Chapter 4
The Psychological Model of Scaffolding for the Development of the Healthcare Relationship:
Addressing a Contemporary Challenge of Healthcare Systems

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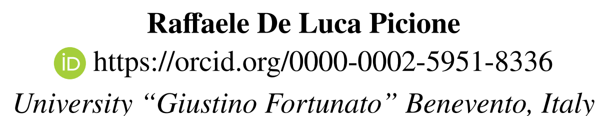
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ABSTRACT

Taking into account the current transformation of the healthcare systems in the Western societies, the authors argue that several challenges can be addressed only starting from a relational perspective. In the field of the health practices, psychological vision has been addressed for a long time on single individuals (generally the patients) in order to offer sustain and help to treat their suffering during a disease. In the authors' perspective, being a patient means to take up a positioning within a cultural-normative frame. In this sense, the psychological intervention requires to be directed toward the relational field. The proposal is aimed to present the constitutive elements and tenets of a clinical psychological model of intervention aimed to develop the healthcare relation: the scaffolding for the healthcare relationship. It is based on a clinical, semiotic, and dynamic perspectives of health psychology. By its implementation, the aims of ownership, cum-sensum, sharing decision making, and emotional elaboration are pursued.

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INTRODUCTION. THE TRANSFORMATIONS OF THE CURRENT SCENARIOS OF HEALTHCARE CONTEXTS

Currently, the scenarios of the processes of care and healthcare are undergoing multiple transformations. They involve various dimensions, from medical and scientific to social, cultural, economic and political ones. The breadth and variety of these transformations within westernized societies are such as to assume a systemic scope. Therefore, an approach based solely on understanding the conditions and disease experiences of individual patients is incomprehensible or inadequate for the complexity of contemporary scenarios.

In our perspective, we trace these systemic transformations to two macro-domains: on the one hand, the changes are generated within the same medicine; and on the other hand, they are about the strategic political lines in their effort to offer directives and forms of regulation of what is happening in health systems.

In the first macro-domain, we observe that medicine offers itself as a continuously evolving system supported by scientific research and the development of new diagnostic and treatment devices. The impact of its progress is shown widely and in various areas. There are many and shareable cues of these progresses. Take in account the reduction of mortality compared to diseases considered fatal until a few decades ago (just think, for example, of the life predictions of heart attacks or cancer patients). The same condition of chronicity, for which a person can be considered not curable tout-court, in many cases it can be seen as the effect of medical progress through the implementation of new care and assistance protocols.

Medical conditions that until a few years ago were considered an unfortunate sentence, can now be considered as health conditions within a chronic process. In addition, think also of the increased predictive capacity of contemporary medicine, through which it is able to increase the possibilities of diagnostic tools to predict the future onset of a disease. It is made possible by the new frontiers of medicine - for example genetics - and by the ability to produce diagnoses, often of a probabilistic nature, well in advance of the possible manifestations and onset of diseases. This capacity is made possible both through the precision and deepening of examinations and tests on the individual, and through the increasingly extensive knowledge coming from the extension of epidemiological studies and longitudinal studies on large sectors of the population.

In the other macro-domain, we observe the effort to identify strategic lines aimed at defining in terms of principles, priorities and regulation of social relations within the health system. Here, also, there are typically systemic dimensions that characterize the contemporary scenario. The increased demand for health services, the repeated processes of spending review on health expenditure, the decrease in professional resources despite the increase in demand, the search for forms of supply efficiency and the identification / reduction of waste, etc., all these can be read as phenomena that declare the inappropriateness of old management styles in the face of the changes that have taken place. In fact, health management models in terms of “total care of the patient” seem to show their pachydermal impracticability.

We observe the request for revision of the service delivery model based on the classic paternalistic model based on an asymmetrical arrangement between the physician who possesses strong power and the patient who in a dependent manner entrusts his health to him. Cultural and social adherence to this approach ensures that the doctor carries out his / her activity according to the objective and general knowledge available, without being disturbed by the patient’s idiosyncratic and subjective aspects. This asymmetry is also based on the action of relying on a person at a particularly critical moment in their life (the onset of a disease) towards those who are recognized as competent to deal with such circumstances.

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