Chapter 8
Emotional Intelligence, Alexithymia, and the Doctor-Patient Relationship

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8.1 Introduction

8.1.1 Emotions in Doctor-Patient Encounters

Emotional topics are common in medical consultations as well as in psychotherapy. Patients often present to the doctors and therapists their hopes, uncertainties, feelings, and worries. However, patients often will refrain from conveying their emotions explicitly in the consultation. Rather, emotions may be expressed as an indirect hint about underlying worries or concerns, often referred to as cues [1–3] or clues [4]. However, studies indicate that most consultations contain few cues to underlying emotions. Feelings may also be expressed more unambiguously, labeled in the literature, for instance, as concerns [1] or empathic opportunities [5].

Studies show large variations in how health professionals respond to patients' emotion. Most studies have assessed physicians' responses. For instance, Mjaaland [6] found in a study of medical interviews in a general hospital across specialties that physicians provided room for further disclosure in response to about half of all emotional cues and concerns, but more often with reference to the medical than the affective content of the cue or concern. Similarly, Butow et al. [7] reported that oncologists effectively identified and responded to the majority of informational cues; however, they were less effective in addressing cues for emotional support. In another study on cancer care, Pollak et al. [8] found that oncologists reacted with empathy to 29 % of patients' expression of negative emotion. A number of studies report similar results, indicating that the emotional aspect of patients' messages is often overlooked and not responded to by physicians [6, 9–11]. Rather than follow

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up on emotional cues, physicians often, but not always, respond with biomedical questioning and information giving or rather nonspecific acknowledgment or premature reassurance [9–12].

The responses of nurses to cues and concerns have also been investigated and the results vary. In a study from a surgical oncology clinic, Uitterhoeve et al. [13] found that nurses explored or acknowledged 45 % of patients' emotional expressions, but more than half of the expressions were met with distancing behaviors. Eide et al. [14], on the other hand, found that 75 % of all emotional expressions were met with implicit recognition, whereas another 13 % were explicitly recognized in a study of admittance interviews at a pain clinic [14]. The differences between findings may be due to both methodological differences and different clinical tasks and settings.

In a recent study, Del Piccolo et al. [15] investigated cues and concerns in psychiatric consultations. They found that psychiatrists quite often provided space for further disclosure of the emotional cue, but most often without an explicit reference to the cue or concern. Psychiatrists made a specific mention of the patient's cue or concern only when the emotional expression had been initiated by them, but empathic responses were infrequent.

Many patients welcome the opportunity to talk about their feelings, but other patients are rather reluctant. However, in any case, awareness toward patients' emotions is an important element in the clinician's repertoire of clinical skills, both in conventional medical consultations and psychotherapy. In a conventional consultation, the main purpose of the consultation is most often to set a diagnosis or somehow monitor an already known disease as well as provide information and treatment to the patient. Psychotherapy, "the talking cure," aims to reduce distress and modify behavior, most often within a series of encounters, ranging from a few hours of short-term therapy to treatment lasting for several years. In both cases, the clinician may be faced with patients' emotion and will be challenged to find ways to respond. Expression and non-expression of emotion are important elements in the ongoing relationship between doctors and patients.

8.1.2 Individual Differences in How to Handle Emotions

Emotional expressions vary in terms of valence and intensity of the emotion expressed, from fervent rage to calm delight, from deep sadness to animated joy. But there are individual differences, not only in what patients feel but in the way patients handle their emotions as well as how clinicians respond. These differences may relate to what we call regulatory aspects of emotion. Emotion regulation is defined by Gross [16] as the processes by which emotions are influenced, when one has them, and how one experiences and expresses them. Studies on emotion regulation attempt to find answers to a number of different questions: To which extent are the emotional qualities of the stimuli perceived? How is the emotion identified (and with what degree of clarity), tolerated, labeled, and expressed, verbally and nonverbally? How attentive is the person to his or her emotions, and how well are emotions monitored and controlled?

A number of different terms have been suggested to cover these aspects of emotional behavior, with different emphases, operationalizations, and theoretical

foundations, such as affect regulation, mood awareness, levels of emotional awareness, affect consciousness, and emotional approach coping.

Some of the research on emotion regulation seeks to find general elements in the process of emotion regulation. Other research seeks to identify stable individual profiles of emotion regulation. The two most frequently studied concepts in the latter tradition are alexithymia and emotional intelligence.

Thirty-five years ago, Peter Sifneos and his colleagues [17] observed that patients with psychosomatic disorders often had difficulties to express emotions in medical consultations. He coined the term alexithymia, which literally means lack of words for feelings (a-lexi-thymia), which he considered a stable personality trait in some individuals. Alexithymia has been defined and operationalized in different ways. Currently, the most commonly used method to measure alexithymia is the Toronto Alexithymia Scale, developed by Taylor et al. [18]. In the 20-item version, TAS-20, alexithymia is defined as a cognitive-affective style or trait involving (1) difficulty identifying feelings and distinguishing between feelings and bodily sensations, (2) difficulties expressing and communicating subjective feelings verbally, and (3) a certain concrete, externally oriented, bluntly reality-based style of thinking.

Around 1990 Peter Salovey et al. [19] developed the concept of emotional intelligence. Emotional intelligence is described as an individual characteristic that reflects the "ability to monitor one's own and other's emotions, to discriminate among them and to use this information to guide one's thinking and actions [20]." The concept has gained popularity in psychological research over the last 10 years. The term has also become a household word in popular psychology, not the least through the best-selling book on emotional intelligence by Daniel Goleman [21].

In spite of the increasing number of research papers, few researchers have investigated the impact of alexithymia and emotional intelligence on the doctor-patient relationship. Interestingly, a few studies have been done on either clinicians' emotional intelligence or patients' alexithymia. However, there have been no studies on the relationship of clinicians' alexithymia or of patients' emotional intelligence with the doctor-patient relationship. Nor has there to our knowledge been any study which simultaneously investigates emotion regulation or affective awareness components in both patients' and clinicians' behavior.

8.2 Clinicians' Emotional Intelligence and the Doctor-Patient Relationship

Arora et al. [22] have recently reviewed the research literature on the relationship of emotional intelligence with clinical competence and skills in medicine. Their expectation was to find positive association between measures of emotional intelligence and variables relevant to the doctor-patient relationship.

The findings in the empirical literature give partial support to this expectation. Weng [23] studied the association between emotional intelligence and variables related to the doctor-patient relationship in a sample of 983 patients and 39 physicians representing 11 different specialties. The measure of physicians' emotional intelligence was based on ratings by nurses who had collaborated closely with the

physicians. The strongest association was found between physicians' emotional intelligence and patients' trust in physicians. Patients' trust in physicians was strongly related to their satisfaction, but there was no direct link between physicians' emotional intelligence and patients' satisfaction [23].

In a subsequent study, Weng et al. [24] investigated the associations of emotional intelligence of surgeons with patients' ratings of the quality of the doctor-patient relationship, surgeons' empathy, and patients' satisfaction. The surgeons' emotional intelligence predicted the quality of the doctor-patient relationship, but again no direct association was found between physicians' emotional intelligence and patients' satisfaction.

Recently Kaplowitz et al. [25] studied the impact of therapists' emotional intelligence on psychotherapy in a small pilot study of 23 therapist-patient dyads [25]. The researchers found, to use their own words, "… modest preliminary evidence for the hypothesis that therapists' emotional skills positively influence therapeutic efficacy." Higher emotional intelligence of therapist predicted better improvement of patients' interpersonal problems, as assessed by the therapists. Moreover, higher therapists' emotion management abilities (a component of the emotional intelligence measure applied) were significantly associated with greater improvement in patient-rated symptomatology. However, no significant relationship was found between therapists' emotional intelligence and working alliance.

8.3 Patients' Alexithymia and the Doctor-Patient Relationship

The concept of alexithymia was based on the observations of Peter Sifneos in psychotherapy with patients with psychosomatic complaints. Still there is surprisingly little research on the potential impact of alexithymia on the process and outcome of psychotherapy. Krystal [26] suggested 30 years ago that psychotherapists often assume that patients generally have "the affective functions necessary for the utilization of psychotherapy." However, this is not always the case. Ogrodniczuk and his colleagues [27] have recently elaborated on Krystal's observation in a series of studies on the effects of alexithymia on the process and outcome of psychotherapy.

Ogrodniczuk et al. [27] point to a number of myths regarding alexithymia and psychotherapy. One myth is that patients with alexithymia not only are reluctant to talk about emotions in therapy sessions but also are reluctant to even take part in psychotherapy. However, in a study of 145 new patients from two different psychiatric outpatient clinics, they found that alexithymia scores (as measured with the TAS-20) did not significantly differ between groups of patients who chose medication treatment, psychotherapy, or no treatment at all [27]. Another myth is the notion that alexithymia is resistant to change even in those patients who engage in psychotherapy. However, a number of studies have reported that alexithymia scores may decline during psychotherapy and that such changes are correlated with improvements in therapy.

However, consistent with earlier studies, what Ogrodniczuk et al. [27] confirmed was the widely held idea that alexithymia is associated with poor outcome in psychotherapy. Interestingly, the researchers found that the therapists' reactions to the patients partially mediated the effect of alexithymia on the outcome of psychotherapy. The negative effects of patients' difficulties in communicating feelings and of externally oriented thinking were mediated by therapists' negative attitudes and reactions toward these patients.

There are few studies on the effect of emotion regulation and affect awareness on the doctor-patient relationship outside of psychotherapy. A series of studies on arranged consultations in a laboratory setting have investigated how individual differences in terms of trait anxiety and alexithymia influence how patients respond to emotional talk in medical consultation.

In our first study, students with high and low trait anxiety volunteered to take part in arranged consultations with a physician [28]. They were instructed to bring up any medical complaint that they had at the present or had suffered in the past or a medical concern about their parents or other close relatives. The interviews were performed in two different experimental conditions. In one condition, labeled as patient-centered, the physician attended to psychosocial topics and responded explicitly to emotional concerns. In the other condition, labeled as physician-centered, the physician concentrated strictly on the medical complaints and largely ignored psychosocial issues and emotional concerns. Dependent variables were affective responses as measured with the Profiles of Mood States (POMS) and cortisol responses. We expected stronger emotional responses to the consultation in patients with high state anxiety. Moreover, we expected that patients with high state anxiety would respond with attenuated emotional activation in the patient-centered condition. However, contrary to our expectation, this study found a significant interaction effect between trait anxiety and experimental conditions, with higher arousal among high-anxiety patients in the patient-centered than in the physician-centered condition, while the opposite among low-anxiety patients [28].

Our subsequent study found physician-patient interaction in arranged consultations with fibromyalgia patients with and without alexithymia. Similar to the study of high- and low-anxiety students, fibromyalgia patients with alexithymia reported more confusion, less vigor, and higher heart rate activation in arranged consultations with a "patient-centered" psychosocially focused communication style as compared to a "physician-centered" symptom-focused communication style [29]. Yet, it was found that these patients were more satisfied with many empathic statements from the doctor [30]. When the patients later viewed the videos of the consultations, patients with alexithymia displayed more confusion, less vigor, increased electrodermal activation, and a feeling of less control in consultations with a psychosocial emphasis. In contrast, for patients without alexithymia, the "patient-centered" psychosocially focused communication style was associated with fewer phasic electrodermal responses (as measured by the number of spikes) and a feeling of more control in the consultation than was the physician-centered condition with a focus on symptoms [31].

8.4 Conclusions

There is some evidence that clinicians' emotional intelligence and patients' alexithymia may have some impact on the process and outcome of consultations. The following tentative conclusions can be drawn from some studies. First, clinicians' emotional intelligence seems to be associated with patients' experiences of trust in their physicians. Some findings indicate its positive impact on outcome in psychotherapy, but not on the therapeutic alliance. Second, alexithymia is negatively associated with outcome in psychotherapy. This effect is partially mediated by negative therapist's attitude toward patients with alexithymia. Third, some studies indicate a consistent interaction effect between alexithymia and communication style in patients' responses to emotional content in medical consultations. An emphasis on emotional themes in the consultation was associated with higher arousal, less feeling of control, and less satisfaction in patients with alexithymia, while it was associated with a more accepting reaction in patients without alexithymia. Applying measures of alexithymia as well as emotional intelligence both to clinicians and to patients could provide valuable information on the potential relationship between patients' and clinicians' emotion regulation and how such potential associations are related to qualities of the doctor-patient relationship.

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