ASPECTS OF DOCTOR – DEPRESSIVE PATIENT RELATIONSHIP

MIHAELA DANA BUCUȚĂ[1]

[1] *"Lucian Blaga" University of Sibiu*

Keywords: *depression, doctor-patient relationship, medical aid, interpretative phenomenological analysis*

Abstract: *This study addresses the doctor-depressive patient relationship from the perspective of the process peculiarities pertaining to asking for and receiving medical help. The purpose of this study is to deeply explore the process of requesting and receiving medical aid in dealing with depression, in order to identify its improvement opportunities. The test group consists of 20 patients diagnosed with depression and the examination method is the interpretative phenomenological analysis. Results indicate the fact that depressive individuals' decision to seek professional help appears during the second evaluation (Lazarus and Folkman 1984), when they evaluate their available resources and when they find that they neither possess them nor are able to longer cope with the situation. Medical aid is perceived to be useful or less useful primarily based on the personal level of support and the quality of the doctor-patient relationship. The quality of the relationship depends on the reception of the three types of medical aid: emotional, informational and instrumental support.*

INTRODUCTION

Several theories and models have been developed and implemented to explain and understand how people ask for help when confronted with mental health problems. The identification and study of those factors, which could predict whether and how people seek help when they need it, has been the focus of much research.(1) Despite their usefulness in understanding medical aid seeking behaviour, no theory is yet completely accepted.(2) Studies show that despite substantial efforts, aimed at informing individuals about health care, they do not guarantee that people will take the steps required to seek professional help. Stigmatization closely relates to the actual professional aid seeking behaviour. To avoid identification with a group vulnerable to discrimination, stigma and self-stigmatization lead to avoidance in accessing psychiatric services, often delaying diagnosis and treatment.(3) Despite the consensus that stigma inhibits aid seeking, there are very few empirical studies that actually measured this relationship.(2)

Influencing social support is difficult.(4) Studies on professional aid, a process generally excluded from the social support literature and from paraprofessional help (5) provides evidence that interpersonal support can substantially reduce psychopathological disturbances.

It is a known fact that a less than good doctor - patient relationship affects the quality of care and the ability of the patient to cope with the disease, leading to noncompliance with medical indications.(6) The patient repeatedly opts for other doctors ("doctor-shopping"), is anxious and may even choose unscientific treatment modalities.(7) Moreover, when talking about patients belonging to groups vulnerable to discrimination, such as depressed patients, the quality of the doctor - patient relationship becomes even more important. Although there are numerous studies that focus on the doctors' interpersonal communication and relationship-building skills,(6) there are yet few studies that emphasize "the patients' voices", their experiences and the significance of the relationship with their doctor.

Reducing side effects, adverse reactions and potential complications represents in this context a fundamental coordinate of the medical activity, which joins with promoting patient welfare.(8)

PURPOSE

This study is part of a broader investigation targeting depressive experience and the meaning of psychosocial support.(9) The purpose of this study is to deeply explore the process of asking for and receiving professional (medical) help in dealing with depression, in order to identify its improvement opportunities.

Another methodological purpose derives, on the one hand from the increasing value attributed to qualitative methodologies in health research and from the proliferation of research using interpretative phenomenological analysis in the area of health and disease, on the other.(10)

The second purpose of the present study is therefore to display the interpretative phenomenological analysis (IPA) as a qualitative research method that could bring valuable data to health and disease research.

MATERIALS AND METHODS

The study centres on the following research questions: "How do people suffering from depression experience the process pertaining to requesting and the receiving professional (medical) aid and what are the meanings they associate with it?"

What are the needs of the people suffering from depression and how satisfied are they with the process of requesting and receiving medical aid?

In agreement with the purpose and the questions of this research, the method chosen is the interpretative phenomenological analysis, due to its usefulness when "there is a concern regarding complexity, processes or innovation".(11)

The IPA approach is associated with research areas, such as the phenomenological and symbolic interactions which holds that people are not passive recipients of an objective reality, but rather come to interpret and understand the world by

[1]Corresponding author: Mihaela Dana Bucuță, B-dul. Victoriei, Nr. 40, Sibiu, România, E-mail: mihaela.bucuta@ulbsibiu.ro, Phone: +40269 235804
Article received on 06.04.2015 and accepted for publication on 29.05.2015
ACTA MEDICA TRANSILVANICA June 2015;20(2):27-30

formulating their own biographical narratives in a form that makes sense to them.(10) Within the biomedical approach to disease, clinicians have realized the importance of understanding the patients' perceptions about their bodily experiences and the meanings they attributed to them.(12)

IPA is thus not only phenomenological due to its concern with individual perceptions, but also interpretative or hermeneutical, because it recognizes the primary role of the scientist in attributing meaning to the individuals' personal experiences.(13) Moreover, IPA involves "a double hermeneutics" within which "the researcher attempts to understand the participants' efforts to comprehend their world".(14) Allowing both aspects in the scope of research can lead to a richer analysis.

Although IPA involves a broad and deep analysis of a set of case studies, the analysis is not simply supported, but rather discussed in relation to alternative literature.(14) IPA is fully congruent with the increasing patient- centred orientation.

Sampling: As an ideographic method, the small size of the research batch becomes mandatory in IPA, as an analysis of large data sets may fail to present "the potentially subtle curve of significance".(15) Criteria for inclusion in the research group:

- Main criteria: medical diagnosis of a mild to moderate episode of depression, gender, hospitalized and non-hospitalized patients, marital status.
- Secondary criteria: intensity of depression; patients at the first episode of depression/ patients with more episodes of depression; level of education.

The sampling structure generated a batch of 40 subjects, of which, after applying the selection criteria, 20 people consented to participate in the study.

Data collection: semi-structured, phenomenological interview. Interview duration varied depending on the mood and needs of the participants, averaging about an hour and a half.

Data analysis and interpretation followed the procedure indicated by J Smith, which is unique to the interpretative phenomenological analysis:

1. Searching for the first case themes
2. Coding
3. Searching for connexions,
4. Generating the theme matrix
5. Continuation of the analysis with the subsequent cases
6. Obtaining the final matrix
7. Analysis and discussion of the research results: the two levels of interpretation ("depressive person's voice" and researcher interpretation).

Validity: In accordance with the methodological principles of quality in qualitative research (16), two validation procedures were used: participant as well as inter-assessor validation.

RESULTS

The analysis started with the assumption that the "participant, as a cognitive, emotional and physical being" is trying to make sense of his or her own (psychological and social) world. The processing of data yielded a matrix presenting five major themes: Making sense of depression, Living with depression, Self-perception, Coping and finally Social support. In this study, I focus on the fifth theme, that of social support, with the subtheme of requesting and receiving medical aid.

The first level of data analysis focuses on "the voice" of the depressed patient, his or her experience regarding the complex process pertaining to requesting and receiving medical aid.

Requesting medical aid: The road travelled by the study participants began in almost all cases from the family doctor to the specialists (cardiology, endocrinology etc.), and only afterwards to the psychiatrist. From the aspects, that mark the onset of depression, somatic and physiological complaints were selected as being the reason for requesting the first medical examination: insomnia, rapid weight decrease, restlessness, extreme fatigue.

"I realized during... the hospital stay what the problem was ... Well, the doctors we talked to then- I already told you - I did all examinations ... medical investigations, including uh ... CT, all were good (pause) ... I did everything ... really every possible test .... There was nothing! Everything was perfect!" (Liviu, 2).

By the process of exclusion, the patient began suspecting psychiatric disorders and underwent a psychiatric examination:

"Well ... In the end I guessed it myself – I said: Lord! It is not a pathological symptom, it's rather a problem of the nervous system, which needs to be more protected and I need to strengthen". (Liviu, 3)

But to call on a psychiatrist is not easy; fear of mental illness, of receiving the "verdict" in the form of a psychiatric diagnosis, fear of gossip, stigma, and not least misunderstandings regarding their condition, pushes many patients to postpone the specialist/psychiatric consultation.

"A: And unfortunately I had to go to a psychiatrist ...

Q: Why do you say unfortunately?

A: Because ... I was trying to do it alone. I said maybe, maybe these episodes are fleeting. I'll get over them. Uh ... dun no uh ... you know ... what might the colleagues say ... others ... dun no ... I tried on my own but I failed" (Ioana, 10).

Medical aid: For those suffering from recurrent depression, once the diagnosis is finished and the treatment agreed (during the first depressive episode), the application and specialized aid follows an already well-known path. During the first depressive episode two years ago, Mircea first addressed the family doctor because *"I don't feel good, I have no appetite and I lost weight, I'm always very tired ... and I can't sleep, and ... I'm trembling all the time"* and has done many examinations. *"I did all the tests, also the heart, and blood, and the glands ... and al"*. Only after these tests, following the suggestion of the family doctor, did he request a psychiatric consultation (in a private clinic). During the second episode he immediately requested psychiatric aid:

"Yes. I realize that it doesn't make sense to me to go look somewhere else because ... here's support, because ... I had previous experience". (Mircea, 15).

Hospitalization, beyond providing treatment, becomes an autonomous form of help for many of those admitted: to *"relax"* is as important as the treatment.

"I relax here ... they give me good medicine, I can't say anything, I feel good. 'Cause home na uh ... there're always problems! And stress and all ... 'Cause at home everything falls on me..." (Maria, 7).

Of the whole study group, only two participants addressed the psychiatrist directly. Livia immediately addresses the psychiatrist, at the suggestion of a family member (a social worker in the psychiatric hospital). The request for psychiatric consultation and specialized aid are however loaded with fear.

"I dun no ... I was thinking! Being uh ... Having gone there, in psychiatry, and I saw so many cases believe me! I was horror-struck! I was actually horror-struck! I said, God forbid, I shall not end here! That fear!" (Livia, 8)

In this context, drug treatment may be regarded fearfully, distrusting.

The main demand of all participants, among the few

explicit requests for help, mentions a treatment that should help them *"feel better"*. Answers to the question *"How do you feel about the aid from your doctor"* also reveal, however, other needs and types of support in the doctor–patient relationship.

Confidence: Analysis of the results shows that for depressed people the relationship with the treating psychiatrist is essential in their confrontation with depression. Trust in this relationship has a direct effect on the acceptance and compliance with the treatment.

"Yes, yes. Uh ... I trusted the doctor, the treatment he gave me was appropriate,... because at one point, before coming here I was afraid to take medicine! Effectively... I was afraid to take medicine! Effectively... Very afraid". (Marian, 2) This trust is earned and bases on treating the patient with kindness and respect.

"Cause if a physician is ... is talking nice, it's kind a different! Or ... You can see that you got a treatment or something and come, you have full trust". (Lucia, 8) The non-hospitalized patients, unlike the hospitalized ones, do not make many references to trust.

Encouragement: To live with depression is to live with much fear, pain and uncertainty regarding the ability to overcome this disease and implicitly, uncertainty about the future. Dissuasion is omnipresent. In this context, seeking the specialized (psychiatric) help proves on the one hand that what these people go through is a serious (and stigmatizing) illness and grants on the other hand hope for getting the disease's diagnosis and for healing by following the prescribed treatment. The need to be encouraged, assured and reassured that healing is possible is one of the biggest needs of the study participants. It truly receives value if it comes from a doctor because *"he knows the disease best"*.

"I think I'll get better, right? Let's hope, because that's what the doctor said ... And so, after treatment, I feel as if... mmmm... I even rested these nights, so .... (emphasizes) it's pretty well! After the pills! I took ... tablets"! (Lucia, 7).

Informational support: Most do not require explicit information on the nature of depression, although the need to understand what is happening is very high. In most cases, the specialist's information is limited to the diagnosis (misunderstood by those with lower education and little understood by those with secondary and higher education) and the treatment schedule.

DISCUSSIONS

Depressed patients need help in the intense confrontation with depression. If identifying and naming the aid sources is easy, i.e. psychiatrist and family, it is extremely difficult for patients to identify and name their needs.

The results show that those primary network doctors who neglect psychosomatic components preferentially seek somatic diagnoses. They are not trained in detecting mental disorders and can contribute to somatisation, results also reported by other studies.(17)

The patient expects doctors to be competent, to accept and to encourage their patients.

In the eyes of depressive people, competence means *"good treatment"* and especially availability, openness and empathy. Acceptance relates to the quality of time spent with the patient: *"having patience with someone"* and encouraging bears significance in sparking hope.

To be able to trust the psychiatrist is another need expressed by most participants. This is not easy, considering the stigmatization, which patients fear so much. For people suffering from depression, confidence in the physician develops only if they are treated with great kindness, care, openness and willingness to be heard.

Being encouraged is extremely important; for most, the hope to get out of the *"dire state"* primarily relates to the psychiatrist.

Another need (especially of those during the first episode of depression) is to feel understood. During the ordeal of trying to make sense of the depressive experience, to understand what is happening, they need a companion who does understand, not judge, we can help them understand and finally, accept themselves. This expectation is directed towards the doctor, because he *"knows the disease best"*.

Although rarely expressed to specialists, the results show that there is a need to receive informational support from doctors. Information on diagnosis, – to help them understand what depression is, – and on treatment, – the effect of medicines, the time required to improve symptoms, the order in which they subside, side effects of the drugs, drug dependence and the evolution of depression. Results show that depressed patients perceive that doctors insufficiently meet this need.

The patient expects to receive guidance, information on how to cope with the depression and what to do so that they can cope better/easier with depression. In this regard, survey participants assessed that far too few physicians meet this need.

The informational support given is seen by most participants as a proof that doctors care, support and encourage them; this aspect is what ultimately leads them to feel they can trust. The tangible form of support we appreciate from doctors consists predictably in the competent use of medical skills.

For people with multiple depressive episodes, hospitalized in a psychiatric hospital, this did not just mean providing treatment, but also the temporary removal from a stressful family environment, this being in itself a form of help. Access to treatment is often conditioned by financial difficulties, medicine and health services having strong connections with other systems: the economic, political and social systems.(18)

What causes specialized aid to be perceived as useful while sometimes the same aid being perceived as useless? The results of this study indicate that depressed people appreciate the support as useful or less useful primarily based on the personal support setting, and the quality of the doctor-patient relationship. The results are consistent with numerous studies showing the positive effect of clinical empathy and appropriate doctor behaviours.(19)

The perspective of depressive people on the topic of usefulness or uselessness of the medical aid is summarized in the following table, according to a system of predefined social support categories, after Cuttrona and Russell.(20)

Table no. 1. Usefulness or uselessness of the medical aid according to Cuttrona and Russell's predefined social support categories

Support type	Useful	Inappropriate
Emotional support	- Listening (giving time); - Benevolence, openness; - expression of interest and compassion regarding the expressed suffering; - „taking care".	- Lack of respect or care; - Insensitive comments; - trivializing the symptoms;
Informational Support	- Information (mental disease characteristics, the nature of depression, the effects of treatment); - Advice, precise instructions;	- Suggestions to "*have patience*"; - Diagnostic's communication without explanations; - Allocation of a treatment plan without assertions (the symptoms'

		remission, secondary effects, suggestions about what to do with-out explaining how);
Instrumental Support	- Competence;	- deficient medical treatment

CONCLUSIONS

Searching for support proves to be a social action involving complex interactions between depressive individuals and the people close to them (2), including those between the person and the doctor. The decision of depressive individuals to seek professional help appears during the second evaluation (21), simultaneous with the evaluation of their available resources and finding they do not have any left and cannot cope on their own.

There is a risk that some doctors in the primary care network contribute to somatisation (17), through neglect of psychosocial components and through preferential search of somatic diagnoses. The assessment of the psychiatric diagnosis and the appropriate treatment confer depressed patients the status of being ill, which most often sensitizes and mobilizes the partner and the family in providing aid. Although experiencing an acute need to be helped, depressed patients are facing serious difficulties in identifying their needs. They also present difficulties in requesting and receiving assistance, including help. The main sources perceived as helpful are the family and the doctor. There are similarities between the expectations they have from family and doctors. The main needs are related to a feeling of closeness, to be understood and be accepted.

All participants said their expectations from doctors consist in their expertise and capacity regarding medical aid. The results show however the high emphasis on the doctor-patient relationship during administration and evaluation of medical aid. Many depressed people only feel truly understood by the current treating psychiatrist due to their professional authority and their function as clarifying interpreter, i.e. the psychiatrist puts into words and thus gives form to the feelings so hard to understand by the depressed person. Informational support coming from the doctors is seen by most participants as a proof that they care, that they support and encourage them; this is what ultimately leads them to feel they can trust. Predictably, the tangible form of support from doctors that patients appreciate consists of the usage of competent medical skills.

The results of this study emphasize the importance of the relationship with the physician in assessing medical aid. Useful in relation to any patient, transversal skills such as the ability to empathize, to communicate, to resonate with the patient, to win their trust (6) are indispensable in addressing depressive patients, who are vulnerable and at risk of discrimination. It is an aspect, which should be given more attention to in any action regarding prevention and intervention in cases of depression.

REFERENCES

1. Nadler A. Help-seeking behaviour: Psychological costs and instrumental benefits. In Clark M.S. editor. Prosocial Behaviour. Review of Personality and Social Psychology Newbury Park, CA: Sage Publications. 1991;12:290-311.
2. Soponaru C. Căutarea ajutorului profesional psihologic. In Dafinoiu I, Boncu Ș, editors. Psihologie socială clinică. Iași:Editura Polirom; 2015.p. 433-448.
3. Corrigan P. How stigma interferes with mental health care. American Psychologist. 2004;59:614-625.
4. Lakey B, Lutz CJ. Social support and preventive and therapeutic interventions. In G.R. Pierce G. R, Sarason B.R, and I.G. Sarason I.G. Editors. Handbook of Social Support and the Family. New York: Plenum Press; 1996.
5. Christensen A, Jacobson NS. Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. Psychological Sciences. 1994;5;8-14.
6. Sassu R. Prevenția discriminării în cadrul relației medic-pacient. În: Morar S, editor. Nondiscriminare în sistemul de sănătate. Sibiu: Editura Techno Media; 2015. p. 223-239.
7. Shrivastava SR, Shrivastava PS, Ramasamy J. Exploring the dimensions of doctor-patient relationship in clinical practice in hospital settings. International Journal of Health Policy and Management. 2014;2(4):159-160.
8. Morar S. Noțiuni generale despre discriminare. În: Nondiscriminare în sistemul de sănătate. Sibiu: Editura Tehno Media; 2015. p. 7- 27.
9. Bucuță MD. Experiența depresivă și semnificația suportului social. *in press*
10. Brocki JM, Wearden AJ. A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. Psychology and Health. 2006;21(1):87-108.
11. Smith JA, Osborn M. Interpretative Phenomenological Analysis. In J.A. Smith. editor. Qualitative Psychology: A practical guide to research methods. London: Sage Publications; 2003. p. 3.
12. Smith JA, Jarman M, Osborn M. Doing Interpretative Phenomenological Analysis. In Murray M, Chamberlain K, editors. Qualitative Health Psychology. London: Sage Publications; 1999.
13. Giorgi A, Giorgi B. Phenomenology. In: Smith J.A, editor. Qualitative Psychology: A practical guide to research methods. London: Sage; 2003.
14. Smith JA. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative reasearch in psychology. Qualitative Research in Psychology. 2004;1:39-54.
15. Collins K, Nicolson P. The meaning of 'satisfaction' for people with dermatological problems: Reassessing approaches to qualitative health psychology research. Journal of Health Psycholog. 2002;7:615-629.
16. Elliott R, Fischer CT, Rennie DL. Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal of Clinical Psycholog. 1999;38, 215-229.
17. Katon W. Depression: somatic symptoms and medical disorders in primary care. Psychiatry. 1982;23;274-287.
18. Corman S. Politici sociale de profilaxie și combatere a discriminării. În: Morar S, editor. Nondiscriminare în sistemul de sănătate. Sibiu: Editura Techno Media; 2015. p. 239-256.
19. Ahrweiler F, Neumann M, Goldblatt H, Hahn EG, Scheffer C. Determinants of physician empathy during medical education: hypothetical conclusions from an exploratory qualitative survey of practicing physicians. BMC medical education. 2014;14(1):122.
20. Cutrona CE, Russell DW. Type of social support and specific stress: Toward a theory of optimal matching. In: Sarason, G, Sarason BR. and Pierce GR, editors. Social Support: An Interactional View. New York: Wiley; 1990. p. 319-366.
21. Lazarus RS, Folkman S. Stress, Appraisal and Coping. New York: Springer; 1984.