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The mental representation of the emotional universe and that related to bonding among university students of health sciences

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Abstract

Stress and the emotional responses of anxiety, fear and anger, the prevelance of a psychiatric and or psychological symptomatology and a huge emotional exhaustion affect the relationship between the health professional and the patient as regards bonding. This symptomatology may even appear in university students of Health Sciences.
Concious of the need to train the management of emotions and bonding in university students, we organised a theoretical-practical workshop in the Department of Occupational Therapy, Speech Therapy and Nursing at the University of Castilla-La Mancha.
A total of 77 students participated, all of whom responded to a series of questions. The qualitative analsis of these questions reflects that the most difficult emotions to train are admiration and security. The emotions that most habitually appear are happiness and sadness, while those of anger, fear, disgust and curiosity appear to a lesser extent.
With regard to the results of the variables related to bonding, it was shown that the students know which elements make the therapeutic bond easier or more difficult. Finally, the majority of the experiences that the students recounted were related to the spheres of health, education and their relationships with partners.

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Keywords: emotions, therapeutic bond, higher education, recounting experiences

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1. Introduction

Stress and the emotional responses of anxiety, fear and anger (Falkum & Vaglum, 2005; Mc Pherson, Hale, Richardson & Obholzer, 2003;Vargas-Terrez, Moheno-Klee, Cortés-Sotres y Heinze-Martin, 2015), along with the prevelance of a psychiatric and/or psychological symptomatology and a tremendous emotional exhaustion (Barbero, Fernández-Herreruela, García-Llana, Mayoral-Pulido y Jiménez-Yuste, 2013; Esquerda, Yuguero, Vinas y Pifarré, 2016; Fundació Galatea, 2012; Gil-Monte, 2003; Zapf, 2002) frequently appear among service organisation professionals (doctors, nursing professionals, those employed at prisons, the police, social workers, etc.) who come into direct contact with the users of those organisations (patients, pupils, prison inmates, the homeless, etc.). There is even a high suicide rate (Montes-Hidalgo y Tomás-Sábado, 2016; Tomás-Sábado y Montes-Hidalgo, 2015; Vargas-Terrez et al., 2015).

In many cases, these responses and symptomatology also appear among nursing and medical students and those doing their practical training (Brant, Wetherell, Lightman, Crown, & Vedhara, 2010; Esquerda et al., 2016; Vargas-Terrez et al., 2015), and may have a negative effect on their capacity to learn, memorise, concentrate and on their clinical capacities, thus implying a risk and a worsening in the quality of health care with which patients are provided. In other cases they may even lead them to abandon their Bachelor's or Post-Graduate Degree or their practical training. The presence of these symptoms may consequently affect the relationship between the health profesional and the patient, thus affecting the treatment received, communication, empathy and the professional's ethical competence as regards the patient (Esquerda et al., 2016; Galán, Romero, Morillo y Alarcón, 2014; Vidal, Tirado y González, 2015).

Of the strategies that may help reduce the psychological symptomatology, it is possible to highlight the development of appropriate emotional abilities and/or skills (Montilva, García, Torres, Puertas y Zapata, 2015; Tomás-Sábado y Montes-Hidalgo, 2015; Vidal, Tirado y González, 2015) such that they contribute towards inmproving the health professional-patient relationship with the objective of establishing a good therapeutic bond.

The university authorities in charge of educating future health professionals via their Bachelor's and Post-Graduate degrees should be made aware of the possibility that their students may develop a serious psychological symptomotology in order to detect any mental health problems in time so as to control, manage and handle them. This response should be provided via the curriculum during the years of university education (Esquerda et al., 2016; Galán et al., 2014; Montilva et al., 2015) or by means of preventative programmes or self-care workshops, etc. (Barbero et al., 2013; Vargas-Terrez et al., 2015).

Concious of the need for university students to be trained in the management of emotions and bonding, we organised a theoretical-practical workshop in the Separtment of Occupational Therapy, Speech Therapy and Nursing at the University of Castilla-La Mancha with the objective doing so. This was intended to be a tool that would allow students to attain professional and personal knowledge of the emotional universe and that relate to bonding in order to increase their flexibility in these matters, along with their life satisfaction.

2. Methods

The experience, which was entitled 'Learning to manage emotions in order to establish a therapeutic bond', took place in the Department of Occupational Therapy, Speech Therapy and Nursing at the University of Castilla-La Mancha in February 2016 all day Friday and on Saturday morning. It cost 15.00€ to enrol in the workshop and implied the recognition of 0.5 ECTS credits.

The objectives of the training workshop were:

- To train the students in the knowledge and recognition of basic emotions.
- To help them learn to manage their emotions in order to adapt to life.
- To improve the students' capacity to attain a more satisfactory therapeutic bond with the patient.

Those taking part were Occupational Therapy, Speech Therapy and Nursing students, along with any professionals related the the sphere of health who wished to enrol. A total of 77 students enrolled.

On Friday morning, two theoretical conferences entitled 'Basic Emotions. Pleasant and Unpleasant' and 'The Therapeutic Bond with the Patient' were given by Dr. Manuela Martínez Lorca and Dr. Mª Carmen Zabala Baños, respectively, both of whom are professors in the aforementioned department at the UCLM.

The afternoon session was eminently more practical with the development of a workshop in which a 'Toolkit with which to learn to manage emotions' and a 'Toolkit with which to establish a therapeutic bond with a patient' were created. The participants were divided into 12 work groups, each of which contained 6 or 7 people. They were given a piece of paper containing the tasks and questions that they had to resolve in their respective groups. Each group was located in a different part of the university in order to work in peace and quiet. After an hour, the groups had to return to the classroom to comment on what they had done and to share the experience thay had had, any doubts, questions with which difficulties had arisen, problems, etc. The event then concluded for that day.

On Saturday, a round table entitled 'Professional Experiences: Various professional viewpoints regarding the bond with the patient' took place, during which the participating professionals divulged their experiences as regards bonding during their daily encounters with patients.

The participants consisted of two psychologists who work at an Evaluation and Psychotherapy Centre, an occupational therapist and a nurse who work at SESCAM, which are clinics provided by the Autonomous Community of Castilla-La Mancha in addition to being associated with the UCLM, and a speech therapist who works at a speech therapy centre and is also an associate professor at the UCLM. A fruitful and enriching question session among the professionals and the attendees then took place.

Finally, the students thanked the health and educational professionals for taking part in the workshop and requested that the educational professionals organise future events related to the subject in question.

3. Results

Once the questions had been answered by the students in their corresponding groups, we then went on to analyse them by means of a qualitative analysis. This allowed us to obtain a greater quality and profundity as regards the students' experiential experience. We analysed the responses of the 12 participating groups, which were grouped into different analysis categories. An illustrative example of these categories, together with the proposals made for each of them by one of the groups is shown in Table 1.

3.1. Emotions for which training is more difficult

According to the sample, the pleasant emotions that it is most difficult to train are security and admiration, since they are those which are least frequently experienced. With regard to unpleasant emotions, those which appeared with the greatest frequency were fear and anger because, as the students stated, "*they are unpredictable emotions which are difficult to control*". A smaller number of students indicated that these were sadness, guilt and disgust. Curiosity, happiness and surprise did not appear in the results.

3.2. Frequently experienced emotions

There are generally a wide range of emotions that tend to be experienced more frequently since, as one group stated, "*we may feel various emotions throughout the day*" and as another suggested, "*they are emotions which are more adapted to our context according to the moment at which we feel them*". Another group admitted that, "*They are those of everyday life*".

The results show that the emotional universe most frequently experienced by our students is happiness. Some of the arguments put forward for this are, "*when you feel self-satisfied*" or, "*because there is always one moment in the day when you feel happy*".

Another emotion frequently felt by the students is sadness. However, anger, fear, disgust and curiosity appear less frequently in the emotional universes.

1. Which emotions are the most difficult to train?:
Security, because before being able to show the patient security it is necessary to be a secure professional.
Fear, because one is not able to express it in front of the patient
2. Which emotions do you most frequently express?:
Sadness
Fear because we do not know how to confront difficult situations
Happiness because we are overcoming problems
3. Identification of pleasant or unpleasant emotions and their sensorial characteristics or features:
Emotion chosen: Fear
Colour: black
Shape: irregular
Taste: bitter
Size: large
Smell: vinegar
Sound: silent
4. Elements that facilitate the establishment of the therapeutic bond:
Empathy
Patience
Active listening
Admiration
Confidence
Security
Respect
5. Elements that make the establishment of the therapeutic bond difficult:
Fear
Long silences
Rejection
Guilt
Lack of motivation
Uncertainty
Racism
6. Recounting experiences in the establishment of a therapeutic bond:
When calling an ambulance, the doctor who arrives on it treats the patient in question unprofessionally and with little respect

Table 1. One group's responses to the questions asked.

3.3. Identification of pleasant or unpleasant emotions and their sensorial features

In this category, the students had to choose a pleasent or an unpleasent emotion and ascribe a series of sensorial features to it. All of the groups chose an unpleasant emotion, with anger being the most predominant, followed by sadness and fear. Disgust appeared to a lesser extent.

The students were fairly unianimous as regards the sensorial characteristics that they ascribed to these emotions. Anger was therefore associated with the colour red, a large and enormous size, a shrill noise, a pointed shape and the smell of bleach or sulpher.

Sadness was large and grey with the sound of the wind or raindrops, in the shape of a tunnel or circle and with a rotten or enclosed damp smell..

Fear was identified with the colour black and was huge in size, silent and of an irregular shape, with a damp smell or that of vinegar.

Disgust was pistachio green, small with a deafening sound, a variable shape and the smell of a rubbish dump and of rotteness.

3.4. Elements that make it easier to establish a therapeutic bond

The students highlighted the following elements as being important as regards establishing a therapeutic relationship between a health profesional and the patient: empathy, patience, active listening, the patient's

unconditional admiration, visual contact, confidence, security, attention, curiosity, concern, respect, authority, friendliness, being accompanied, being present and vocation.

3.5. Elements that make it difficult to establish the therapeutic bond.

The difficult elements listed by the students are the following: fear, anger, sadness, guilt, disgust, long silences, rejection, demotivation, uncertainty, racism, showing superiority, arrogance, cold treatment, being distanced from the patient, lack of respect, not knowing how to listen, lack of confidence, lack of vocation, lack of concern, indifference, value judgements, labelling the patient, impatience, blocks and concern about professionalism itself.

3.6. Narrative experiences in the establishment of the therapeutic bond.

Finally, the majority of the bonding experiences that the students recounted were those such as difficulties in establishing relationships in the spheres of health and education, and the relationship with partners.

More specifically, with regard to bonding experiences in the area of health, the person most frequently cited was the doctor or department member with little interest in the patient or student and who does not maintain eye contact, with a lack of professionalism, appraisal, friendliness and respect. In these cases, the patient or student feels a lack of understanding, sadness, anger and worthlessness as a person.

With regard to the relationships with partners, the students highighted situations between classmates or flatmates. These situations are characterised by a lack of confidence, respect, communication, authoritarianism on the part of another person, with the consequential bad atmosphere at work or at home, thus resulting in bad academic results.

To a lesser extent, the students also mentioned the situation in which the person with a lack of a bonding relationship is a professor. In this case, the profesor has difficulties in establishing a good bond or relationship, with the consequential lack of motivation and lack of interest and progress as regards the student of that subject.

4. Conclusions

Despite the fact that we have no intention of applying them in general terms, the qualitative result shown here provide a series of interensting elements that could be borne in mind and followed up in future studies.

First, the emotional universes that are most difficult to train are those of security and admiration, since they are rarely experienced. A possible explanation for this may be that these emotions have recently been considered to be basic emotions, which have not formed part of the emotional universe and have not been worked on, taught or trained. Moreover, in order to feel admiration for ourselves, our reference points must previously have looked at us, admired us and contemplated us in an inconditional manner (Aguado, 2014; 2015).

These results therefore lead us to state that the emotions of security and admiration should be trained in future health professionals, since these professionals must be sure of their capabilities and admire themselves for having them, where admiration is understood as saying yes to oneself and legitimising oneself as a professional.

Furthermore, the students stated that fear and anger are the most difficult unpleasant basic emotions to train because they are “unpredictable and difficult to control”. This datum shows that these two emotions should be changed for emotional universes that are better adapted to the stimulus situation, particularly in the students’ future professional career. It is therefore necessary for them to learn to activate antidote emotions such as curiosity, admiration and security (Aguado, 2014; 2015).

Second, and with regard to the emotions that are felt most frequently, joy appears in first place. This datum reenforces the overgeneralised and socioculturally accepted idea that the goal in life is to be joyful and happy (Aguado, 2014; 2015). This idea of happiness and joy as a goal may place us in a situation of vulnerability and frustration if we are unable to attain this state. We should, perhaps, review these ephemoral goals and replace them with others that are longer lasting and more adaptive, such as satisfaction. Happiness is constrained by the fact that things do not always turn out well, while satisfaction is not ephemeral and implies learning and reflection which lead us to balance our lifestyles, thus providing our lives with well-being and equilibrium.

The students also frequently experience sadness. Sadness is considered culturally to be something negative that is not allowed. As with happiness, we should change our viewpoint regarding the utility of sadness. Well-managed sadness leads to reflexion and to an awareness that may provide us with strategies and mechanisms that will lead to the change that we need. Sadness is a fundamental emotion for survival, which leads us to advance, change, distance ourselves, etc. Our students feel the emotional universes of anger, fear, disgust and curiosity to a lesser extent.

With regard to curiosity, our attention was drawn by the fact that this state appeared to a lesser extent in the university environment. This shows the need to orient teaching practices towards curiosity as a basic emotion as regards increasing our interest in academic knowledge, since curiosity is the primary ingredient of emotion, while simultaneously activating our attention and with it the cerebral machinery of learning and memory. And this takes places naturally, by means of the codes in ours brains that were constructed more than two-hundred million years ago and which we have inherited (Mora, 2013).

Third, when carrying out the task of identifying emotions with sensorial characteristics, it is noteworthy that upon being able to choose a pleasant or an unpleasant emotion, all the groups identified with an unpleasant emotion, that most frequently chosen being anger, followed by sadness and fear. Disgust appeared to a lesser extent. We therefore observed that the students found it easier to identify unpleasant emotions than pleasant ones. We do not know why this might be, although we can hypothesize that this result reflects the difficulty involved in naming agreeable or pleasant emotions. That is to say, becoming emotional is bad, negative, dangerous and is that for which we are genetically, biologically and philogenetically prepared as regards survival and adaptation. It would appear to be more adaptive to feel the reverse than to be in a pleasent emotional state (Ekman & Friensen, 1972; Ekman, 1999; Lewis, 2000; Prinz, 2004). However, we now know that human beings may be calm, interested, peaceful, feel under control, feel rooted, can learn from others, imítate, etc., with the appearance of emotional universes such as curiosity, admiration and security (Aguado, 2014; 2015).

There is similarly a relatively high level of unanimity as regards the students' sensorial identification of emotions in the various analysis variables. It is as if in the collective imagination and as a consequence of the fact that emotions are in our genome as mammals, there is an unspoken agreement to identify the shapes, colours, smells, textures, etc., of emotions in the same way.

With regard to the variables related to the therapeutic bond, it is possible to observe that the students distinguished those elements that make the establishment of a therapeutic relationship between the health professional and the patient easier or more difficult in an appropriate manner. Feeling unpleasant emotions therefore makes that bond more difficult (Aguado, 2005; 2014; 2015; Barbero et al., 2013; Martínez-Lorca, Martínez-Lorca, Aguado y Zabala-Baños, 2015), as do arrogance, a cold treatment, distancing oneself and not listening (Bascuñán y Luz, 2005; Esquerda et al., 2016; Galán et al., 2014; Loayssa, Ruiz y González, 2015;Tamburrino, Nagel, Chahal & Lynch, 2009; Vidal et al., 2015). Other pernicious elements may be the absence of professional motivation, tiredness, stress, burnout (Barbero et al., 2013; Zapf, 2002); making value judgements or labelling patients, etc.

Moreover, those factors that make it difficult to establish a bond are clearly shown by the experiences recounted by the students. These examples were therefore related to the sphere of health. There were also examples, although to a lesser extent, of relationships with partners or with a teaching professional. It is therefore possible to find bonding situations in which having an appropriate emotional and relational management is highly relevant and important, particularly in the spheres of health and education, if we are to bond in a more satisfactory manner that will be of benefit as regards improving assistential quality (Barbero et al., 2013; Ellis, 2008; Serrano et al., 2014) and teaching (Berrios, López-Zafra, Pulido-Martos & Augusto, 2013; Extremera y Férnadez, 2004; Lantieri y Nambiar, 2012; Pérez-Escoda, Filella, Soldevila y Fondevila, 2013).

With regard to those elements that are facilitators, our results reflect how the students express the most frequently evidenced elements, such as empathy, active listening, visual contact, respect, etc. (Aguado, 2005; Bados y García, 2011; Bascuñán y Luz, 2005; Galán et al., 2014; Rodríguez, Blanco y Parra, 2012). However, one new piece of data is that the students have included other elements such as the patient's unconditional admiration, being accompanied and being present. Despite the fact that it is true that these factors were mentioned during the conference when discussing the therapeutic bond, it is still a datum that should be highlighted (Aguado, 2005; Bados y García, 2011).

All of the above manages to attain and guarantee the establishment of a therapeutic bond that will favour health professionals becoming references and activating the basic emotions of curiosity, admiration and security (Aguado, 2005; 2014; 2015). If the health profesional does not, therefore, manage to make the patient feel a certain amount of

security, s/he cannot intervene in any way. Confidence in the professional as a referential figure removes the patient's sensation of neglect and insecurity, and establishes a secure basis on which to examine the various unhappy and painful aspects of his/her life, many of which it is difficult to think about and reconsider without a trustworthy companion who will provide encouragement, help, sympathy and, in some cases, orientation (Bowlby, 1988; West& Shedon-Keller, 2011).

The results presented in this work are not without their limitations. Although the students talk about and indicate the best cognitively known emotional universes, we cannot be certain that when they talk about feeling an emotion that is really what they are feeling in a psychophysiological manner. Similarly, the training was basic and related to the objective, and its planning was therefore short in order to allow the students to become familiar with the subject and internalise it.

Finally, out work shows interesting results in the field of university education as regards important and seldom-taught topics such as emotions and bonding relationships. In the future, other proposals similar to that proposed here should be set up and particularly evaluated in order to discover the degree of knowledge and internalisation that those attending that training course have. We propose an interesting and passionate road on which the university should guarantee providing that training throughout the curriculum or by means of special university courses, with the objective of producing better future health professionals as regards emotional and psychosocial spheres in order to attain the best possible degree of well-being, not only among those future professionals, but also among patients.

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