



EMOTIONAL INTELLIGENCE IN CONTEXT OF THERAPEUTIC- RELATIONSHIP

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ABSTRACT

From the technical point of view, the medical act is limited to establishing a diagnosis for the purpose of recommending a treatment. Are things so simple? From a hermeneutic-philosophical point of view, any medical act involves a meeting between two individuals, with the establishment of a special type of inter-human relationship, conditioned by the specific context of this encounter. For this reason, emotional load can reach extreme levels by the existence of factors that include: an nearness that goes beyond the comfort zone of the individual, touching body area, approaching intimate subjects, to receive news (good or bad). But what is the rol of emotional intelligence, in therapeutic communications? This study approach the subject in modern medical conception who places more emphasis on the involvement of emotional factors in medical communications. The article brings attention, through a study on 200 patients, the importance of the emotional approach of the patient in the light of previously exposed. The patient - centered medicine has emerged as a need to change the paradigm of the medical act, in which the patient's approach is individualized and holistic, in a bio-psycho-social context. The present substudy is a part of a large study carried out between 2008-2016; is a prospective, mixt study who fulfills the conditions for human studies. Applying this medical model leads to the emergence of new concepts in medicine, that go beyond the classical model, namely: redefinition of the therapeutic relationship and its model of functioning.

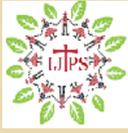
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INTRODUCTION

Numerous studies published in recent years highlight the role of EI in medicine, highlighting its importance in patient-centered medicine. Starting from this premise, the manifestation of EI in the therapeutic relationship, the present study, demonstrates the causal link between this and the acceptance of diagnosis in patients with psychosomatic disorders. It is important to emphasize that a series of relational variables that can be considered an attribute of emotional intelligence, seen as an ability to understand and manage emotions, contribute to accepting the diagnosis in the study (Jhonson D.R, 2015).

1. PROBLEM STATEMENT

It is recognized that resistance to therapy can be related to the patient's approach, referring mainly to communication between the two actors of the relationship. In the light of this approach, the results of medical literature studies demonstrate that the notion of



therapeutic alliance alters a classical concept: diagnosis and prognosis of evolution are not exclusively patient or physician-related, representing in fact, an interactive process. We preferred to use the notion of therapeutic alliance because its linguistic significance suggests the notion of partnership needed to achieve the goal of any medical act. What are the factors that contribute to the success of the medical act, turning it into a successful action in the fight against diseases, beyond scientific knowledge - medical "technique"? Studies show that the therapeutic relationship has an important share in the economy of any medical act, as evidenced by the literature data. At the same time, it is recognized that "the therapeutic relationship is one of the most profound and difficult to define inter-human relationships." (Gelso; Gelso & Hayes, 2014; 1998).

As a result of these findings, we considered that the notion of therapeutic relationship is based on the following concepts: 1. Working relationship; 2. Configuration of transfer; 3. Real relationship.

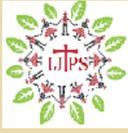
The medical and psychological interdisciplinary studies conducted by working groups based on a series of meta-analyses have led to the conclusion that there are several elements of the therapeutic relationship that have proven effective, such as congruence / authenticity, repair of deterioration of the therapeutic alliance and the countertransference; these were considered promising, but the studies currently in place have provided insufficient evidence to be considered conclusive. However, a series of conclusions also supported by studies can't be denied.

The therapeutic relationship has emotional and informational components; De Blasi et al. (2001) called them emotional and cognitive care. Emotional care includes mutual understanding, empathy, respect, authenticity, acceptance, and warmth. Cognitive care involves aspects of communication, information gathering, information sharing, patient education, and management of expectations. This concept interconnects the dual, emotional and cognitive relationship of the doctor-patient relationship, thus being able to improve the quality of the interpersonal relation. As far as psychosomatic disorders are concerned, starting from diagnosis, acceptance and awareness, they involve a special approach from the perspective of the doctor-patient relationship. First of all, it is an emotional analysis of this special type relationship, and then, about the phenomenological - hermeneutical context's of the psychosomatic disorders.

Diagnosis of psychosomatic disorders, beyond the specifics of a medical diagnosis, involves a biopsychosocial diagnostic component.

It is obvious that somatization increases the addressability and rate of use of medical services. The mechanism underpinning the relationship between knowledge, somatization and some type of behavior (abnormal, dysfunctional) to illness is not yet fully elucidated, although it is recognized and accepted that somatization is related to perception and a number of cognitive-behavioral factors. Essentially, in patients with symptomatic-somatic disorders, there is a causal effect between somatization and abnormal behavior.

From the perspective of the therapeutic relationship, it is important for the doctor to recognize somatization and, implicitly, abnormal behavior towards the disease in order to avoid sending the patient to other medical specialties, a process that generates unnecessary costs in the health system (investigations, treatments) and many situations are at the root of the iatrogenic disease phenomenon. From a different perspective of the therapeutic relationship, it is important for the physician to recognize the abnormal behavior of psychosomatic disease of the disease and not to encourage and strengthen it by the attitude towards the patient (Chaturvedy S.K, Desai G & Shaligram D, 2009).



There is also scientific evidence that somatization is related to emotional disturbances. In patients with emotional disturbances (anxiety, depression, or just negative affectivity), there is a diminished capacity to become aware of certain emotional experiences associated with diminishing the to express emotions. This aspect is directly related to the therapeutic relationship, in the context in which, , the patient will exhibit a certain attachment in relation to the physician. Research linked by attachment theory shows that a dysfunctional attachment (as an expression of some childhood traumas, for example) will impose a therapeutic relationship characterized by manifesting a defensive style in the processing and expression of emotions. An essential aspect of the therapeutic relationship is precisely its nature based on unconditional acceptance and empathy, a deeply emotional relationship that, in the context of the previously exposed, can be significantly influenced in a negative sense. This emotional dysfunction, with consequences at the level of the therapeutic relationship, will have implications in both diagnostic and later therapeutic acceptance.

In this context, the therapeutic relationship - the particular social concept - represents a major pillar of diagnosis and later acceptance of specific therapy. Psychosomatic disorders probably illustrate, in the best way, the interface between health and illness, seen from the cognitive and emotional perspective. In this sense, psychosomatic disorders can be defined as a transformation of emotional pain and an internal and relational conflict, in a physical expression, with an accepted social and cultural code.

Communicating a diagnosis has major implications in all areas of patient life. For this reason, in addition to the current impact, in the case of chronic conditions, there are long-term implications. Understanding and accepting the diagnosis depends on certain variables, referring in this case to the experience of the disease, the type of personality, the perception of the symptoms, the level of training and the cultural codes of the patient, the type of person and the ability to adapt to the disease. The consequence of accepting the diagnosis is to accept the social role of the patient. The status of somatic affections is supported by a series of evidence (laboratory analysis, imaging), but in the case of psychosomatic disorders, we are in the field of subjective manifestations that blame the patient and stigmatize it . Therefore, a first step in creating and strengthening the therapeutic alliance is to destigmatize the patient and provide emotional support.

Marinker's theory (Marinker, 1975) postulates the existence of three different ways of perceiving the disease: having a disease, to feeling ill, or being recognized as sick. Depending on the beliefs, the personal or social aspirations, the cultural code of the person, the person accepts or not the role of sick. An essential role in the process of diagnostic acceptance is played by the patient's perception of the disease. Each individual has a certain representation of the disease, starting from the state of health. A possible reason for not accepting the diagnosis and, implicitly, therapy at the level of the therapeutic relationship could be the inconsistency between the terms used by the physician and those used / understood by the patient to define the same notions: health, illness, and also for the description of his own symptomatology. To accept the diagnosis, it is absolutely necessary to create a safe context for the patient . The doctor will use the patient's personal resources to build an efficient coping mechanism.

The therapeutic relationship influences the patient's thinking, expectations and trust, investing the doctor with authority, proving that doctor-patient diada are essential for a positive therapeutic response (reducing symptoms or slowing progression of disease, avoiding complications, accepting therapy). Studies have confirmed that the patient's evaluation from the perspective of the therapeutic relationship has been more strongly



correlated with the favorable outcomes than the assessment from the therapist's perspective. In the medical profession, trust is seen as a global attribute of relationships. Satisfaction must include communication, competence, and patient biopsychosocial approach, including the approach to privacy. This is considered vital to effective cooperation in accepting diagnosis and treatment recommendations.

The notion of attachment is also found in the therapeutic relationship. The attachment theory (Bowlby, 1971 & Aynsworth, 1967) refers to the need of human beings to form and maintain strong emotional ties with / towards other human beings. From the point of view of medical practice, the applicability of the attachment theory refers to the retrieval of the attachment experience in the therapeutic relationship.

The patient's attachment gives the physician the opportunity to perform the anamnesis and implicitly, the fitting into the context of the therapeutic relationship. The consequence of this is the understanding and acceptance of the clinical process by the patient. An emotionally strong therapeutic relationship facilitates both parties' access to effective collaboration that promotes the recognition of mental states that motivate a certain behavior in the relational context. There are more and more studies in the literature that address the role of attachment in somatization. Thus, uncertain emotional attachment leads to increased addressability of patients with psychosomatic disorders in primary medicine (Taylor & Marshall, 2012) Depending on the attachment style, the patient exhibits a certain type of behavior in relation to the disease and in relation to the doctor.

Consequently, the physician needs to decipher the patient's attachment style so that the relationship he / she will establish with him / her is adapted to the attachment pattern.

Recent studies (Rask, Carlsen et al., 2016] demonstrate that patients with somatic symptoms require a complex approach to health care in terms of time and biomedical and psychosocial needs.

In support of the importance of attachment theory in the context of the therapeutic relationship, there is another study (Jimenez, 2016), which reveals that a type of unsafe attachment in chronic illness is correlated with low treatment adherence, increased mortality, the excessive use of medical services, and generally poor medical results.

The patient's approach will be structured by referring to the three fundamental dimensions described above. In this sense, each person functioning by thinking, feeling and adopting a certain type of behavior.

Therefore, when we make the anamnesis, it is necessary to consider explaining the patient's choices and "how" and "why" he did a choice. But for this we need to first describe how he work before finding a plausible explanation for it. The way to achieve this goal is to describe both the situation and the way the person works.

From the perspective of the person's description, it is important to know the person's psychological profile before we solve the problem he is facing. In concrete terms, we will achieve this, respecting the same three fundamental dimensions of the person: cognitive, emotional and behavioral.

Thus the pattern of the personality of the individual will be outlined. In this context, it is important to define a series of psychological variables of the patient. Starting from the above-described aspects, we can identify the strengths we will use as the patient's resources in the medical approach. We will be used the vulnerabilities on either to minimize them, either to give them a positive connotation.



2. RESEARCH QUESTIONS

The research question in this sub-study is: doctor behaviour related to the therapeutic relationship, considered an attribute of Emotional Intelligence (EI) contributes to acceptance of diagnosis at patient with psychosomatic affections?

3. PURPOSE OF THE STUDY

The physician's contribution to the medical act has undergone a number of changes with the emergence of the concept of patient-centered medicine. The doctor is no longer in the position of a person making decisions that the patient to follow them. The notion of medical service places the doctor in the area of the service provider and its activity is quantified and appreciated by the patient's satisfaction index. This has led to the need to increase the emotional involvement of the physician, which must provide emotional support to the patient, aspect demonstrated in the present study.

The relational variables mentioned are found in the questionnaire items: Determinants of Patient Satisfaction with Physician Interaction.

4. RESEARCH METHODS

The article brings attention, through a study on 200 patients, the importance of the emotional approach of the patient in the light of previously exposed. The patient-centered medicine has emerged as a need to change the paradigm of the medical act, in which the patient's approach is individualized and holistic, in a bio-psycho-social context.

The present substudy is a part of a large study carried out between 2008-2016; is a prospective, mixt study who fulfills the conditions for human studies.

Research Constructs

The sub-study was structured on the basis of the above-mentioned questionnaire. I used the following items:

(F1) I understand my illness better after meeting with my doctor (the cognitive and emotional meaning of illness)

(F2) The consultation (medical examination and anamnesis) does not last as long as it should (allocated time)

(F4) The doctor gives me the chance to say or ask whatever I want (permissiveness or good communication)

(F6) The doctor is interested in me as an individual and not just by my illness (empathy)

(F7) The doctor explains how to take care of me in my condition (communication)

(F8) The doctor greets me before listening to my simptoms (complaints) (respect/consideration)

(F10) Doctor does not use medical terms that I do not understand (communication)

(F17) The doctor listens to me with great patience (communication)

(F11) I can talk openly to the doctor about my sensitive issues (empatie)

(F20) Above all, I am pleased with the relationship (collaboration) with my doctor (indice de satisfactieie crescut)

5. FINDINGS

1. From the analysis of the mentioned items, corroborated with a number of items from the other sub-studies, we have in fact found that is exactly the position occupied by the doctor and the patient on the scale of attitude towards the disease, and that when the patient is satisfied with the explanations given by to the physician, the proportion of patients in the uncertainty area is low (item F1, 5.16%), while, if the patient considers that the physician



ignores certain accusations or empirical explanations he expresses, the level of uncertainty increases, reaching a quarter of respondents "25.76%" who are in the uncertainty area (uncertainty of relationship and diagnosis).

2. Regarding the friendly attitude of the physician, respondents who are participated in the study consider friendly physician. This aspect, viewed from the perspective of the attachment theory, is of particular importance, as it contributes to the consolidation of the therapeutic relationship. When individuals feel vulnerable to threatening situations, such as illness, they are looking for an "attachment person" to feel safe. In the case of patients, this person is the doctor and the results of the statistical processing of the data obtained confirm this fact by perceiving the doctor's friendly attitude to a significant percentage, "64.56%" of patients. An important issue to be clarified in the context of the research theme is the analysis of the sample of respondents who chose the " Uncertainty " option.

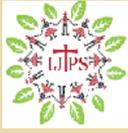
3. Another aspect was the state of uncertainty found in all sub-studies. In evidence - based medicine and patient-centered medicine, uncertainty is an important aspect of medical practice. Starting from the existing uncertainty in formulating a diagnosis presumption, we inevitably come to the relational uncertainty, determined precisely by the impossibility of establishing the evidence-based certainty diagnosis. In the case of psychosomatic disorders, this component is all more obviousness, as the degree of indeterminacy and uncertainty appears in the name of the disease itself. Medically Unexplained Symtoms, or somatic symptoms, are notions that do not have a certainty that can be established , and can be attributed to a multitude of causes (psychological variables, impossible to turn into objectively clinically-biological entities, quantifiable). For this reason, patients are often in the uncertainty area of accepting explanations, as we have seen, or making decisions, considering that the area of uncertainty gives them the possibility of a new diagnostic option at any time (by requesting a new consultations), therapeutic or relational (dissatisfaction with the therapeutic relationship due to the physician's communication of a diagnosis that the patient does not accept, or an indication of therapy that the patient does not agree to, considering it inefficient, risky or inappropriate for his medical problem).

CONCLUSION

The analysis of the data obtained, referring to the " Uncertainty " option, revealed in all items its presence, in the proportion between " 5.16% " in Item F1 regarding the perception of the disease, and " 25.76% " at item F12 which refers to the physician's perception and attitude towards certain patient's claims about the disease. We have actually found that this is exactly the position occupied by the physician and the patient on the scale of attitude towards the disease, and that when the patient is satisfied with the explanations given by the physician, the proportion of patients in the area of uncertainty is low (item F1, 5.16%), whereas, if the patient considers that the doctor ignores certain accusations or empirical explanations he expresses them, the level of uncertainty increases, as a quarter of respondents " 25,76% " are in the uncertainty area.

The exposed variables found in selected items can be considered attributes of emotional intelligence, in the sense of the ability to understand and manage emotions that will later be translated into cognitions and behaviors.

The quantitative and qualitative analysis of data obtained by statistical processing reveals that the therapeutic relationship in terms of addressing the significance of the disease by the physician and the patient influences the patient's decision to accept or not the diagnosis.



Another important aspect is that of the uncertainty that can be said to be a characteristic of patients with psychosomatic disease.

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