doctors (Skirbekk et al., 2011). Thus, a doctor-patient relationship should be directed into securing the mandates of trust in order to enable openness in the social interaction and to augment the patient's sense of worth, especially psychiatric patients.

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