„OVIDIUS" UNIVERSITY OF CONSTANTA
DOCTORAL SCHOOL OF THE FACULTY OF MEDICINE

PSYCHOSOMATIC DISEASE IN INTERNAL MEDICINE – DIAGNOSTIC AND THERAPEUTIC ACCEPTANCE

SUMMARY OF THE PhD THESIS

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Constanța
2017

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CONCLUSIONS

The doctoral thesis titled "Psychosomatic diseases in internal medicine - diagnostic and therapeutic acceptance" contains 44 figures, 78 tables and 287 bibliographic references. For the purpose of summarizing the abstract, we selected a limited number of figures and tables (the numbering in the thesis has not been retained) that we considered representative for the clarity of the exposition and the bibliography chosen is selective.

Key words: psychosomatic, biopsychosocial, stress, personality, thanatophobia, symptoms without medical explanation, somatic symptoms, stress, patient satisfaction index, iatrogenic, therapeutic relationship, econometrics, psychotherapy, health, illness, motivational interview.

INTRODUCTION

I. Conceptual landmarks of research

I.1. Actuality of the research topic.

The current trend is to draw a net line between psychiatric and psychosomatic disorders, which are now increasingly attributed to internal medicine (Zipfel S., Herzog W., Kruse J., Jenningsen P., 2016). The prevalence of psychosomatic disorders is steadily increasing, with statistics ranging from 16.1% to 57.5% in primary medicine with a prevalence rate of 11% in the general population at 12 months. (Murray, Toussaint, Althaus and Lough, 2013).

While the beginning of the century has meant a confrontation with infectious diseases, today medicine must accept the challenge of psychosomatic disorders, which requires another approach to the disease to discover how people can remain healthy in a challenging psychological environment.

This thesis is the result of the research work carried out in order to generate knowledge about a particular inter-human phenomenon, the therapeutical relationship, in the sense of the doctor-patient alliance and its influence in the final stages of the medical act, the diagnostic and therapeutic acceptance, in the patient with psychosomatic disorders.

I.2. Description of the situation in the research domain and identification of research issues.

The purpose of this study is to demonstrate that a complex interpersonal relationship - the therapeutic relationship, in the sense of alliance, has an essential contribution in the stage of communication-acceptance of diagnosis and therapy, components of the economy of any medical act. The new trends in medicine, patient-centered (individualized) medicine coupled with the patient's biopsychosocial approach have changed the classical concept in the sense that diagnosis and indication of therapy are not exclusively physician-related, and this is now an interactive process . In this context, the therapeutic relationship is a defining element for what transforms the medical profession into "art", namely, the philosophical - hermeneutical component from the perspective of inter - human communication. ("Philosophy is the Medicine of the Soul" Cicero).

This research attempts to decipher the perception of patients with psychosomatic disease in terms of the significance of psychosomatic disease and integration into their own set of values so as to accept the diagnosis and the indications of therapy.

The approach has resulted in a systematic investigation aimed at generating knowledge about a particular phenomenon, making the diagnosis and therapeutic acceptance more specific. The study is in the field of fundamental research, but it also includes a component with practical applicability, namely a working algorithm useful in everyday medical practice.

I.3. Objectives

The main objective

Demonstration of the influence of the therapeutic relationship in diagnostic and therapeutic acceptance in patients with psychosomatic disorders, while identifying obstacles that interpose between the patient and the doctor, preventing the achievement of this goal. The concrete way of realization was to observe, isolate and define a certain phenomenon, establishing its frequency of manifestation.

Secondary Goals:

1. Analysis of the psychological variables that contribute to the establishment and consolidation of the therapeutic relationship.
2. Identification of barriers between the doctor and the patient, preventing diagnostic and therapeutic acceptance.
3. Structure of items on syndromes according to DCPR for each scale used and elaboration of mathematical models for the purpose of introducing quantifiable factors into equations in order to standardize the observation and conceptual definition of some therapeutical models in order to maximize the use of medical information in relation to its beneficiary.
4. Modeling the correlation between certain syndromes structured by the author according to DCPR, therapeutic relationship and diagnostic and therapeutic acceptance, using a statistical and mathematical method of correlations between phenomena.
5. Framing the patient with psychosomatic impairment into a risk category based on a strictly determined factor, which allows the elaboration of an algorithm for the efficient management of the cases diagnosed with psychosomatic affection, in order to increase the diagnostic and therapeutic acceptance degree, individualizing the therapy.
6. Demonstrating the importance of the individualized approach of the patient in the context of the medical act in order to increase the degree of diagnostic and therapeutic acceptance.
7. Elaboration a work algorithm included in the category of practical approaches to optimize the decision-making process on both sides, physician and patient, thus demonstrating that the design of the study complied with the principles of evidence-based medicine.
8. Defining and demonstrating statistically-mathematical notions of risk and critical risk in patients with psychosomatic disease and the importance of these notions in the decision making process (diagnostic and therapeutic acceptance) in this category of patients.
9. Defining the risk of erroneous decision and demonstrating its importance in the process of diagnostic and therapeutic acceptance in patients with psychosomatic disease.
10. Estimation of the theoretical weight of the intervention measures in case management of the patient diagnosed with psychosomatic condition.

- **Conceptually**, the subject of the research is the classical and contemporary theories regarding the importance and influence of the therapeutic relationship in the medical act, making the resistance of the patient with psychosomatic condition in accepting the specific diagnosis and therapy.
- In **terms of content**, research has been structured from the DCPR (Diagnostic Criteria for Psychosomatic Research) criteria, using three types of questionnaires. In this respect, we directly observed the participants in the study (anamnesis and analysis of interviews, questionnaire processing) to understand and describe a certain behavior in the face of the disease, starting from the therapeutic relationship.
- **The operational aspect** addresses the importance of establishing a therapeutic relationship with the signifiance of a doctor-patient alliance, being aware of the difficulty of dealing with this category of patients, where the acceptance of diagnosis and therapy is the aspect of the difficulty of the medical approach. That is why we have developed the econometric, statistical-mathematical models, with which we have defined four psychological profiles of the psychosomatic patient, and introduced the notion of affective prognosis, the essential component of decision-making capacity.

I.4. Material and method

We included 200 participants, 100 participants without psychosomatic disorders (control batch) and 100 participants with psychosomatic disorders.

The research was conducted over a period of 8 years (2008-2016). The design of the study is part of the prospective and mixed studies; quantitative and qualitative methods have been used concurrently and combined in the interpretation phase. The advantage of the mixed approach was the possibility of validating the results obtained from two perspectives.

The quantitative approach aims to evaluate the frequency of the phenomenon - diagnostic and therapeutic acceptance. The quantitative analysis aimed at quantifying the structured data in the form of the working hypothesis. We used measurable data to formulate facts and developed research patterns (econometric models), thus validating the hypothesis of a phenomenon in a concrete, mathematically demonstrated way.

The modeling of psychosomatic disorders is a complex phenomenon of impact as well as a synthesis of research with generalizable subsequent valences.

The modeling effects aimed at introducing quantifiable factors into equations in order to standardize the observation and conceptual definition of some therapy models to maximize the use of medical information in relation to its recipient - the patient.

The modeling of the models followed the traceability of clear objectives with ramifications on various syndromes characteristic of psychosomatic disorders.

Qualitative analysis. Qualitative methods provided important data to describe phenomenon that, if processed using quantitative methods alone, risked ignoring the factors that are particularly important in explaining the conceptual framework and relationships that govern the medical act. The qualitative study has increased the level of understanding of the context of phenomenon. Its use also offered an increased perspective on the periphery of the phenomenon studied, which was particularly important at the beginning of the study. Qualitative methods have allowed identifying models and types of configurations among variables to make distinctions within the studied phenomenon.

With the help of qualitative research it was possible to decipher how patients perceive the health and disease experience and how to interact between the "actors" involved in the therapeutic relationship for the acceptance of diagnosis and therapy. According to the principles of the qualitative approach, we have emphasized the experiences we have gained by generating data on interpersonal relationships in different social contexts. Through this study, I have tried to generate depth information that is difficult to quantify, such as meanings, understandings, and experiences. In fact, "qualitative research is not antagonistic, but only complementary to quantitative research "(Al Busaidi, 2008).

The main research methods used in the paper were: analytical method, comparative method, iteration, quantitative method, deduction, statistical groups, argumentation and logical demonstration.

The analysis shows that the selected sample is representative of the proposed objective, namely: determination of the validity of the hypothesis that the therapeutic alliance influences the diagnostic and therapeutic acceptance in patients with psychosomatic disorders.

The questionnaires used as clinimetric tools for the purpose of collecting data are three, namely, "The Scale of Attitude towards to Illness", "General Practice Assessment Questionnaire - GPAQ" and "Determinants of Patient Satisfaction with Physician Interaction".

Both quantitative and qualitative analysis were performed on three defined **profiles**: **generally,** patients **with psychosomatic disease** and patients **without psychosomatic disease.**

For the accuracy of the analysis, we have defined **three characteristic sub-profiles** for the category of patients with psychosomatic disease, namely: **demoralized - worried**, **demoralized - disappointed** and **demoralized - desperate.**

As part of the analysis of each of the branches, we structured syndromes with the diagnostic criteria of the **DCPR (Diagnostic Criteria for Psychosomatic Research).**

The identification of the main and secondary objectives was the process underlying the development of a set of mathematical models through which certain therapies related to diagnostic, therapeutic and alliance acceptance could be implemented (Patient Satisfaction Index on Relationship).

The purpose of setting up traceability models in this study was to provide a phenomenographic representation of the processed data. The realization of the three models outlines a phenomenon - diagnostic and therapeutic acceptance and at the same time certifies the conclusions obtained in the study after the statistical processing of the collected data, being a measure of their validity.

The three configured models align with the psychosomatic research direction, which seeks to find arguments in favor of a biopsychosocial and patient-centered approach using biomedical models. The purpose of this approach is to identify specific quantifiable mechanisms that reveal a causal chain of events.

The use of an econometric model that brings together several DCPR concepts is a novelty in addressing somatisation / MUS / TSS patients in medical literature in Romania.

In other terms, this econometric model establishes the dependence between the human capital embodied in the therapeutic relationship, and the efficiency of the medical act, completed in this case, by diagnostic and therapeutic acceptance.

I.5.The research methodology and theoretical and scientific support of the thesis.

At present, knowledge in the domain of psychosomatics is deepened and re-evaluated, with existing studies demonstrating the need for a detailed analysis of the implication of psychological factors in the onset of somatic diseases, with particular reference to certain categories of diseases such as neoplasia, cardiac, neurological or gastroenterological diseases.

The direction of approach in psychosomatic research is geared towards mixed studies. The reason is the possibility offered by the qualitative component of the mixed studies to decipher the intrinsic mechanisms at the level of phenomenological significance of the human experiences, offering also ways of describing them through the elaboration of some concepts. We considered it appropriate to use this approach in this study to draw a series of conclusions of double value, theoretical and practical.

In-depth studies on interpersonal relationships, their influence and importance in medical practice have opened up new research directions and re-conceptualizing current knowledge, demonstrating that at this time there is still insufficient knowledge of human experiences with regard to psychosomatic disorders and patient behavior in dealing with them.

The literature includes works that increasingly address the experiences experienced by people, generating data about inter-human relationships in different social contexts, such as the therapeutic relationship.

I.6. Compliance with Ethical Principles of Studies on Human Subjects

The study complied with the principles of human studies. We obtained the informed consent of the patients initially, enrolling in the study, acknowledging the rights of the participants, the risks and benefits, the purpose, the way of working. In this respect, the study complied with the Belmont Report (http://ohsr.od.nih.gov/guidelines/belmont.html) and the Nuremberg Code (http://www.cirp.org/library/ethics/nuremberg) .

I.7. Implementation of scientific results.

Accepting diagnosis and therapy, the final stages of any medical act, is the element of difficulty in addressing this category of patients.

The objectives and approach taken by this study provide a way to increase the performance of the medical act in relation to psychosomatic patients, quantified by the patient's satisfaction index, the measure of the quality of the medical act. The validity of this approach is confirmed theoretically by the results of the study,

II. The content of the thesis

The doctoral thesis with the **"Psychosomatic diseases in internal medicine - diagnostic and therapeutic acceptance"** has an interdisciplinary character, bringing together aspects specific to medical practice with elements specific to medical psychology. This integration makes possible an interface approach attributed to psychosomatics. The paper is structured in two parts: a first part - the stage of knowledge comprising five chapters and the second part, the personal contribution. Treated concepts are of major importance both by approaching from a new perspective in medicine, namely, the patient-centered medical act personalized in the biopsychosocial manner but also by the type of affection chosen, the psychosomatic disorders according to DSM 5, the Symptoms of the Somatic Disorders (TSS).

II.1. In the First Part - Current stage of knowledge, we have defined the domain of psychosomatics that approaches the human being in a different sense, accepting the coexistence of somatic and psyche, regarded as inseparable and complementary, based on the bio-psycho-social model. In this context, psychosomatic / psychosomatic medicine can be defined as an interdisciplinary field, which brings into discussion the involvement of emotional factors in the etiology of somatic affections. Characteristic of this type of disorder is that it is disabling for the patient, similar to the organic (somatic) affections.

Concentration of attention is directed to the existence of a significant proportion of psychosomatic diseases in the internal medicine, materialized by the diagnosis and application of the specific therapy plan, starting from the optimization of the therapeutic relationship.

This paper brings to the forefront the idea that there is a direct *causal link between the therapeutic relationship and the acceptance of diagnosis and specific therapy in the case of psychosomatic disorders, starting from the data in the literature.*

At the same time, it is stressed the need for documented information and interdisciplinary collaboration of medical professionals with regard to diseases psychosomatic, with direct reference to the therapeutic relationship and its importance in diagnostic and therapeutic acceptance. *This is all the more necessary since patients with somatization disorders and their support organizations are vehemently disputing the explanations given by the medical world that associate the existence of somatic disorders with a range of psychiatric, psychological,*

social or spiritual problems, keeping a dose of increased reticence, skepticism and frustration over the psychological explanations offered.

The value of the work in the field of fundamental research is related to the confirmation, made by comparison with the studies published in the literature so far.

The objective of the project is to emphasize the importance of the therapeutic relationship in accepting diagnosis and therapy for psychosomatic disorders, starting from the classical notion of "resistance" by identifying specific barriers that are in the way of achieving this goal. In other terms, this work can be assimilated to a different type of approach to the phenomenon of resistance (in the classical sense) to diagnosis and therapy, in order to effectively manage it. The paper has as its starting point the results of the existing research.

It is recognized and accepted that psychosomatic disorders occur at people with psychological vulnerability, thus understanding the existence of a fragile emotional status. For this reason, the therapeutic relationship, a type of interpersonal relationship of particular type, plays a particularly important role in the management of psychosomatic disorders through the emotional component that seems to be the premises of a certain behavior towards the disease and determines the motivation of certain choices in particular situations.

This study succeeds in demonstrating how psychological factors reunited in the form of clinical syndromes can influence the behavior of the disease, having as a reference factor the therapeutic relationship.

This first part has a theoretical character, bringing together definitions, theories, paradigms, postulates and classifications, characteristics and particularities of the psychosomatic domain, but also with reference to the therapeutic relationship. The personal contribution in this first part is the activity of searching, corroborating and comparing the data existing in the literature with the emphasis on their novelty and uniqueness. This stage was followed by the ordering and conferring of a systematic nature of the information accessed in order to draw a more recent picture of the current state of knowledge regarding the psychosomatic diseases, the therapeutic relationship and its importance in the conduct of the medical act.

In this regard, we have developed a short history of psychosomatic, conceptual framework and definition of the domain of study, diagnosis criteria and classification of psychosomatic disorders, reported to DSM IV and DSM 5, taking into account the fact that during the study the 5th edition DSM (2013).

II.2. Part II - Personal Contribution

This section of the thesis refers to: the results obtained from the statistical processing on the qualitative and quantitative branch of the study.

II.2.1. QUANTITATIVE ANALYSIS

The "Scale of Attitude towards to Illness" Questionnaire - Structure Data

The "Scale of Attitude Scale" questionnaire - is structured on a series of clinical syndromes with a profile of the patient's attitude towards the disease.

Sample Structure Indicators

Respondent/rank criteria/options	Age	Sex	Occupation
			Without
			10
Option 5	(60-70]		In the medical field
Number of answer	18		6
Option 4	(50-60]		Public services
Number of answer	38		71
Options 3	(40-50]		Technical and economic sector
Number of answer	57		91
Options 2	(30-40]	Female	Unemployed in payment
Number of answer	73	89	1
Option 1	(20-30]	Male	Pensioner
Number of answer	13	111	21
No of valid responses	**200**	**200**	**200**
Average scoring	2,8900	1,4450	3,3500

Source: Developed by the author

Age: The representative segment of the surveyed population is the 40-50 year segment, that manifest concern for disease prevention.

Sex: From the age point of view, it is clear from the studied sample that there is some balance between the sexes, but that men are more concerned about the attitude towards the disease.

Occupation: From the point of view of the sample and of the representative age group, it is found that most of the interviewees are active in the private sector professions.

THANATOPHOBIA SYNDROME - ITEMS S13; S14; S15

Death anxiety is an absolutely natural human experience, fitting into the normality of psychological conditions. If its presence reaches the proportions of a state of terror and the patient's functioning in all spheres of its existence is altered, we are talking about a pathological behavior in the context of the current study of thantatophobia syndrome (DCPR). The fear of death is coexisting with fears about the illness. In the case of patients with psychosomatic disorders, tanatophobia is closely related to the denial of the disease, the non-acceptance of the diagnosis in the sense of the medical construct of psychosomatic condition, in which the involvement of the psychological factors is major. By not accepting the diagnosis of psychosomatic condition, this category of patients will often believe in a potentially life-threatening condition, thus increasing their psychological vulnerability in this direction.

Thanatophobia

The respondent/ rank criteria/options	Are you scared of news that reminds you of the existence of death (funeral, obituaries)? (S13)	Are you scared by the thought of death ? (S14)	Do you scare by the thought that you might soon die?{S15)
Options 5	Most often	Most often	Most often
Number of answer	1	5	6
Options 4	Often	Often	Often
Number of answer	13	14	12
Options 3	Sometimes	Sometimes	Sometimes
Number of answer	40	39	31
Options 2	Rare	Rare	Rare
Number of answer	32	42	44
Options 1	Not	Not	Not
Number of answer	111	97	104
No of valid responses	**197**	**197**	**197**
Average scoring	1,7868	1,9239	1,8426

Source: Developed by the author

***Interpretation*:** the analysis of representative thanatophobia items revealed that scoring averages have close values, S13 << 1,78 >>, S14 << 1,92 >>, S15 << 1,84 >>, proving a statistical correlation at the level Of the sample studied. The comparative analysis of the options reveals the highest number of options 1 << No >>, items S13 << 111 >>, S14 << 97 >>, S15 << 104 >>. The analysis on the other options reveals a decrease of the thanatophobia, on the chosen items, on the studied profile, options 4 << Often>> and 5 << Most often >>, having close values.

***Conclusion*:** *The highest incidence of thanatophobia syndrome in the sample of patients with psychosomatic impairment is related to the news that refers to death. This fact is objectively correlated with the presence in the media of the news with which patients come into contact daily. Thanatophobia manifests itself with the highest intensity in terms of the meaning of the notion of death.*

In the profile of patients with psychosomatic affection, the highest frequency of thantatophobia syndrome refers to the meaning of death "per se" (S14).

In the profile of patients without psychosomatic disease, we found the highest value of the phenomenon, also for item S14.

The comparative analysis of the three items with regard to thanatophobia, on the three studied profiles, revealed the highest intensity of manifestation, for the same item, S14, whose significance is related to the very meaning of death, and not necessarily to the existence of a disorder.

Conclusion: The manifestation of tanatophobia syndrome is a feature found in all three profiles but with the maximum frequency of manifestation in the profile of the respondents with psychosomatic disorders.

SOMATIZATION SYNDROME - S30; S31; S32; S33; S34

Somatization as an entity belonging to diagnostic criteria for psychosomatic disorders (DCPR) is identified by the respondents participating in this study through the S30-S34 items of the "Scale of Attitude towards Illness" questionnaire. As a form of clinical manifestation, somatization can be defined as the existence of physical accusations in the absence of some

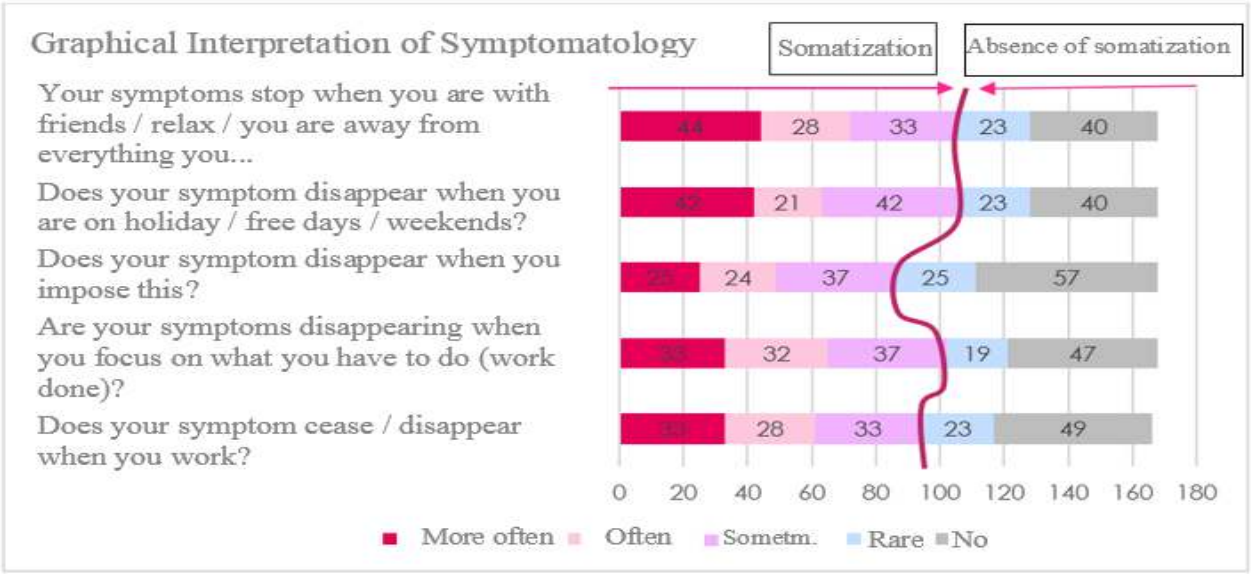
known medical conditions. *I chose to analyze the somatization syndrome, in its own right, in order to highlight its characteristics at the level of the studied population sample, somatization being the theoretical mark of this study.*

Somatisation Syndrome

The respondent/ rank criteria/ options	Do your symptoms cease/disappear when you work? (S30)	Do your symptoms disappear when you focus on what you have to do (activity carried out)? (S31)	Do your symptoms disappear when you want them to? (S32)	Do your symptoms disappear when you are on holiday/day off/weekend? (S33)	Do your symptoms cease when you are with friends/relax/are far away from everything that worries you/ dissatisfies you?
Option 5	Most often	Most often	Most often	Most often	Most often
No of answers	33	33	25	42	44
Option 4	Often	Often	Often	Often	Often
No of answers	28	32	24	21	28
Option 3	Sometimes	Sometimes	Sometimes	Sometimes	Sometimes
No of answers	33	37	37	42	33
Option 2	Occasionally	Occasionally	Occasionally	Occasionally	Occasionally
No of answers	23	19	25	23	23
Options 1	No	No	No	No	No
No of answers	49	47	57	40	40
No of valid responses	**166**	**168**	**168**	**168**	**168**
Average scoring	2,8373	2,9107	2,6131	3,0119	3,0774

Source: Developed by the author

Graphical interpretation of symptomatology in relation to somatization syndrome



Source: Developed by the author

The items analyzed, selected in this set, refer strictly to the somatization syndrome (item S30-S34) belong to the "Scale of the Attitude towards Illness" questionnaire.

The graphical interpretation of the responses of the items that reveal S30-S34 somatization syndrome from the Scale Scale questionnaire. The graph reveals that the number of respondents choosing options suggestive of somatization, namely, <<Most often; Often; Sometimes>>, it is superior to the number of respondents who do not manifest this phenomenon.

Particularly for item S30, for the whole population of respondents, we counted a total of 105 individuals with somatization syndrome versus 63 individuals who did not find this syndrome. Analyzing items S30-S34, we noticed the same distribution of the somatization phenomenon, for

each item: somatization syndrome appears to a greater extent in respondents with psychosomatic disorders.

***Conclusion**: somatization syndrome occurs in the general population, but its incidence is higher in patients diagnosed with psychosomatic disease.*

Questionnaire "The Determinants of Patient Satisfaction with Physician Interaction"

The Questionnaire " The Determinants of Patient Satisfaction with Physician Interaction" brings data on the physician-patient meeting, and implicitly to the therapeutic relationship, but approaches from a different, more comprehensive perspective than that GPAQ approach. In this case, there is also a quantification of items, of the elements pursued.

The therapeutic relationship

It is a psychosocial concept in which interactive communication between the two partners of the relationship has a primordial role. The therapeutic relationship, with alliance connotation, has a cognitive component and an emotional- affective component with an equal contribution to the therapeutic goals. Based on the attachment theory (Bowlby and Aynsworth), the therapeutic relationship provides the patient, beyond the strictly medical, science-based information, an emotional support, essential in the context of somatic symptoms disturbance. In TSS / MUS, emotional support is all the more important, as it is recognized that anxiety and depression are comorbid with symptomatology in a significant proportion. We have structured our analysis on three levels:

1. **PHYSICIAN'S** contribution to the therapeutic relationship.
2**. PATIENT'S** contribution to the therapeutic relationship.
3. Diagnostic and therapeutic acceptance - **the effectiveness of the therapeutic relationship**

Structural factors

The respondent/ options	Affected/ unaffected	Age	Sex	Religion	Marital status	Occupation	Level of education
		(70-80]				Without	
		1				10	0
Opttions 5		(60-70]		Orthodox		In the medical field	Higher education
No of answers		18		193		6	157
Options 4		(50-60]		Protestant		Public services	Secondary education
No of answers		38		2		71	37
Options 3		(40-50]		Catholic		Technical and economic sector	Gymnasium studies
No of answers		57		2		91	0
Options 2	Unaffected	(30-40]	Female	Orthodox Old Rite	Unmarried	Unemployed in payment	Non formal education
No of answers	100	73	89	0	47	1	0
Options 1	Affected	(20-30]	Male	Atheist	Married	Pensioner	No studies
No of answers	100	13	111	3	150	21	1
No of valid responses	**200**	**200**	**200**	**200**	**197**	**200**	**195**
Average scoring	1,5000	2,8900	1,4450	4,9100	1,2386	3,3500	4,7897

Source: Developed by the author

The analysis of the structural factors, obtained after the questionnaires were filled in by the respondents, revealed the following: the samples are equal in terms of the number of patients, determined at the design time of the study, for a balanced distribution of the data. Respondents' age 20-80 years, **gender distribution** is in favor of males (F / M: 89/111). Regarding **religion,** most respondents belong to the Orthodox rite, 4 respondents belong to other religions, and 3 are atheists. **Civil status**: the vast majority of respondents are married, C / N ratio: 150/47. The factor of structure, **occupation** reveals that the first place in number is respondents working in the technical-economic sector, followed by respondents working in the field of public services. In terms of the **level of training**, the highest number of respondents have higher education, followed by the number of those with secondary education. There is only one respondent without studies, but not illiterate.

The General Practice Assessment Questionnaire "GPAQ"

The *"GPAQ" Questionnaire (General Practice Assessment Questionnaire)* aims to evaluate the practice of primary medicine. One of the priority characteristics regarding the increase of the quality of the medical act, as evidenced by the studies performed lately, is the strengthening of the doctor-patient relationship and in this context the increase of the patient's satisfaction with the medical act. This is all the more important in the case of psychosomatic disorders, in which case because of the peculiarities of this type of patients, it is very easy to reach the escalating duct of antagonism.

The use of the GPAQ questionnaire in this study aimed to validate the conclusions drawn from the statistical analysis of the answers to the questionnaire "Determinants of patient satisfaction with Physician Interaction".

1. ***PHYSICIAN'S contribution***
2. **PATIENT'S *contribution***
3. Diagnostic and Therapeutic Acceptance - **The Efficacy of the Therapeutic Relationship**

1. ***PHYSICIAN'S contribution***

ITEMS: *GPAQ2; GPAQ3; GPAQ4; GPAQ5; GPAQ6; GPAQ8;*

THE PHYSICIAN'S Contribution

The respondent/ options	Is he polite and caring? (GPAQ2)	Does he listen to you? (GPAQQ3)	Does he give you enough time? (GPAQQ4)	Does he evaluate your health status? (GPAQQ5)	In explaining your medical condition and treatment (GPAQQ6)	Procuring or explaining the prescribed treatment (GPAQQ8)
Option 6	a. Very good	a. Very good	a. Very good	a. Very good	a. Very good	a. Very good
No of answer	118	113	96	102	101	101
Option 5	b. Good	b. Good	b. Good	b. Good	b. Good	b. Good
No of answer	59	58	70	64	66	58
Option 4	c. Satisfactory	c. Satisfactory	c. Satisfactory	c. Satisfactory	c. Satisfactory	c. Satisfactory
No of answer	14	21	23	25	25	33
Option 3	d. Weak	d. Weak	d. Weak	d. Weak	d. Weak	d. Very weak
No of answer	1	1	2	3	2	1
Option 2	e. Very weak	e. Very weak	e. Very weak	e. Very weak	e. Very weak	e. Fails
No of answer	0	1	1	0	0	1
Option 1	f. Fails	f. Fails	f. Fails	f. Fails	f. Fails	
No of answer	0	0	2	0	0	0
No of valid responses	**192**	**194**	**194**	**194**	**194**	**194**
Average scoring	5,5313	5,4485	5,2990	5,3660	5,3711	5,3247

Source: Developed by the author

Interpretation: The number of patients who expressed the maximum satisfaction of these items is very close, 102, 101, and 101 respondents in the study group. This demonstrates *that there is a concern that is polarized around the same frequency of manifestation, in terms of professional abilities and physician behavior in this direction.*

The comparison between previously analyzed items belonging to this category and item GPAQ 4 <<Does he give you enough time? >>, *demonstrates that patients, depending on their number, give less importance to the time factor as long as the relational efficiency , namely communication, respect, recognition and professional abilities regarding the doctor, are at the highest odds.*

2. PATIENT'S contribution

Items: GPAQ1, GPAQ7, GPAQ9, GPAQ10, GPAQ11;

The Patient's Contribution

The respondent/options	How skillful your doctor in calming you down (GPAQ1)	Involving you in making decisions about your care (GPAQ7)	Do you think your doctor is honest and trustworthy? (GPAQ9)	Do you trust that your doctor respects your privacy? (GPAQ10)
Option 6	a. Very good	a. Very good	a. Very good	a. Very good
No of answers	99	90	123	126
Option 5	b. Good	b. Good	b. Good	b. Good
No of answers	74	69	54	55
Option 4	c. Satisfactory	c. Satisfactory	c. Satisfactory	c. Satisfactory
No of answers	18	32	16	10
Option 3	d. Weak	d. Weak	d. Weak	d. Weak
No of answers	0	2	0	2
Options 2	e. Very weak	e. Very weak	e. Very weak	e. Very weak
No of answers	0	0	0	0
Option 1	f. Fails	f. Fails	f. Fails	f. Fails
No of answers	2	1	1	0
No of valid answers	**193**	**194**	**194**	**193**
Average scoring	5,3782	5,2577	5,5309	5,5803

Source: Developed by the author

Conclusion: As a result of the "horizontal" quantitative analysis for the four items analyzed above we found the following aspects: the first two items analyzed, the one about the *physician's ability to alleviate the patient's anxiety due to the existence of the symptomatology and the one referring to the participative aspect of the patient with his / her own healing, the number of respondents with the maximum satisfaction option is close to << a. Very good >>, (99, respectively 90 respondents*). We also found that, with regard to patient anxiety and involvement in their own healing, in the second item*, the number of respondents is almost double, with respect to the << c. Satisfactory >> option, confirming the previous observation with the assumption of responsibility for own healing from the patient's perspective.*

The comparative "horizontal" analysis of the following two items, which addresses ethical aspects of medical practice, allowed me to formulate the following observations: the number of respondents who chose the maximum option << a. Very good >> in terms of satisfaction with respect to the honesty and confidentiality of the doctor, is close to value (123 respondents to GPAQ 9 and 126 respondents to GPAQ 10). This finding, in conjunction with the number of respondents

who chose the option << b. Good >>, (54 to GPAQ 9 and 55 to GPAQ 10), confirms the previously formulated observations. Option << c. Satisfactory >> in relation to the number of patients is confirmed in the same way (16 respondents to GPAQ 9 and 10 respondents to GPAQ 10).

3. ***Diagnostic and therapeutic acceptance*** - effectiveness in the therapeutic relationship

Item: GPAQ11

Diagnostic and therapeutic acceptance

The respondent/options	Are you satisfied to go be consulted by this physician ? (GPAQ11)
Option 6	a. Very good
Number of answers	113
Option 5	b. Good
Number of answers	59
Option 4	c. Satisfactory
Number of answers	21
Option 3	d. Weak
Number of answers	1
Option 2	e. Very weak
Number of answer	0
Option 1	f. Fails
Number of answers	0
Number of valid responses	**194**
Average scoring	5,4639

Source: Developed by the author

Comparative analysis of GPAQ items 11 *<< Are you satified to go to this doctor's consultation? >>* and F20 *<< Above all, I am pleased with the relationship (collaboration) with my doctor >> reveals similar proportions of respondents on each option*. Thus, at option *<<a. Very good >>,* the proportion is 58,255%, while the proportion of respondents to item F20 with the similar option <<Totally agree>> is 55,33%. In the same way, the comparison on options, similarly, reveals: *GPAQ 11 << b.Good >>,* 30,41%, and F20 << Agree >>, 25,38%; GPAQ, << c. Satisfactory >>, 10.82%, and F20 << Incert >>, 17.77%.

Conclusion: *These findings are similar to the proportion of respondents on each option, a way of validating the answers obtained for each questionnaire regarding the therapeutic relationship in the case of the patients belonging to the studied group.*

QUALITATIVE ANALYSIS

We have configured the qualitative component of the study as 6 tests, structured on DCPR syndromes (Diagnostic Criteria for Psychosomatic Research) - the diagnostic criteria for psychosomatic disorders mentioned above. The motivation for the structure of the tests is the need to establish correlations between the therapeutic relationship and the acceptance of diagnosis and therapy, with particular reference to the coexistence of specific syndromes of patients with psychosomatic disease.

In summary, I will expose short test number 5

Short test 5 **- therapeutic acceptance in relation to the therapeutic alliance**

The test was based on **two key items:**

GPAQ 11 "Are you happy to go to a doctor's consultation?"

F18 "I intend to follow the advice given by my doctor".

Test 5 aims to formulate some interpretations and draw conclusions in support of the working hypothesis, based on the qualitative analysis of the data obtained from the respondents by completing the three types of questionnaires*, referring to the acceptance of the indications of therapy.* The analysis carried out has as a benchmark the satisfaction index of the patient, regarding the therapeutic relationship.

The filters were applied in order to obtain profiles of the respondents, representative for the formulation of the interpretations that confirm or negate the working hypothesis.

Analyzed Profile Options:

Item **GPAQ11** - options: on all profiles: 4 << WEAK >>

Item **F18 -** options: **demoralized-worried profile**: 4 << AGREE >>; 5 << TOTAL AGREEMENT >>

On **demoralized-disappointed** profile: 3 << UNCERTAIN >>

To **demoralized-desperate** profile: 2 <<DISAGREEMENT >>

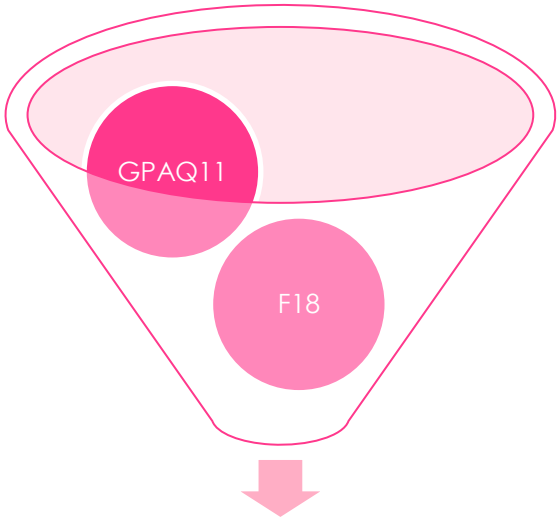
The choice of options was dictated by the level of statistical representativeness obtained from the processing of the data from the questionnaires.

Data centralization table with boundary difference

Questions according to the questionnaire	**Demoralized-worried profile – GPAQ 11 (4); F18 (4,5)**	**Demoralized - disappointed profile - GPAQ 11 (4); F18 (3)**	**Demoralized-desperate profile -GPAQ 11 (4); F18 (2)**
The respondent	**Average scoring ***	**Average scoring ***	**Average scoring ***
I better understand my illness after meeting with my physician (F1)	4,1667	3,25	5,00
The physician provides real / adequate / reasonable information about my illness (F3)	4,0833	3,14	3,00
The physician gives me the chance to say or ask whatever I want (F4)	3,9167	3,33	4,00
The physician is interested in me as an individual and not just by my illness (F6)	3,5833	3,29	2,00
Are you satisfied to go be consulted by this physician?(GPAQ11)	4,0000	4,00	4,00

Source: Developed by the author

Key items - Test 5 in short



Source:Developed by the author

ANALYSIS OF EFFECTS ON SYNDROME, CONSEQUENCE OF TEST 5 SHORT

Establish the Satisfaction Index on the Therapeutic Relationship

Item GPAQ 11 "Are you happy to go to a doctor's consultation?"

Interpretation: Scoring average values in the demoralized-embraced profile (4.00), demoralized-disappointed profile (4.00) and demoralized-desperate profile (4.00). Options: << SATISFACTORY>> on all profiles.

Table summarizing the data with difference between the GPAQ11 limits

Questions according to the questionnaire	**Demoralized-worried profile – GPAQ 11 (4); F18 (4,5)**	**Demoralized - disappointed profile - GPAQ 11 (4); F18 (3)**	**Demoralized-desperate profile - GPAQ 11 (4); F18 (2)**
The respondent	**Average scoring ***	**Average scoring ***	**Average scoring ***
Are you satisfied to go be consulted by this physician?(GPAQ11)	4,0000 <Satisfactory>	4,00 <Satisfactory>	4,00 <Satisfactory>

Source: Developed by the author

Conclusion: *The comparative analysis of options on the three profiles of respondents with psychosomatic affection reveals the same value of the average score and identical options, demonstrating that in these patients the satisfaction index regarding the therapeutic relationship is identical, very low.*

Therapeutic acceptance

F18 "I intend to follow the advice given by my doctor".

Interpretation: Analysis of F18 on the three profiles and the established categories in patients with psychosomatic disease reveals the following values of the average score: for the demoralized-worried profile (4,16), the demoralized-disappointed profile (3,00) and the Profile, demoralized-desperate, (2.00). The options on the three profiles are: << Agree >>, << Uncertain>>, <<Disagree>>.

Data centralization table with boundary difference - F18

Questions according to the questionnaire	**Demoralized-worried profile – GPAQ 11 (4); F18 (4,5)**	**Demoralized - disappointed profile - GPAQ 11 (4); F18 (3)**	**Demoralized-desperate profile - GPAQ 11 (4); F18 (2)**
The respondent	**Average scoring ***	**Average scoring ***	**Average scoring ***
I intend to follow the advice given by my physician (F18)	4,1667 <<Agree>>	3,00 <<Uncertain>>	2,00 <<Disagreement>>

Source: Developed by the author

Conclusion: *We found a decrease in compliance with the indications of therapy (and implicitly in accepting the diagnosis) in patients with psychosomatic impairment. The more severe the psychosomatic damage, the lower the compliance. We also noticed the existence of uncertainty, similar to other tests, which translates the indecision of the patient with psychosomatic disturbance.*

This conclusion overlaps the data mentioned in the specialty literature, characteristic of patients with psychosomatic disease.

Diagnostic Acceptance

Item F1 "I better understand the disease after meeting with my doctor."

Interpretation: The average scores on the three profiles analyzed are as follows: (4,16) to the demoralized profile - worried, (3,25) to the demoralized profile - fuzzy and the value (5,00) to the demoralized-desperate profile. Options << Agree >> options << Uncertain>>, << Totally agree >>. *We have also noticed that the demoralized-disappointed profile shows the << Uncertain >> option, present in all the items selected in the configuration of this test, to this profile.*

Data centralization table with boundary difference – F1

Questions according to the questionnaire	**Demoralized-worried profile – GPAQ 11 (4); F18 (4,5)**	**Demoralized - disappointed profile - GPAQ 11 (4); F18 (3)**	**Demoralized-desperate profile - GPAQ 11 (4); F18 (2)**
The Respondent	**Average scoring ***	**Average scoring ***	**Average scoring ***
I better understand my illness after meeting with my doctor (F1)	4,1667 <<Agree>>	3,25 <<Uncertain>>	5,00 <<Totally agree>>

Source:Developed by the author

Conclusion: In patients diagnosed with psychosomatic disorders, who have a satisfactory therapeutic relationship with the treating physician (item GPAQ11, option 4) and who accept the diagnosis (item F18, option 4 <<Agree>>), patients of the *demoralized-worried profile,* confirms that it accepts the disease by understanding its mechanism / significance. In the same patient category but in the *demoralized-disappointed profile*, the *<< Uncertain >>* option confirms that patients are not willing to accept medical explanations. These patients have other expectations as to the explanations for the affliction they suffer. However, it accepts the diagnosis and does not contribute to an alteration of the therapeutic relationship. In the *demoralized - desperate profile*, the higher scoring average than the other two profiles and the option of *<<Totally Agree>>* patients can be explained by the desperation of patients who need emotional support, and therefore accept that the claimed symptom is concretised even in a diagnosis of psychosomatic affection, which it accepts when the therapeutic relationship is optimal. The explanation may also be given by the need for an anchor in these patients, an anchor they find in the doctor.

The findings obtained from the analysis of this item are correlated with those obtained from the analysis of item F6 "*The physician is interested in me as an individual and not just my illness,"* where the options are similar, reporting the analysis to the same key item F18.

Corroborating the conclusions with the deductive iterative process, we have had the opportunity to conclude ***that acceptance of the diagnosis is determined by a good therapeutic relationship, explanations that the patient accepts, but also by the personalized, personalized approach in a biopsychosocial manner.***

Item F13 "Consider my doctor's advice (indications) appropriate to my medical condition."

Interpretation: Scoring average values on the three profiles studied: (3.91) in the demoralized profile - worried, (3.43) in the demoralized-disappointed profile, while in the demoralized-desperate profile, the scoring average is (4.00). Options: << UNCERTAIN>>, << UNCERTAIN >>, << AGREEMENT >>.

Data center with difference in boundaries – F13

Questions according to the questionnaire	**Demoralized-worried profile – GPAQ 11 (4); F18 (4,5)**	**Demoralized - disappointed profile - GPAQ 11 (4); F18 (3)**	**Demoralized-desperate profile - GPAQ 11 (4); F18 (2)**
The Respondent	**Average scoring ***	**Average scoring ***	**Average scoring ***
I consider my doctor's advice (indications) appropriate to my medical condition (F13)	3,9167 <<Uncertain>>	3,43 <<Uncertain>>	4,00 <<Agree>>

Sursa: Developed by the author

Conclusion: *Patients with psychosomatic damage belonging to the first two profiles are in the uncertainty area, while patients with severe psychosomatic disturbance accept the indications of therapy, one of the motivations being probably the same, the need for an "anchor" identified in the physician, which determines acceptance of diagnosis and indication of therapy.*

Scientific novelty and originality of research:

1. *As the first element of origin of the study, I mention the design of a mathematical model that provides predictions about the correlations between the three basic concepts addressed in the study, namely, the therapeutic relationship in relation to diagnostic and therapeutic acceptance. This is an increasingly common topic in medicine and presents a great practical utility. The use of an econometric model that brings together the three concepts is a novelty element in addressing somatisation / MUS / TSS patients in the Romanian medical literature. The structured econometric model establishes the dependence between the human capital materialized in the therapeutic relationship, and the efficiency of the medical act, completed by diagnostic and therapeutic acceptance.*
2. *A second element of originality results in the elaboration of a quick diagnostic guide for psychosomatic disorders, which is useful for the practitioners, who are frequently confronted with the presence in the consulting cabinet of patients belonging to the profile with psychosomatic disturbance. I also consider as an element of originality the theme chosen, namely the approach to the concept of establishing a causal relationship, which is statistically demonstrated and validated by a quantitative and qualitative mixed approach, between the therapeutic relationship and the acceptance of diagnosis and therapy in psychosomatic disorders.*
3. *A fourth element of originality of this study, belonging to the domain of psychosomatic, interdisciplinary discipline, is the approach of the chosen theme following the model of the principles of evidence-based medicine (there are two groups of patients participating in the study that were compared with each other and the variables psychological studies were representative of psychosomatic diseases, so that there are no bias errors due to individual factors). Another element of originality refers to the possibility of this study to achieve affective prognosis, providing a way to anticipate respondents' choices, using forecast charts that offer the possibility to anticipate certain decisions that impact on the health of individuals in the future.*
4. *Affective prognosis is an important component in the patient's study of decision-making capacity. The fact that it is applied in a study of psychosomatic disorders is an element of originality.*
5. *Incorrect forecasts can lead patients, or their health care provider, to unfavorable choices, in cases where treatment would involve a drastic change in lifestyle. The reconsideration of the living situation and adherence to a long-term psychotherapeutic treatment is a favorable choice for patients with psychosomatic disorders. This study provides evidence of the specificity of psychotherapy as an optimal method of treatment in patients with psychosomatic disorders, as demonstrated in the elaborated work algorithm. The use of two scales with quasi-essentials to validate the study internally is another element of its originality. Defining in particular for the medical field, use in the study and argumentation of the notion of uncertainty in patients with psychosomatic disease is another element of originality.*
6. *Theoretical importance and applicative value of research. The doctoral thesis elaborated has a theoretical-conceptual character, specific to fundamental research, but also a methodological and applicative one. Beyond the theoretical value, the results of the research embodied in this study can be used in day-to-day clinical practice, providing an easy tool to apply.*

CONCLUSIONS

The result of the research is the summary of the partial results on the two branches of the study (quantitative and qualitative).

We have structured the findings of the study with the criteria of the DCPR (Diagnostic Criteria for Psychosomatic Research) and the analysis of qualitative and quantitative components. In line with these, we have drawn the following conclusions:

1. *The established working hypothesis as the main objective is substantiated by the findings of this study that demonstrated that the therapeutic relationship influences the achievement of the ultimate goal of the medical act, diagnostic and therapeutic acceptance, in patients with psychosomatic disorders. The conclusions reached at the end of the study are in line with the main objective set at the beginning of the study, but also with the secondary objectives, namely the concrete identification of the barriers that stand in the way of diagnostic and therapeutic acceptance. Through the observation, isolation and definition of a particular inter-human phenomenon of a special type, such as the therapeutic relationship and its implications for the ultimate goal of the therapeutic act - its diagnosis and acceptance as well as therapy, we have demonstrated the need to apply the principles of patient-centered medicine and the approach bio-psycho-social context, integrating it into a wider context that touches all aspects of its life without detaching it from the family, professional or cultural picture, dimensions that are of major importance for psychosomatic disorders.*
2. *The study has demonstrated, by identifying psychological variables of physician and patient, that patient-centered medicine gives the latter the feeling of being treated as an entity without being assimilated to the other individuals, that it is offered unique solutions to problems which belong only to him. All these are solid reasons for the patient to gain confidence in his doctor and therefore to accept its explanations as well as the proposed solutions (diagnosis and therapy). The results of the study demonstrate that when the patient invests the doctor with authority, in relation to his professionalism and concretized by an optimal therapeutic relationship, he accepts the diagnosis and the therapeutic recommendations. The current study is in the category of those whose results can be used in clinical health services, addressing a specific phenomenon and how to apply it by demonstrating hypotheses and providing explanations.*
3. *Although **somatization syndrome** is manifested at a higher frequency in the group of psychosomatically affected patients, the results of the study on the qualitative branch reveal that the symptomatology diminishes or disappears when the patient directs attention to other activities or when the stress factor disappears (holidays, meetings with friends, concentration on an objective / task), while in the absence of psychosomatic impairment this does not happen (argument for differential diagnosis).*
4. ***Thanatophobia Syndrome**. The comparative analysis of the three items with regard to tanatophobia, on the three profiles studied, revealed the highest intensity of manifestation for the same item, whose significance is related to the very meaning of death, and not necessarily to the existence of a disorder.*
5. *The manifestation of thanatophobia syndrome is a feature found in all three studied profiles (generally, psychosomatically affected and without psychosomatic impairment) but the*

maximum frequency of manifestation was found in the profile of respondents with psychosomatic impairment.

6. ***The phenomenon of accepting the diagnosis*** *is based on an understanding of the mechanism of its production, as demonstrated by the results of the study, a correlation between the two branches. At the level of therapeutic relationship, it is demonstrated that when the physician is invested with authority and trust by patients with psychosomatic impairment, then they agree with the explanations provided by the physician. The analysis of* ***the time given by the doctor*** *brings to question a sensitive aspect of the medical act in general, namely, the insufficient time the doctor has at his disposal to establish an optimal therapeutic relationship with the patient. Polarization of the options demonstrating the desire to be given a longer time to the patient with psychosomatic affection demonstrates the importance of the time variable in this category of patients.*
7. *The present study argues in favor of using the principles of patient-centered medicine and the patient's bio-psycho-social approach, which is integrated into a broader context that addresses all aspects of his or her life without detaching it from the family, cultural dimensions, which are of major importance in the case of psychosomatic disorders. The importance of the solid aspect of the therapeutic relationship in the sense of therapeutic alliance in the studied population sample is revealed by the concordance, with a positive connotation between the doctor's and the patient's views.*
8. *The quantitative analysis we performed on the interviewed sample shows that over 25% of the respondents, namely 28.21%, did not understand the terminology used by the doctor confirming the importance of communication. 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 confirms this fact by the increased percentage of << 64,56% >> of patients, who consider the friendly attitude of doctor. An important aspect to be clarified in the context of the research theme was the analysis of the sample of respondents who chose the << Uncertain >> option.*
9. *The present study demonstrates that patients with psychosomatic disorders are often in the uncertainty of accepting explanations or making decisions, considering that the area of uncertainty always offers the possibility of a new diagnostic option (by asking for a new consultation), 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 like, considering it ineffective , risky or inappropriate for his medical problem).*
10. *The study demonstrates exactly the position of the doctor and the patient on the scale of attitude towards the disease. When the patient is satisfied with the explanations given by the doctor, the proportion of patients in the uncertainty area is low (5.16%), whereas if the patient considers that the doctor ignores certain accusations or empirical explanations he expresses, the level of uncertainty increases, as a quarter of respondents << 25,76% >> are in the uncertainty area.*
11. *The present study demonstrates that the patient's satisfaction index correlates positively with the patient's sense of comfort in the medical relationship, with the possibility of discussing sensitive issues that concern him / her with respect to the physician's privacy, patiently with the patient and especially with the support provided by the physician to overcome the anxiety-related concerns of the disease. We have found that, in terms of the*

perception of the diagnosis of psychosomatic condition, at the level of the qualitative ram, the patients belonging to the profile without psychosomatic affection (NA) manifest, at the theoretical level, the understanding of the significance of the disease (particularizing, psychosomatic affection). In patients with general profile (G) and those with the profile of psychosomatic disease (MA), we found the position of the answers in the option area << Uncertain>>. This finding is correlated with the results obtained on the quantitative branch, which is an argument in favor of the validity of the conclusions formulated. The observed aspect correlates directly and positively with the non-acceptance of the diagnosis of psychosomatic condition, confirmed by the clinical practice, which reports this phenomenon, in the literature.

12. *Psychological variability - demoralization - leads to the establishment of a fragile therapeutic alliance that is followed by poor adherence to medical indications: diagnosis and therapy. We have noticed that there is a direct proportionality between increasing the level of demoralization as a psychological reference and non-adherence to medical indications. With the increase in the degree of psychosomatic disturbance, the level of patient satisfaction decreases so that the profiles and categories with severe psychosomatic disturbance reach the same area of uncertainty. We have found a decrease in the level of satisfaction in relation to direct proportionality with the increase in the degree of psychosomatic disturbance (from the demoralized-worried to the demoralized-desperate profile).*
13. *Resolved scientific problem refers to an increasingly common issue of patient-centered medicine, namely, the importance of the therapeutic relationship in the medical act. Particularly, this study addresses this issue in patients with psychosomatic disorders, where diagnostic and therapeutic acceptance is the element of difficulty of medical practice.*

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CURIS Cecilia, Family Medicine Depression Management - A Cognitive-Behavioral Approach, National Family Medicine Conference The First Line in Medical Assistance, Brăila, October 2008 [presentation in ppt format]

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CURIS Cecilia, Conference "Galati Medical Days," Psychosomatic Disorders in Family Medicine "2012 [ppt presentation].
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CURIS Cecilia, Conference - World Health Day, Psychopathology and Psychotherapy of the Obese Patient and Nutrition Disorder - Nervous Anorexia and Bulimia, Galaţi 2015 [ppt presentation]
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CURIS Cecilia, "World Health Day" Conference, Masks of Depression - Diagnostic Traps in Primary Care, April 2017 [ppt presentation]
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