

Affective distance in the Doctor-patient relationship. Importance in the evolution of the disease.

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ABSTRACT

The American anthropologist Edward T. Hall coined the concept of Proxemic for studying the use and perception of social and personal space, that is, proximity or distance between people and objects during interaction, taking a concept of measurable distance. In psychoanalysis the concept of distance is wider, because the qualities of proximity, distance and space-time mobility of the object are not only subject to the order of the topographic space and chronological time but also to the psychic reality. This idea, based on the consideration of affectivity within a model that takes into account the intrapsychic and the intersubjective, allows us to propose the concept of Affective distance as a result of both types of distance: physical and emotional.

In this work, we reflect on this concept and about intimacy and its importance in the relationship that patients establish with the doctor or therapist in relation to the development and evolution of diseases. We present a data from a prospective longitudinal study that we have done measuring this distance in patients with hematopoietic transplantation, finding that those patients located the doctor at closer distances survived more than those who placed it at greater distances.

INTRODUCCION

If we think about somatic diseases, we can see that clinical doctors are the first to treat patients with this type of disease and in many cases they receive a demand for psychological attention that although they sometimes detect, they do not manage to prosecute, let alone satisfy. Hence, there is an inconsistency between the acceptance of the "psychological factors" and the subsequent behavior of both the doctor and the patient.

On the part of psychoanalysis, classically, the accentuation of the differences between hysteria and psychosomatics

and the use of phrases and euphemisms promotes the tendency to leave the psychosomatic problem in the hands of the doctor and in the field of medicine, or to face psychotherapies that address the patient rightly in a superficial plane, but that later they do not advance to deeper planes with the theoretical excuse of the "deficits" that the patient presents.

This reality enters into contradiction on the one hand with Freud's own idea about the somatic illness and about the relationship between the psyche and the soma.

Already in the description of the experiences of satisfaction and pain, Freud provides us with examples of the association of heterogeneous elements in the psyche, configuring complex mnemonic traces. For example, in the satisfaction experience digestive movements of the stomach are associated with the memory of the maternal breast and its reactivation by the renewal of the state of need (hunger) (Freud, S., 1895).

In his description of "paths of reciprocal influence", Freud describes how heterogeneous elements influence each other (Freud, S., 1905). There he says that any modification made in the field of biological needs and functions may have an impact on the erogeneity linked to the body that fulfills these functions. And conversely, any change in the erogeneity of an organ can affect its biological functions (Freud, S., 1905 a: 1214).

But it also comes into contradiction with the descriptions and work that the psychoanalyst Michael Balint carried out in the 50s with family doctors on the relationship of these with their patients and the importance of it in the future and prognosis of the patients. somatic diseases.

Balint argued that the clinical relationship is more than actions and behaviors and includes the feelings and ideas linked to these. He believed that in this relationship there are

a series of phenomena that have to do with this emotional dimension. Balint reasoned that doctors have a series of individual attitudes toward the patient, expectations about their behavior and established ways of relating to them that depend on their beliefs and personality.

Balint also developed the idea that the doctor himself is a central component of the therapy. Moreover, he stressed that the medicine most used in the practice is the doctor himself and this can have curative or harmful effects.

Taking both the idea of Freud, and Balint, as psychoanalysts and as doctors, we wanted to focus our attention on the relationship we establish with our patients, on their connection to us as therapists and as doctors and how the vicissitudes of this will influence in the prognosis of the disease.

ATTACHMENT, DISTANCE, PROXIMITY AND HALL'S PROXEMICS

The attachment theory postulates the human need to form close affective bonds that manifest themselves in behaviors of proximity, distance and contact with the caregiver, as well as through affective reactions to separation.

In this sense, attachment can be related to a discipline called proxemics, developed by the anthropologist Edward T. Hall, which measures the spatial configurations of human beings in terms of distance.

Bearing in mind that in general terms the behavior of attachment is the search for proximity to beings that are considered protective, the distance and rejection configurations play a fundamental role and are explored in many of the questions of the Adult Attachment Interview (AAI). This distance is thought to be more affective than

physical but the use of terms "feel close" and the emphasis placed on the separation experiences of the parents shows that there is a base of bodily experiences, such as tactile experiences of separation, closeness or proximity, which serve as a substrate on which the affective experiences of feeling close to or far away from someone are mounted. These affective experiences are no longer tactile because they have suffered the modifications printed by language and culture: nowadays it is no longer necessary to touch someone to feel close to them (Ulnik, 2004).

In 1963 Thomas Hall developed his research, he pointed out that every organism has a detectable limit. And in that way he considered that between an individual and another there must be a certain space depending on the circumstances and the environment.

Proxemics studies the use and perception of social and personal space, that is, of proximity or distance between people and objects during interaction, the postures adopted and the existence or absence of physical contact.

What is interesting is the employment and the perception that the human being makes of his physical space, of his personal privacy, of how and with whom he uses it, in different areas of his life. Man's handling of space and distance with others configures a level of signs that are transmitted non-verbally and that condition their relationships and conflicts with others.

Therefore, proxemics is a type of non-linguistic communication established by signs that are constituted through spatial configurations of distance, such as the distance of a person from his interlocutor. In this way, man is conceived with limits that go beyond his body and that are



dynamic for each relational situation.

Hall (1963) described 8 types of distances between two interlocutors and grouped them into 4, which he called: public, social, personal and intimate distance.

- **Public distance:** is the one that is usually used in public places, where there are unknown persons. It is generally greater than 3.60 m and is the one used, for example in conferences, airports, etc.

- **Social distance:** it is what a social animal needs to be in contact with its group, the distance we use to interact with people in our daily lives, people with whom we have no friendly relationship, such as a doctor, a mason, etc. It is approximately 1,20m.

- **Personal distance:** is used in close relationships, such as family and friends. The distance is between 45-120 cm. If we stretch the arm, we get to touch the person with whom we are holding the conversation.

- **Intimate distance:** is the closest and is limited to people with whom you have some intimate connection, such as family, couple, friends. The communication will also be made through the look, touch and sound. The distance can range from 0 to 45 cm; if it is less than 15 cm, it is considered a sub-intimate zone or an intimate private zone.

We think, that in population with somatic diseases and especially in the serious diseases that are incapacitating and require multiple treatments and hospital admissions, these distances will be modified. At least, in the process of transplantation, by an essential factor that is immunosuppression and its consequences, one of them the physical isolation required to avoid exposure to infection.

AFFECTIVE DISTANCE AND TEST OF AFFECTIVE DISTANCES (ULNIK)

The concept of distance taken by Hall is a measurable concept. When in psychoanalysis we speak of distance, we refer to an abstract idea, not easily measurable, that allows us to say that a patient places an emotional distance or that establishes a double distance with the object.

The idea of distance, both physical and psychic, is a theoretical construction that develops arbitrarily to establish an order in real space that escapes our possibility of perception and even understanding.

There is a concept of distance established by physics that we could define as the interval that separates two points in space. But according to the dictionary of the RAE, distance can also be the difference between one thing and another. With this definition we see how physical distance can be representative of a discrimination or separation of a physical nature. The concept of distance used in psychoanalysis is even broader, since the qualities of proximity, distance and spatial and temporal mobility of the object will not be subject only to the order of the topographic space and chronological time without also to the psychic reality. This idea added to the consideration of affectivity within a model that takes into

account the intrapsychic but also the intersubjective, allows proposing the concept of affective distance as the result of both types of distance: the physical and emotional (Ulnik, 2004).

Following the theoretical framework of proxemics, there are distances that progressively move away and correspond to different social areas that Hall separated into intimate, personal, social and public. Related to the classification of this author, Ulnik formulated a test with a similar scheme to measure the different emotional distances.

The test examines the ability to distinguish different affective distances for each link. In this way, what we observed in the clinic regarding the doctor-patient relationship and the therapist-patient relationship materializes, for example, because we can observe both fusional distances and of symbiotic and distant and contradictory characteristics (Ulnik, 2014).

STUDY OF THE PATIENT-DOCTOR (PD) RELATIONSHIP THROUGH THE AFFECTIVE DISTANCES TEST:

Some authors have stated that patients classified as difficult to treat there is an internal conflict, characterized by their need for proximity to others and at the same time fear of such closeness, which generates distance behaviors. Ulnik et al, (2014) have studied this internal conflict of proximity and distance, through ADD, in patients with chronic skin diseases that are difficult to treat (Ulnik et al, 2014).

In our opinion, patients with hematological diseases have several points in common with dermatological patients, such as, for example, the chronicity of the disease, frequent visits to the doctor and the difficulty of their treatment. And as with patients with skin diseases, in some patients with hematological cancer, good adherence is observed to the person of the doctor and in others, on the contrary, there is a tendency to detach abruptly. Ulnik translates it as behaviors that are the expression of fantasies and mechanisms of unconscious defenses that arise in response to vital experiences of childhood that involve the most significant relationships with primary objects. And he has considered that the proximity-distance conflict could be related to a cold mother or a captive mother and that attachment experience would determine behaviors that later manifest themselves in the relationship with the doctor and in the way in which the subject links with his disease (Ulnik et al, 2014).

According to these studies, the results of treatments are sometimes not due to the disease itself but to the psychological characteristics of the patients and the links they establish (Ulnik et al, 2014). In our opinion, psychological and linking factors may also be influencing the outcome of hematopoietic transplantation and for this reason we insist on these evaluations.

Other studies also evaluated some important aspects in this doctor-patient interaction and called "difficult patient" those who do not respond to standard therapy or who do not achieve a satisfactory relationship with the doctor for presenting unfounded complaints, unjustified anger

and difficulties to establish a relationship of interpersonal trust. And it is that difficulties arise in the doctor-patient relationship; Due to the same chronicity of the disease, the patient adopts a series of behaviors that transform him into a difficult patient. Most investigations conclude that it is essential to improve patient medical communication and that the physician must take into account the subjective discomfort that the patient presents (Ulnik, 2004).

OBJECTIVE AND HYPOTHESIS

Our objective in this research is to **find out the importance that the patient-doctor relationship has on the prognosis of the disease** and to suggest how these patient-medical interactions respond to patterns built in the first stages of an individual's development.

And emphasize that the responses of patients in these interactions can be interpreted by professionals as hindering reactions, when we could give the value of **indicators of fears, and so calm and accompany, facilitating a positive variation in the response.**

For this we take patients in the process of **bone marrow transplantation**, because as medical psychoanalysts in a hospital we were consulted by many of these patients from the Onco-Hematology Service.

Bone marrow transplantation is a highly specialized and complex medical procedure, which aims to replace bone marrow tissue and is used primarily for the treatment of patients with hematological cancer such as leukemia, myeloma, lymphoma or others.

There are many studies that talk about psychosocial variables related to the outcome of the bone marrow transplant, although the information about its influence is contradictory.

MATERIAL AND METHOD

What variables have been studied?

1. Psychological Variable: **Affective patient-doctor distance measured before the bone marrow transplant**, with the Affective Distances Test (in mm), and then grouped into categories. For the analysis we have used these distance categories, which for the Patient-Doctor relationship are: **1-in contact, 2-reachable, 3-close, 4-distant, 5-very distant** (see Tables 1 and 3).
2. Biological variable: **Post-transplant Global Survival (SG)** was recorded, which includes all live patients after transplantation. The Global Survival (SG) has been evaluated at **3 months, 6 months, 12 months and 24 months post-transplant.**

What kind of study is it?

This is a **prospective longitudinal study**, in which all patients undergoing haematopoietic transplant were

included in the Morales Meseguer Hospital in Murcia during a period of 16 months. 49 patients were included (24 women and 25 men). In the present work, psychological variables are related to evolutionary biological aspects of transplantation.

Test of Affective Distances (see Annex at the end of the document)

It consists of a series of millimeter **sheets** in which a human figure printed on the far left appears. Each of the slides presents a slogan referring to a linked situation, such as: the relationship with the mother, the father, the friend, the co-worker, the sexual partner, the enemy, the president, the doctor, the donor, etc.

The interviewee is offered a series of **self-adhesive human figures**. The subject has to paste one of those figures on each sheet, at the distance from the printed figure that he considers appropriate according to the consigned link situation. For example: "imagine that the doll that is on the edge of the sheet is you. Take off one of the self-adhesive figures and imagine that it is the doctor. Glue it on the sheet, at a distance that seems like it. The minimum possible distance is one doll on top of another, the maximum possible is to where the squares arrive".

The distance in each sheet is measured in **millimeters** and then grouped into 11 different **distance units**, which range from the total contact (zero distance) to the maximum distance, which is the other side of where the printed figure is. The resulting **categories** are as follows (see Figure 1).

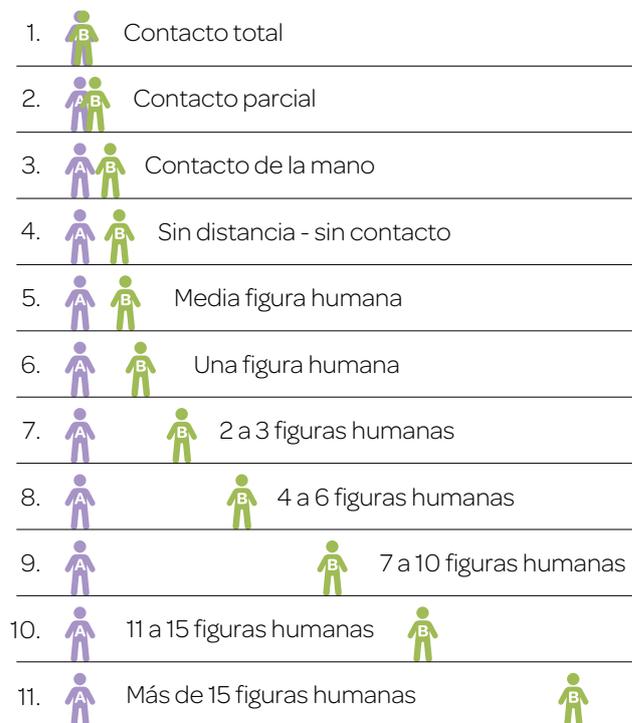


Illustration 1. Human Figures Units (Ulnik et al, 2014).

Although the Affective Distances Test allows to obtain

quantitative values because the distances between the human figures in each sheet can be measured, it is important to note that the answers have a **qualitative value** that varies according to the bond area that we are investigating. For example, the first 3 categories represent the human figures in contact, 1 being the total contact by the complete superposition of the figures and 3 the minimum contact of being "by the hand" or just touching with the tips of the fingers (Ulnik, 2014).

These three units of distance (1, 2 and 3) represent an intimate area in which small differences can be highly significant. Both in the bond of sexuality and in that of the mother-child relationship every millimeter of distance between the figures can have a great qualitative value, although the physical distance is always close and hardly different between the two responses.

Just as there are **qualitative differences according to the linking areas**, there are also **qualitative differences according to the relationship** we are exploring. Thus, when studying sexuality, we can group responses 1, 2 and 3 under the parameter "in contact" and all the others under the parameter "without contact" (Ulnik, 2013).

In the **Patient-Doctor relationship**, which is the one we evaluate in this paper, we consider an achievable and **more expected distance to the unit of distance 6** (correspond to numbers 1 and 2) because although there is no contact, for this type Bonding is considered to be close when it is accessible. From the unit of distance 8 (numbers 4 and 5) it is already considered distant. (see Table 1 and Illustration 1).

FH	Tipos de contacto	Paciente-Doctor
1	Contacto total	1. En contacto
2	Contacto parcial	
3	De la mano	
4	Sin distancia	2. Alcanzable
	Sin contacto	
5	1/2 FH	3. Cercano
6	1 FH	
7	2 a 3 FH	4. Distante
8	4 a 6 FH	
9	7 a 10 FH	
10	11 a 15 FH	
11	+ de 15 FH	5. Muy distante

Table 1. Categories FH for patient-doctor (Ulnik 2014)

Once the Patient-Doctor Affective Distances evaluated before transplantation were categorized and the survival after bone marrow transplantation was recorded, **the**

statistical analysis was performed between both variables in search of associations.

The analyzes were performed in Excel and SPSS. The normality of the quantitative variables was assessed by the Kolmogorov-Smirnov test. After verifying this normality, we used the t and ANOVA test to evaluate differences between quantitative variables, and the chi-square test to analyze the association between qualitative variables.

RESULTS

Patient-doctor affective distances and post-transplant survival

The relationship with survival was evaluated considering the categories individually: 1-in contact, 2-attainable, 3-close, 4-distant. No patient placed the doctor at a distance 5-very distant, so this last category was not taken into account.

In the analysis of categories it is observed that the **patients who answered with distance 1 ("in contact") survived all, both at 3 and 6 and at 12 months post-transplant.** At 12 months, up to 55% of the live patients had placed the doctor in 1 ("in contact"), with a p-value of 0.059 (see Table 2). However, there was no significant association although it was very close to doing so and due to this and appreciating the trend, overall survival at 24 months was analyzed..

Supervivencia global				
Distancias afectivas Paciente-Doctor (4 grupos)		Vivo	Fallecido	p-valor
SG 3 m	1	22 (49%)	0 (0%)	0,326
	2	11 (24%)	1 (50%)	
	3	6 (13%)	1 (50%)	
	4	6 (13%)	0 (0%)	
SG 6 m	1	22 (51%)	0 (0%)	0,274
	2	10 (23%)	2 (50%)	
	3	6 (14%)	1 (25%)	
	4	5 (12%)	1 (25%)	
SG 12 m	1	22 (55%)	0 (0%)	0,059
	2	9 (22%)	3 (43%)	
	3	5 (12%)	2 (29%)	
	4	4 (10%)	2 (29%)	

Table 2. Patient and doctor affective distance and Global Survival

According to the results of the 24-month global survival analysis with respect to patient-doctor affective distances, a statistically significant association (p-value 0.048) was found among the

patients who had located the doctor at distance 1 (“in contact”) at the start of the transplant and a greater overall survival at 24 m. 57% of the survivors had placed the doctor in contact and only one patient of those who answered with 1 died. For this relationship, the value of the corrected typified residuals was observed, which was higher than 1.96 for this association (2.6) (see Table 3).

Supervivencia global				
Distancias afectivas Paciente-Doctor (4 grupos)		Vivo	Fallecido	p-valor
SG 24 m	1	21 (57%) 2,6	1 (10%) -2,6	0,048
	2	8 (22%) -1,2	4 (40%) +1,2	
	3	5 (14%) -0,5	2 (20%) 0,5	
	4	3 (8%) -1,8	3 (30%) 1,8	

Table 3. Affective distance patient-doctor and SG

Figure 2 reflects the **associative trend of patient-doctor (PD) distance in contact in relation to post-transplant global survival (GS)**. It is observed that a longer time post-transplant there is a greater relationship between placing the doctor at a distance 1 (in contact) with greater survival.

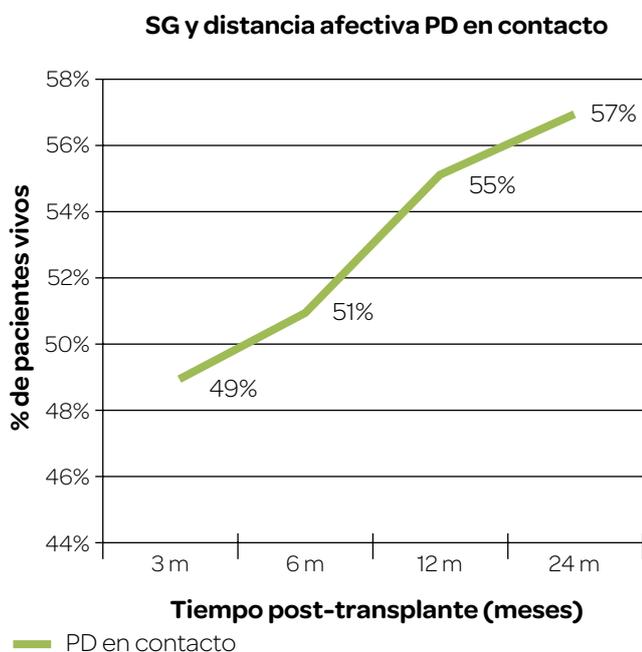


Illustration 2. SG and affective distance PD “in contact” (1)

DISCUSSION

Patient-Doctor affective distance as predictive of

post-transplant survival

The objective was to evaluate the relationship between Patient-Doctor affective distances of patients before transplantation and post-transplant survival. For this, we have administered the Affective Distances Test, which measures based on the projection on a spatial distance of an intrapsychic experience of emotional distance.

We evaluated patient-doctor affective distances and analyzed their association with post-transplant survival. Recent research carried out through the Affective Distances Test has associated different affective distances to different degrees of response to treatment in patients with chronic skin diseases (Ulnik et al, 2014). And we think that these results can be applied to patients in the process of hematopoietic transplantation.

Taking the classification of Hall, whose discipline measures the spatial configurations of human beings in terms of distance, **the doctor would belong to the group of “social distance”,** which is the interpersonal distance that an individual uses to be in contact with those of his group when there is no friendship relationship.

Bearing in mind that **attachment behavior is the search for proximity to beings that are considered protective, distance configurations, thought more as affective than physical, can be modified in certain circumstances** (Ulnik, 2004).

We think that in **patients with serious illnesses that endanger physical and emotional integrity and who need close care, the distances with respect to the doctor would be modified and the doctor would become part of the group of people located at “intimate distance” from the patient.** Intimate distance is the closest, which we establish with the family, and in which communication is also made with the look, touch and sound (Hall, 1963). And therefore, **the relationship with the doctor at this time would occupy a privileged place, which in our opinion would condition much of the patient’s well-being, as well as evolutionary aspects of the transplant.**

Our **hypothesis** in this section of the study was that patients with closer emotional distances for the **patient-doctor relationship will have greater post-transplant survival.**

We understand that an adequate relationship with the doctor favors the therapeutic process. And we believe that it is possible to know some aspects of the patient’s relationship with the doctor thanks to the measurement of the patient-doctor affective distance since what is observed in the clinic with regard to the patient-medical relationship (Ulnik, 2014).

And in this study, **patients who placed the doctor at closer distances (in contact) survived more than patients who placed him at greater distances (no contact).** This trend was appreciated from 12 months post-transplant and significantly associated with survival 24 months post-transplant.

So we can identify 1, that is, put the doctor in contact with the patient before transplant, as a protective factor related to survival at 24 months post-transplant.

This result constitutes a very valuable clinical finding that closely **links the patient-doctor relationship to the evolution of the transplant** and in it we identify two fundamental questions that clarify the results:

- A question is **the doctor** himself, his type of answers and the way he has to approach the patient. They are factors that would have more to do with current aspects of the relationship with the doctor, which have a lot of weight in the way in which the patient lives that relationship in terms of **accessibility-closeness** of the doctor. In this approach to thinking, some studies have identified aspects in the doctor valued as positive by patients, such as talking directly about the problem and stimulating the patient's autonomy for decisions about their illness (Dermatis et al, 1991). These elements could make important differences in basic aspects derived from the relationship with the doctor, such as attendance at consultations, adherence to treatment and even basic confidence in the good outcome of the hematopoietic transplant process.
- A second question, related to the **patient**, has to do with the theorization that Bowlby proposed about the active internal models of the self and how the first relationships provide prototypes for all subsequent relationships. That is to say, that the patterns in the relationship that a person has had in their childhood determines important aspects of their psychic organization in relation to the bonds of attachment. As well as in the strategies that he chooses unconsciously in relation to others, particularly in intimate bonds. According to Marrone, it consists in

internalizing a relationship and its externalization in the present (Marrone, 2001).

Therefore, **the patient will establish a relationship with the doctor in a similar way to the rest of the relationships and as it was in the first links.** In addition, in this case **the type of link will be given more clearly, since the figure of the doctor in these patients serious takes the place of an intimate bond.** Therefore, the relationship with the doctor, now lived as intimate by the patient, would facilitate the **reediton linking with parental imagoes.**

The trace of what is linked in the objective relationship is appreciated: all doctors are not equal, but patients in a close and continuous relationship deposit part of their parental imagoes and their linking dynamics (what Bowlby calls "model internal working").

CONCLUSSION

We conclude that: **Placing the doctor as close as possible constitutes a protective factor of survival 2 years after transplantation.** These patients have placed the doctor as a source of safety. This **source of safety is the primary function of attachment relationships, especially in situations that cause fear or anxiety.** A child actively seeks contact with his caregiver during episodes of reunion and uses it effectively as a source of comfort.

For this reason, we consider that **for a patient at risk of death, the doctor occupies a more than nearby place, occupying the position of source of security needed to feel protected, confident, and able to survive the process of transplant and disease.**

Annex

Test of Affective Distances and self-adhesive doll

