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Contraception Among Tertiary Students: Knowledge, use and Behaviour of Female Undergraduates in Edo State, Nigeria

By Aigbiremolen AO, Duru CB, Abah SO, Abejegah C, Asalu OB & Oriaifo B
University Teaching Hospital, Nigeria

Abstract- Background: increased sexual activities among young people, unwanted pregnancies, unsafe abortions and secondary infertility have become major reproductive health concerns in nigeria. Unwanted pregnancy while preventable through appropriate contraception is a risk factor for disruption of education, future unemployment, and secondary infertility.

Aim: To assess contraceptive knowledge, use and related behavior among female undergraduates in tertiary institutions in edo state, nigeria.

Methods: The study was a descriptive cross-sectional survey using semi-structured self-administered questionnaire. Female undergraduates from two tertiary institutions (federal polytechnic, auchi and ambrose alli university, ekpoma) in edo north and central districts were selected using a multistage sampling technique and a sample of 374 students was drawn from both institutions.

Results: The age group of 20- 24 years constituted the highest proportion (61.5%) of respondents with the mean age being 23 ±4.2 years. majority (80.6%) of them were singles.

Keywords: contraception, sexual behavior, unwanted pregnancy, undergraduates.

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Contraception Among Tertiary Students: Knowledge, use and Behaviour of Female Undergraduates in Edo State, Nigeria

Aigbiremolen AO [α], Duru CB [σ], Abah SO [ρ], Abejegah C [ω], Asalu OB [¥] & Oriaifo B [§]

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Results: The age group of 20- 24 years constituted the highest proportion (61.5%) of respondents with the mean age being 23 ±4.2 years. majority (80.6%) of them were singles. Awareness of contraceptives was very high (94.4%) while the commonest method known was condoms (76.1%). Only 31.2 % of respondents had good knowledge of methods and benefits of using contraceptives. Current utilization rate of contraceptive was 39.3% while current sexual activity was 45.2%. association between level of knowledge and use of contraceptive was significant (df = 2; x^2 = 7.756; p= 0.021).

Conclusion: knowledge of contraception was poor while the regular use of contraceptives was lower than of sexual activity. We recommend a more systematic approach to promoting contraceptive use among sexually active undergraduate women through the use of multiple health promotion channels.

Keywords: contraception, sexual behavior, unwanted pregnancy, undergraduates.

I. Background

The environment in higher institutions of learning is characterized by high levels of personal freedom and social interaction. This social interaction often translates to sexual interaction (Alexander et al, 2007). Permissive sexual lifestyle in higher educational institution in Nigeria and a number of other African countries have been documented as featuring a high level of risky sexual behaviors such as transactional sex, multiple sexual partners, and unprotected casual sex. (Manena-Netshikweta, 2007; Katjaviri and Otaala 2003).

Such reproductive health behavior is prone to consequences of unwanted pregnancies, unsafe abortions, disruption of education and secondary infertility (Malhotra, 2008; Akingba, 2002; Adegoke, 2003). Given the increasing level of sexual activities among young people and decreasing age at first sex in developing countries, the use of contraceptives to prevent unwanted pregnancy and unsafe abortion is especially important (Adedoyin et al, 1995; Okonkwo et al, 2005; Uthman, 2008).

It has been reported by the Nigerian Population Commission (NPC) that knowledge of contraception is lowest among women with no education and greatest among women with more than secondary education (NPC and ICF Macro, 2009). This indicates that along the line, there is improvement in contraceptive knowledge though it may not always translate to the same level of utilization. This utilization gap has been highlighted in some studies among adolescents and out of school women (Idonigie et al, 2011; Abiodun et al, 2001). A high level of knowledge and concomitant utilization of contraception is desirable among adult women, a significant proportion of which is in tertiary institutions.

The current contraceptive prevalence rate in Nigeria is about 15% (NPC and ICF Macro, 2009). This low rate underlies the population explosion and other reproductive health challenges being currently experienced in the country. Women in tertiary educational institutions are included in the over 200 million women worldwide who have an unmet contraceptive need (McPhail et al, 2007). This study was to investigate the knowledge, use, and behaviour regarding contraceptives among female undergraduates in tertiary institutions in Edo State.

II. Methods

This cross-sectional survey was carried out among undergraduate females in Ambrose Alli University, Ekpoma and Federal Polytechnic, Auchi, both tertiary educational institutions in Edo State in

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2012/2013. The two institutions are located in urban communities in the central and northern districts of Edo State.

The sample size was determined using the Cochran formula (Cochran, 1963; Israel, 2012), $N= Z^2pq/E^2$ Where, N= Sample size; E=Tolerable Error of margin (0.05); p= prevalence (25.4%) of contraceptive use in a study done in tertiary institutions in Illorin, Nigeria (Abiodun and Balogun, 2009); Z= Standard Normal Deviation (1.96); Q= 1-p (1-0.58=0.42). The minimum sample size was thus calculated to be 288. However 400 questionnaires were administered to the study group to enhance the validity, while 356 questionnaires were analysed after setting aside poorly filled ones.

The sample was designed to accommodate all categories of female students in the tertiary institutions. The multistage sampling technique was used. Two institutions and two faculties each from the institutions was selected by simple random technique. Self-administered questionnaires were subsequently distributed to available students in the selected faculties. The questionnaires were semi-structured and dealt with such areas as the knowledge of the benefits and methods of contraception, and the utilization of contraceptives. Knowledge of contraception was assessed with a scoring system based on responses to mainly questions on the methods and benefits of contraceptives (Box 1).

Statistical package for scientific solutions (SPSS) version 16 was used for data collation, editing, and analysis. Other secondary analyses were done with the WINPEPI software (Abramson, 2011). Results are presented in tables. Test of significance using chi-square was applied to selected variables. Ethical guidiance was provided by the Department of Community Health, Ambrose Alli University, Ekpoma. Permission was obtained from the authorities of the two selected institutions while verbal consent was obtained from each study participant.

Box 1 : Assessment scoring for knowledge about contraception

Knowledge Indicator Question	Score	Remarks
Name methods of contraception you know	3	Maximum score for at least 3 correct methods
Are you aware of emergency contraception?	1	
State some benefits of using contraceptives	3	Maximum score for 3 correct benefits
Highest score	**7**	**Good = 5-7; Fair = 3-4; Poor = 0-2**

III. Results

Respondents in the age group 20 to 24 years constituted the largest group (61.5%) and the mean, median, and modal ages were 23 +/- 4.2 years, 22 years and 20 years respectively. The study group consisted mostly of singles (80.6%) and Christians (85.6%). About the same proportion of respondents participated from the two institutions (Table 1).

Table 1 : Sociodemographic characteristics of respondents

Variable	Frequency (n = 356)	Percentage
Age (years)		
15 -19	67	18.8
20-24	219	61.5
25-29	45	12.6
30-34	11	3.1
>34	10	2.8
Marital status		
Single	287	80.6
Married	57	16.0
Divorced	2	0.5
Cohabiting	10	2.8
Religion		
Catholic	104	29.2
Orthodox	14	3.9
Pentecostal	187	52.5
Muslim	33	9.3
Others	18	5.1
Level of study		
Junior students (1st and 2nd year)	141	39.6
Senior students (3rd year and above)	215	60.4
Institution		
Ambrose Alli University	182	51.1
Auchi Polytechnic	174	48.9
Mean age = 23 (+/- 4.2) years; median age = 22 years; modal age = 20 years		

Table 2 : Awareness and knowledge of contraception among female undergraduates

Variable	Frequency (n= 356)	%
Awareness about general contraception		
Yes	336	94.4
No	18	5.1
No response	2	0.6
Awareness about emergency contraception		
Yes	248	69.7

No	91	25.6
No response	17	4.8
Awareness about methods of contraception (Multiple responses)		
Condoms	271	76.1
Pills	200	56.2
Diaphragms	43	12.1
Injectables	93	26.1
IUCD	78	21.9
Implant	68	19.1
Rhythm	67	18.8
Withdrawal	69	19.4
Spermicidal	38	10.7
Tubal ligation	38	10.7
Level of knowledge		
Good	111	31.2
Fair	112	31.5
Poor	133	37.4
Sources of information (Multiple responses)		
Mass media	121	34.0
Health personnel	106	30.0
Friends/peers	102	28.7
Parents/relatives	62	17.4
School	24	6.7
Seminar/workshop	18	5.1
Internet and mobile phone messages	35	9.8
No response	22	6.2

A high level of awareness about contraceptives was found (94.4%) but the level was lower (69.7%) for emergency contraceptives (Table 2). The highest sources of information about contraceptives were mass media (34.0%); health personnel (30.0%) and friends (28.7%). Over 76% and about 56% of the study respondents identified use of condoms and oral contraceptive pills (OCPs) as methods of contraception. Spermicidal agents and tubal ligation (10.7% each) were the least popular as contraceptives. The school was one of the lowest contributors (6.7%) to information on contraception. Only 31.2% of the undergraduates had good knowledge of the methods and benefits of using contraceptives.

Table 3 : Use of contraceptives and sexual activity among female undergraduates

Variable	Frequency	%
Respondents who have ever used any form of contraceptives n=356		
Yes	202	56.7
No	123	34.6
No response	31	8.7
Methods of contraceptives ever used (Multiple responses) n= 202		
Condoms	116	57.4
Pills (OCPs)	58	28.7
Injectables	16	7.9
IUCD	6	3.0
Implant	5	2.5
Withdrawal	14	6.9
Rhythm	5	2.5
Others (spermicides, diaphragm)	5	2.5
Current use (any method in the last 6 months) of contraceptives n= 356		
Yes	140	39.3
No	180	50.6
No response	36	10.1
Use of emergency contraceptive n= 356		
Yes	38	10.7
No	190	53.4
No response	128	36.0
Types of emergency contraceptive used n= 38		

Laevonorgestrel	11	28.9
Others (Potash, salt and water, gin, Andrew's liver salt, Menstrogen, unnamed injections)	27	71.1
Frequency of use of contraceptives n= 202		
Always	81	40.1
Sometimes	67	33.2
Rarely	47	23.7
No response	7	3.5
Sexual activity in the last 6 months n= 356		
Yes	161	45.2
No	160	44.9
No response	35	9.8

Almost 57% of respondents had used some form of contraceptives compared to only 10.7% who had used emergency contraceptives. The most commonly used contraceptives were condoms (57.4%) and OCPs (28.7%). The least methods used were subcutaneous implants and rhythm method (2.5% each) while only 40.1% regularly used contraceptives. Thirty-nine percent of respondents had used some form of contraceptives in the six months prior to data collection while 45.2% had sex. Among those who have used emergency contraceptives, 28.9% used laevo-norgestrel.

Table 4 : Relationship between level of knowledge of contraceptive and level of study, sexual activity and contraceptive use

	Level of knowledge of contraceptives				Statistics
Level of study	Good (%)	Fair (%)	Poor (%)	Total (%)	
Junior	48 (33.8)	36 (25.4)	58 (40.8)	142 (100.0)	$X^2 = 3.409$, p=0.182
Senior	64 (51.6)	74 (34.6)	76 (35.5)	214 (100)	
Total	112 (31.5)	110 (30.9)	134 (37.6)	356 (100)	
Sex in the last six months					
No	48 (30.0)	43 (26.9)	69 (43.1)	160 (100)	$X^2 = 5.822$, p= 0.054
Yes	55 (34.2)	57 (35.4)	49 (30.4)	161 (100)	
Total	103 (32.1)	100 (31.2)	118 (36.8)	321 (100)	
Current use of contraceptives					
No	51 (28.5)	48 (26.8)	80 (44.7)	179 (100)	$X^2 = 7.756$, p =0.021
Yes	47 (33.3))	52 (36.9)	42 (29.8)	141 (100)	
Total	98 (30.6)	100 (31.3)	122 (38.1)	320 (100)	

The greater proportion of respondents who had good knowledge of contraception were senior students ($x^2 = 3.409$; $p = 0.182$) and those who were sexually active ($x^2 = 5.882$; $p = 0.054$) though there was no statistically significant association. There was a statistically significant association between knowledge and current use (within the preceding 6 months) of contraceptives ($x^2 = 7.756$; $p = 0.021$).

IV. Discussions

A high proportion of the respondents were unmarried youths. This is consistent with the global picture of mostly young persons being in higher institutions of learning (Statistics Canada, 2010; Cadmus and Owoaje, 2009). The greater proportion of young persons found in higher institutions provides both an opportunity and a challenge. It provides an opportunity to learn, grow and develop. This group is faced with the challenge of risky sexual behavior and consequent unwanted and unplanned pregnancies and sexually transmitted infections including HIV/AIDS (WHO, 1999). Notably, Bronfenbrenner's socioecological model (Oswalt, 2008) identifies the school as a component of the microsysytem- having direct influence on the behavior (sexual and otherwise) of the individual.

A high level of awareness (94.4%) of contraceptives is not surprising to find among females in tertiary institutions. Reports from other findings (Abiodun and Olayinka, 2009; Tilahun et al, 2010) corroborates this. However, awareness of emergency contraception (EC) was lower (69.7%) than that for general methods of contraception but much higher than that reported elsewhere (Puri et al, 2007; Frank et al, 2002). This lower awareness may be due to the more technical understanding required to grasp the principles of emergency contraception. In addition, there are no too many methods of EC known and used today. The common methods of EC are laevonorgestrel, high dose COCP and intra-uterine contraceptive device (IUCD) (Weismiller, 2004; WHO, 2012).

The sources of information were diverse ranging from mostly informal sources to a few formal sources.

Informal sources such as friends, peers and relatives are common information sources for young people (Tilahun et al, 2010;) but yet prone to misconceptions, distortions and half-truths. In this study, mass media, health personnel and friends contributed the most as sources of information on contraception.

Internet and mobile phone messages which are relatively new ways of spreading health information also contributed to the knowledge about contraceptives among respondents. These two modern channels have special appeal for young people and should thus, be thoroughly harnessed in disseminating correct information about reproductive health issues (Diaz et al, 2002; McNab, 2009). They have also taken the nature of mass media where no special authorization is required to spread sensitive and behavior-modifying information. Therefore, health professionals and institutions must contribute timely and adequate information through modern electronic media. In the absence of this, falsehood and half truths may become the order of the day because there is no vacuum in nature.

Condoms and oral contraceptive pills (OCPs) were popular among respondents, a finding consistent with other studies (Adegbenga et al, 2003; Chakrapani et al, 2011; Abiodun and Olayinka, 2009). Among the least known methods were those requiring invasive procedures such as Intrauterine Contraceptive Device (IUCD), subcutaneous implants and vasectomy. Similarly, condoms and OCPs were the most commonly used contraceptive methods while the invasive methods were the least used. Other studies report similar results (Omo-aghoja et al, 2009; McMahon et al, 2004).The distinction between invasive and non-invasive methods bothers on such factors as availability, ease of use and requirement of a health professional to use the method.

Being aware of a concept does not always suffice for knowledge. There was a marked difference in this study between a high level of awareness (94.4%) and a significantly low level of knowledge (31.2%) about the methods and benefits of using contraceptives. This is a significant departure from many other studies which tended to focus on awareness alone or translate awareness to knowledge (Tayo et al, 2011; Orji et al, 2005). The challenge of low level of knowledge has been identified as a major factor in the poor adolescent reproductive health status in Nigeria (Federal Ministry of Health, FMOH, Nigeria, 2002). Understanding the methods and benefits of contraception are critical to having motivated users. It has also been noted that motivation is one of the important factors in minimizing failure rates in the utilization of contraception (Egarter et al, 2012).

The low level of knowledge also agrees with the small proportion (40.1%) of those who regularly use contraception, differing from a study by Adegbenga and others (2003). It therefore follows that if they know the benefits and how to use contraceptives, they will not chose the risks of unwanted pregnancies, unsafe abortions, disruption of academics and career and possible death. Contraceptive education which is a component of sex education has been proven to improve risky sexual behaviour (Esere, 2008).

Current sexual activity among respondents was 45.2%, a figure comparable to Kabir et al's (2004) finding of 53.0% among tertiary students in Kano, northern Nigeria. This high level of sexual activity among the respondents is reflective of the social freedom and interaction among students in tertiary educational institutions.

This study did not find a significant association between level of knowledge of contraceptive and cadre of study. However, a higher proportion of respondents with good knowledge were senior students. Similarly, though there was no statistically significant association between level of knowledge and being sexually active, the greater proportion of those who had good knowledge were sexually active students. There was a significant association between level of knowledge and current use of contraceptives. Myer et al (2007) found a significant association between knowledge of emergency contraceptive and its use in South Africa. For those who care to read, contraceptives are usually packed with information leaflets that explain the basis for their use in lay terms. There is also the tendency of contraceptive users to pay more attention to discussions and health information on contraception.

V. Conclusion

Poor knowledge and low utilization of contraceptive and high level of sexual activity exist side by side in the tertiary institution. This reality if left unchecked will continue to fuel the negative consequences that follow risky sexual behavior. Health promotion strategies directed at improving contraceptive utilization among sexually active youths are strongly recommended as part of a comprehensive reproductive health intervention in institutions of higher learning in Nigeria.

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VII. Competing Interests

The authors hereby declare that no competing interests exist.

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Developing the First Validity of Shared Medical Decision-Making Questionnaire in Taiwan

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Abstract- Due to a lack of valid Taiwanese instruments measuring Shared Medical Decision-making (SMDM) in Taiwan. The purpose of the study is to investigate the reliability and validity of the Shared Medical Decision-making process. Total 350 patients were randomly recruited from a medical centre in Taiwan. As a theoretical basis steps of the SMDM process were defined in an expert panel. Item formulation was then conducted according to the Delphi method and a pool of 16 items was constructed. In addition, the Winstep software was used to examine whether the data fit Rasch test model. Items with outfit or infit MNSQs (mean square errors) not in the range between 0.77 and 1.30 are usually deemed as potential misfits. Successive Rasch analyses were performed until a final set of items was obtained. After eliminating 1 item the remaining 15 form a unidimensional scale with an acceptable reliability for person measures 0.77 and very good reliability for item difficulties 0.97. Analysis of subgroups revealed a different use of items in different conditions. Taiwanese Shared Medical Decision-making Questionnaire (SMDMQ) is a 15 items normative instrument. In addition, a theory-driven instrument to measure the process of SMDM has been developed and validated by use of a rigorous method revealing first promising results. Yet the ceiling effects require the addition of more discriminating items, and the different use of items in different conditions demands an in depth analysis.

Keywords: shared medical decision-making, rasch test model, reliability, validity.

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I. Introduction

Evidence based patient choice seems based on a strong liberal individualist interpretation of patient autonomy. As the medical information widespread, many patients expressed their opinion and expect to participate in medical decision-making. According to the literatures review [1, 2, 3, 4], the first definition of this concept can be found in a report on making health care decisions by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Published in 1982 it describes SMDM as a process which is based on mutual respect and partnership [5]. According to Charles et al., SMDM implies that at least two individuals are involved in the process of making a treatment decision [6]. In the commission on the page 38 that clearly declares: "the physician or other health professional invites the patient to participate in a dialogue in which the professional seeks to help the patient understand the medical situation and available courses of action, and the patient conveys his or her concerns and wishes". Also on page 44 describe in more detail "Sheared medical decision-making do not attempt to reach the satisfaction of patient, but to improve participate in this process, patients must engage in a dialogue with the practitioner and make their views on well-being clear". In the provision of preventive medical services, AHRQ more actively set up a "prevention into the medical services group" (Put Prevention Into Practice, PPIP) and the U.S. public and private medical institutions, and require health care providers to provide clinical services such as health screening, vaccination, medical consultation and other services specific practice, this is a government-related agencies to promote patient-centered "shared medical decision-making model".

Furthermore, the U.S. government [7] is sworn by the Federal Court for the "patient informed consent", "patient autonomy" and to emphasize the patient "right to know". In other words, the patient's point of view there are two requirements must be met: The first, "know and understand" the needs (i.e. know where the problem lies and causes pain).The second is the "feel that they are aware and understand" the needs (i.e. if that physicians accept him, and treat him very seriously). In order to satisfied the needs of physicians and patients need that information gathering and exchange between physicians and patients. The resulting instruments of this search measure different aspects of SMDM such as patients' preferences for information and participation, decisional conflict, doctor facilitation of participation and patients' information seeking behavior as well as risk communication and confidence in decision-making, and satisfaction with decision-making.

In the present study, this trend reflects the more researchers participate in this topic. The related clinical practice studies were: Cassileth et al. [8] survey of 256 of a university hospital cancer patients and found that the proportion of patients to participate in decision (Overall: 62.5%, Aged 20-39: 87%, Aged 40-59: 62%, Aged 60 or more: 51%). Strull et al. [9] investigated three different clinics in 210 hypertensive patients in the decision-making role to play: doctors accounted for 78% of key decision makers, decision-making to share 19% of patients, the main decision-makers 3%. Pendleton and House [10] survey of 47 slum outpatients with

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diabetes, including shared decision-making points about the distribution: the average score of 3.9 (range 0-16; the higher score present the better representative of information and the higher the participation). Deber et al. [11] investigated 300 patients received angiography, the results-oriented problem solving response is the average score of 1.8, the average score in decision-making oriented was 3.1 (entirely up by the patient got 1 point, entirely up by the physician got 5 points).Mazur and Hickam [12] University Hospital sampling 467 general outpatients and to investigate the "Who do you like to make a decision?", Was found willing to share decision-making accounted for 68.1%, 21.4% the proportion of doctors, patients share ratio of 10.5%. Charles et al. [6] the literature review for the past authoritarian model, joint decision-making model, patients with different patterns, and further development of medical decision-making model.

The aim of this paper is to assess the validity of these concerns. There have been no previous studies about the SMDM from patients' perspective conducted in Taiwan. Therefore, there is need for psychometrically sound, valid and reliable instruments.

II. Methodology

In order to ensure that the scale has good reliability and validity, we based on Churchill [13] on the steps of the scale development. The relative steps were: Definite that patient participation in shared medical decision-making;

i. Specify and establish the dimensions of patient participation in shared medical decision-making;
ii. Generate a sample of items and assess validity;
iii. Pre-testing and analyze the result ;
iv. Correct the pre-testing scale and establish the official scale;
v. Testing and analyze the result;
vi. Use the Rasch analysis to examine the scale;
vii. Use the Rasch analysis to establish the formal scale;
viii. Assess validity and reliability.

This study based on the four components, there were: i. Patient Autonomy: the rights of individuals to act and make decisions without external constraints; ii. Control preference: the degree of control an individual wants to assume when decisions are being made about medical treatment; iii. Patients' perceived involvement: patients' involvement scale to measure the degree to which individuals perceive that their physicians encourage their involvement in their own healthcare; iv. Risk information communication: open two-way exchange of information and opinion about risk. In order to verify the proposed scale system, we invited 12 experts to examine the content validity and relevance. Further, we integrated all of the opinions and amended repeatedly. Also, we made each item easy to understand to avoid misunderstanding when answering the items. Further, this study will use the Rasch model to analyse the performance of proposed questionnaire by expert panel. Waugh and Chapman [10] has argued that the calculation of scores using the Rasch test model makes it possible to increase the homogeneity of the scales across years and over occasions so that scoring bias can be minimized.

The data were collected between November 2012 and November 2013. All patients were referred to us by their physicians from a medical centre in Taiwan. The physicians explained the study purpose to their patients before referring them to the interviewers. This study was approved by the IRB boards at Chung Shan Medical University Hospital. A trained research nurse interviewed patients in person after their routine consultation. The Winsteps software [15] was used to investigate dimensionality and differential item functioning (DIF) [16]. In general, there are two kinds of item fit statistics, unweighted outfit and weighted infit mean square errors (MNSQs), to examine whether items met the Rasch model's unidimensional requirement. The outfit MNSQs directly squares and averages standardized residuals, while the infit MNSQs averages standardized residuals with weights [17]. The MNSQs statistics are Chi-square statistics divided by their degrees of freedom. The outfit and infit MNSQs statistics have an expected value of unity when the data meet the model's unidimensional expectation [18]. Two major assumptions must hold to yield interval measures: i. for the assumption of unidimensionality, all items must measure patient's positive changes; a value of MNSQs greater than 1.30 indicates too much noise; ii. for the assumption of conditional (local) independence, item responses must be mutually independent, conditional on the respondent's latent ability. A value of MNSQs less than 0.77 suggests too much redundancy. For rating scales, a MNSQs range of 0.77-1.30 is often recommended as the critical range for the MNSQs statistics [19]. Items with an outfit or infit MNSQs beyond this range are regarded as poor fitting. It has been argued that the Rasch test model is superior to factor analysis in terms of confirming a factor structure [14]. When poor-fitting items are identified and removed from the test, unidimensionality is guaranteed and it can be measured at an interval scale [17]. Evidence of the restriction of range effect can be obtained from the Rasch test model by examining the item estimates. Apart from the examination of item fit statistics, the Rasch test model also permits the investigation of person statistics for fit to the Rasch test model. The item response pattern of those persons who exhibit large outfit mean square values should be carefully examined. If erratic behavior were detected, those persons should be excluded from the analyses for the calibration of the items on the Rasch test model [20]. Finally, calculated according to the measurement data subject and the far right near the appropriate degree level will not be within

the range of values and to delete the item separation reliability in the detection of internal consistency.

III. Results

A convenience sample of 350 patients recruited from Chung Shan medical university hospital in Taiwan. The average age of the subjects is 34.68 years old. There are 180 male (51.43%). Among them, 52.8% of the patients were married and 71.43% had passed higher education. A total of 350 valid samples out of the medical fields of General practice (N = 62), Surgery (N = 42), Psychosomatic (N = 36), Family Medicine (N = 44), Ophthalmology (N = 39), Urology (N = 43), Gynecology (N = 41), ENT (Ears, Nose, and Throat) (N = 43) (see Table 1). After completion the questionnaire of 16 questions from the deletion of the original 25 questions by experts. All 16 items were examined by infit and outfit statistics. We investigated whether the 15 items met the requirements of a single construct at a range of infit and outfit MNSQs within a range of 0.77-1.30 [21]. With an outfit of 1.54 item1 was regarded as not fitting the model and eliminated. The remaining items 2-16 all displayed acceptable to good item fit measures (0.82-1.19). The remaining items were then subjected to further analysis according to the criteria of item fit. Table 2 shows the 16 items in the scale after Rasch analysis and their response fields as well as item fit measures, difficulties and the corresponding theoretical steps.

Table 1 : sample characteristics (n=350)

Variables		Number	Percentage (%)
Age	<20	35	10.00
	21-35	76	21.71
	36-50	98	28.00
	51-65	100	28.57
	>65	41	11.72
Gender			
	Male	180	51.43
	Female	170	48.57
Medical fields			
	General practice	62	17.71
	Surgery	42	12.00
	Psychosomatic	36	10.29
	Family Medicine	44	12.57
	Ophthalmology	39	11.14
	Urology	43	12.29
	Gynecology	41	11.71
	ENT(Ears, Nose & Throat)	43	12.29

Table 2 : Item selection and their fit statistics

No	Item	INFIT		OUTFIT	
		MNSQ	ZSTD	MNSQ	ZSTD
1	I will express my preference about treatment option to my doctor	1.21	2.6	1.54	4.10
2	I will inform my doctor of my family health record	1.12	1.40	1.11	1.30
3	I was able to discuss the different treatment options with my doctor in detail	1.10	1.00	1.19	1.80
4	I know I have a right to appoint agent about my treatment decision	0.88	-1.60	0.86	-1.80
5	I will ask the second opinion to conform with my expectation about treatment option	1.03	0.40	0.98	-0.20
6	I now know which treatment option is the best one for me	1.04	0.60	1.04	0.50
7	My doctor and I weighed up the different treatment options thoroughly and selected a treatment option together	1.14	1.70	1.12	1.40
8	Through the consultation with the doctor, I felt jointly responsible for my further treatment	0.95	-0.50	0.95	-0.50
9	My doctor encourage my question about the tests or treatment	0.86	-1.80	0.86	-1.80
10	During the consultation, I felt included in the treatment decision	0.97	-0.30	1.14	1.80
11	When I had important questions to ask my doctor, I can get answers that I could understand	1.06	0.70	1.06	0.80
12	My doctor is willing to explain the treatment or procedure to me in greater detail	1.14	1.50	1.14	1.60
13	My doctor has explain the purpose of any laboratory tests	1.00	0.00	0.99	0.00
14	My doctor has tell me any risk about treatment in detail	0.94	-0.70	0.97	-0.30
15	My doctor and I discussed the prognostic plan with me together	0.95	-0.50	0.90	-1.10
16	My doctor and I reached an agreement as to how we will proceed	0.90	-1.10	0.82	-2.00

In addition to examining the overall fit of each item, it is also interesting to investigate whether the individual items in this instrument function in the same way for different groups of patients. Winstep software,

which is used in this study, has the capability to undertake the differential item functioning (DIF) analysis. In DIF analysis, the presence of item bias is checked and the significance of differences observed between different groups of patients is examined (e.g. medical fields in this study). All items ought to be DIF-free or at least DIF-trivial in order to obtain comparable measures. An investigation of varying subject's difficulties in subsamples revealed the largest differences between conditions. In order to compare different groups of respondents, the test construct must remain invariant across groups. DIF analysis is a way of verifying construct equivalence over groups. If construct equivalence does not hold over all of the groups, meaning that different groups respond to individual items differently after holding their latent trait levels constant, then the estimated measures cannot be compared directly among the groups. The medical fields were tested for DIF in this study, including General practice, Surgery, Psychosomatic, Family Medicine, Ophthalmology, Urology, Gynecology and ENT (Ears, Nose, and Throat). A difference larger than 0.5 logits (equal to an odds ratio of 1.65) in the difficulty estimates between any groups was treated as a substantial DIF [22, 23, 24, 25, 26, 27]. Once found, DIF items were removed from further analysis.

With reference to Figure 1, it shows item difficulties for each condition and the average difficulty for the whole sample for each of 16 items of the scale. Especially items 3, 6, 9 and 15 disperse highly with a maximum range of 1.36 logits. The largest deviations from mean item difficulties can be seen in the family medicine sample. As a result of poor person fit measures and differential item functioning for indications the sub-sample family medicine was excluded from further analysis.

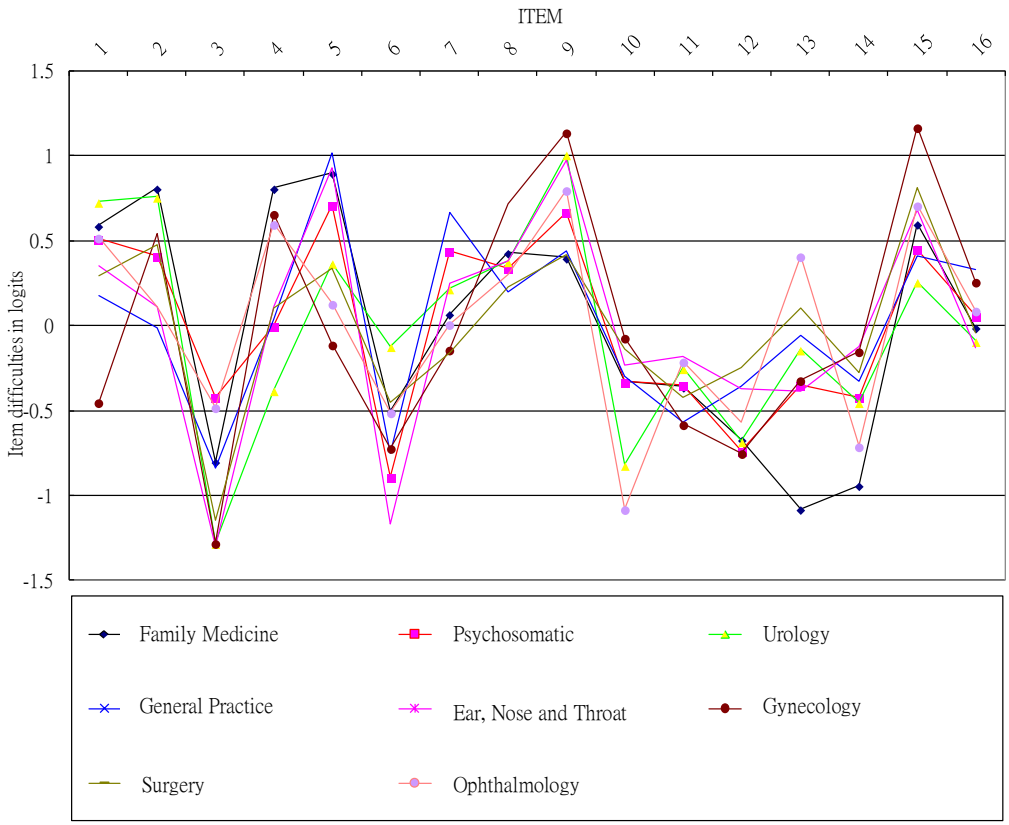

Fig. 1 : Differential item functioning for conditions

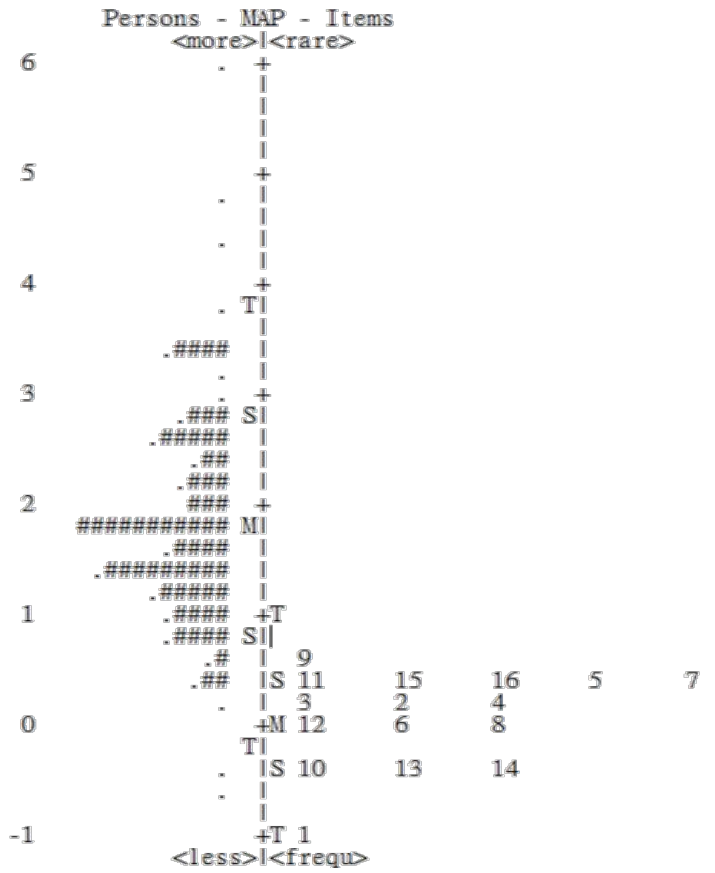

Fig. 2 : Map of persons (left) and items (right) for domains, each rhomb (#) represents 5 persons. (M = mean, S = standard deviation, T = 2 standard deviations)

Further, scale analysis was thus investigated on a reduced sample (N = 306). All 15 items were examined by infit and outfit statistics. Item selection due to analysis of category thresholds and item in fit measure was conducted again and led to the same results as described follow for the original sample. As shown in figure 2, the mean and standard deviation of patient measures were 1.87 and 2.24 logits. The distribution of patient parameters indicated extremely positive values showing a high ceiling effect. The comparison of patient and item parameters did not result in a good fit. While item difficulties (normal mean = 0, S.D. = 1) could be found in a very limited area between -1.00 and 0.80 logits on the latent dimension. The content validity of the instrument was based on formulating the items from the existing literature, using the results of a series of studies designed to understand how patient involves SMDM can best be achieved in professional practice, followed by subsequent development using an iterative design and assessment cycle. Besides, a moderate reliability score of 0.77 for the person parameter was found which can be compared to the measure of internal consistency in classical test theory. Besides the analysis of item reliability 0.97 brought very good results showing that item difficulties can be reproduced precisely.

IV. Discussion

The present study aimed to assess the reliability and validity of the Taiwan Shared Medical Decision making questionnaire and, in doing so, to increase confidence in results from future studies in Taiwan using this instrument. This study was application of modern test theory Rasch test model to construct a common medical decision-making in Taiwan Scale reliability and validity of the study.

In general, classical item analysis was able to provide some information about instrument coherence, but appears not to be sensitive to items that fail to conform to the demands of measurement. Wright [22] has been criticized for not being able to deal with missing data nor for situations in which different groups of respondents have different item subsets. Further, measurement involves the processes of description and quantification. Questionnaires and test instruments are designed and developed to measure conceived variables and constructs accurately. Validity and reliability are two important characteristics of measure-ement instruments. Validity consists of a complex set of criteria used to judge the extent to which inferences, based on scores derived from the application of an instrument, are warranted [23]. Reliability captures the

consistency of scores obtained from applications of the instrument. Traditional or classical procedures for measurement were based on a variety of scaling methods. Most commonly, a total score is obtained by adding the scores for individual items, although more complex procedures in which items are differentially weighted are used occasionally. In classical analyses, criteria for the final selection of items are based on internal consistency checks. At the core of these classical approaches is an idea derived from measure-ement in the physical sciences: that an observed score is the sum of a true score and a measurement error term. That is, there are limitations to using traditional analytical procedures to analyze rating scales which are overcome when Rasch scaling is used to measure item difficulty and abilities estimates of participants engaged in a learning process. Instrument coherence can also be assessed in Rasch analysis by examining items for unidimensionality as indicated by their fit statistics and by looking for differential item functioning.

By using the Rasch measurement model, the measurement properties of the SDM instrument have been investigated; it has been shown that an instrument can be refined by the removal of misfitting items, and item independent estimates of patient locations have been made. In this study, after completion the questionnaire of 16 questions from the deletion of the original 25 questions by experts. Analyses were conducted using survey data from 350 valid samples. We conducted Rasch model analysis of projects suitable, would be inconsistent with the right degree program within the scope of the project 1 "I will express my preference about treatment option to my doctor "to delete. This study is the common medical decision-making Rasch item separation results of the reliability coefficient of 0.77 (equivalent to Cronbach's α) meaning that it represents research-based full scale after the completion of construction, and its level of internal consistency fairly standard, with good reliability. Construction of the final 15 items asked the common medical decision-making scale.

In conclusion, the Taiwan Shared Medical Decision-making Questionnaire (SMDMQ) has demon-strated good reliability and validity. The results also provide some evidence supporting the acceptability of the SMDMQ in these patients. As a result, in order to provide better medical service, we recommend that both physician and patient have better to participate in SDM and toward to understand patients' wishes. Apart from physician should encourage patient to raise any doubts and idea of the disease, and also should inform the risk of all the treatments in detail. Patients in this study are not yet fully subject to universal, high sampling difficult, so only for "Chung Shan Medical University Hospital outpatient division" the patient sample. The studies that follow can use validation for the scale, for different ethnic groups, clinics, hospitals, research, re-examine the scale reliability and validity, so the scale to more general principles.

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Practice of Contraception and Quality of life among Bhutanese Refugee Women of Eastern Nepal

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Abstract- Background: Very less study are done about Bhutanese refugees in Nepal. The purpose of the present study was to examine the knowledge and practice of contraception among married women of reproductive age group and their quality of life from user's perspectives.

Materials and Methods: A Cross-sectional study was done among 350 married women of reproductive age group of Bhutanese Refugee camp using systematic random sampling using structured questionnaires on family planning and self-rated questionnaires on quality of life by WHO (WHOQOL BREF).

Results: A total of 350 married women of reproductive aged women participated in the study. Despite vigorous dissem-ination of health services by the health center in the community, 13.1% of the participants weren't aware about the free availability of family planning methods in the health centre. Sixty two percent women were found to be current users and Depo-Provera (52.3%) was the commonly used contraceptive methods.

Keywords: MWRA (married women of reproductive age), refugee, combined oral contraceptive pills, IUCD (Intrauterine contraceptive devices).

GJMR-K Classification : NLMC Code: W 32.5

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Practice of Contraception and Quality of life among Bhutanese Refugee Women of Eastern Nepal

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Conclusion: Owing to the patriarchal society of Bhutanese refugee of Nepalese origin, male participation for use of family planning was found less. The females were found to be using family planning methods, though the decision resided on the male counterpart.

Keywords: MWRA (married women of reproductive age), refugee, combined oral contraceptive pills, IUCD (Intrauterine contraceptive devices).

I. Introduction

Use of family planning methods have prevented many unintended pregnancies and improved the quality of life by improving the overall maternal health and decreasing the burden of uncontrolled fertility. However, the use of contraception isn't consistent throughout the world; it ranged from as high as 80% in developed countries and as low as 12% in Sub-Saharan Africa.[1] Most of the consumers and target client of family planning programme are women from provider perspectives. Men involvement in family planning use for planning a family is very less. Belief, culture and social structure affect the use of contraception. Study from Kuwait found that husband's opinion and views towards adoption of family planning methods had a large impact on contraceptive behavior.[2] The current prevalence of contraceptive use is approaching to 60% worldwide, 53% in less developed countries and 43% in Nepal.[1, 3, 4] The health center launches programme to increase knowledge of contraception through information, education and communication programmes by community health workers in the refugee community. Measuring the level of awareness of contraception provides a useful measure of the success of information, education and communication activities and helps to identify the areas of need to be strengthened.[5] The contraceptive methods not available in the health centers like sterilization, IUCD (Intrauterine contraceptive devices) are made available to the consumers by sending them to the referral centers nearby as per the understanding with UNHCR.

Bhutanese refugees are staying in eastern part of Nepal after they fled from their country almost two decades back. They live in camps and use the resources provided to them by various programme implementing agencies of United Nation High Commission for Refugees from providers perspectives.

The combined oral contraceptive (COC) pills, injectable and intrauterine contraceptive devices (IUCD) are the most common contraceptive methods used by women. Women's choice, compliance and satisfaction with specific contraceptive methods are influenced by impact of the method on their quality of life and sexual function.[19]

This study was carried out to assess the knowledge, practices and their quality of life from user's perspectives. To our knowledge this study is the first of its kind done among Bhutanese refugees regarding their contraceptive practices and its impact on their quality of life.

II. Materials & Methods

This was a cross-sectional study conducted among the Bhutanese refugee camps of Jhapa district

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of Eastern Nepal from July 2011to July 2012. Collected data were entered into MS Windows Excel in the form of codes. Analysis was performed using Statistical Package for Social Sciences (SPSS) 17.0 version. Ethical clearance was obtained from the ethical committee of B. P. Koirala Institute of Health Sciences prior to the study. Informed consent was taken from all the participants and confidentiality was maintained to the information collected.

This study investigated the contraceptive awareness, practices and its impact on their quality of life among the married women of reproductive age group (15 – 49 years) in Bhutanese refugee population residing in the eastern part of Nepal. Sample size calculation indicated that a study of 350 subjects was adequate to achieve a high degree of precision (95%) based on a study done in Karimnagar, India by Kameswararao Avasarala which showed that contraception users had better quality of life.[6] The study sample was recruited among full time residents of refugee camp by using systematic random sampling. Variables like participants with family members in third country settlement, living outside the camp, not consuming the resources of the camp were excluded which could directly affect the quality of life other than using family planning methods. Data were collected by face to face interview using pretested structured questionnaire on family planning and WHOQOL BREF. It consisted 42 items that included questionnaires on family planning knowledge, their practices and quality of life as well as socio-demographic characteristics. Informed understood written consent was obtained prior to data collection from all the participants and AMDA (Association of Medical Doctors in Asia) Primary Healthcare Project for Bhutanese Refugees which catered health services to the refugees. Care was taken to keep the questionnaire response anonymous and confidential. Only married women of reproductive age group were considered for the study as use of family planning methods as sex life related WHOQOL questionnaire were not appropriate for refugee society where premarital sex is prohibited and considered to be a sin.

The definition of contraceptive users was use of any method of contraception by the respondents or the partner with the aim of controlling the birth. The 'current user' was the use of contraception continuously for the last twelve months and the non-user was non adoption of contraception for the last twelve months.

Data was entered in Excel software and analyzed using the Statistical Package for Social Sciences (SPSS Inc. 17.0 Version). The WHOQOL domain scores were calculated using the WHOQOL BREF syntax and Student t test was applied wherever appropriate. For all the analysis, a P - value less than 0.05 was considered to be significant.

III. Results

A total of 350 married women of reproductive age group were included in the study and table 1 shows the selected socio-demographic characteristics of the respondents.

Table 1 : Sociodemographic Characteristics of the respondents (n = 350)

Variables	Frequency	Percentage
Age group (Years)		
15 – 19	26	7.4
20 – 24	83	23.7
25 – 29	91	26.0
30 – 34	58	16.6
35 – 39	62	17.7
40 – 44	12	3.4
45 - 49	18	5.1
Education		
Illiterate	122	34.9
Literate / Primary	158	45.1
High School	70	20.0
Occupation		
Unskilled	298	85.1
Semiskilled/ Skilled	52	14.9
Religion		
Hindu	257	73.4
Buddhist	75	21.4
Christian	18	5.1
Poverty Line		
Below Poverty Line	342	97.7
Above Poverty Line	8	2.3

Among the participants, majority (87%) were aware about the free provision of family planning methods in the health center but still 13% of them didn't know about this. Depo-Provera, oral pills and male condoms were known to all. Study revealed 62.3% current users of contraception. (Table 2)

Table 2 : Awareness and Practices regarding various contraceptive methods among the respondents (n = 350)

Variables	Frequency	Percentage
Awareness about free contraception		
Yes	304	86.9
No	46	13.1
Awareness about types of contraception *		
Depo-Provera	350	100.0

Oral Contraceptive Pills	350	100.0
Male Condom	350	100.0
Female Condom	266	76.0
Norplant	180	51.4
IUCD	171	48.9
Male Sterilization	151	43.1
Female Sterilization	53	15.1
Abstinence	48	13.7
Current use of Contraception		
Yes	218	62.3
No	132	37.7

** Multiple Responses*

Depo-Provera was the most popular method among the refugee women (57.3%) followed by oral pills (23.3%) and male condom (11.0%) respectively and two of the respondents practiced abstinence as contraception. (Table 3)

Table 3 : Types of contraception used by current users (n = 218)

Variables	Frequency	Percentage
Types of contraception used		
Depo-Provera	125	57.3
Oral Contraceptive Pills	51	23.3
Male Condom	24	11.0
Female Condom	12	5.5
Norplant	4	1.8
Abstinence	2	0.9

Among the non-users, husband's disapproval was found to be the main reason followed by lack of knowledge (37.1%). Substantial proportion had reason of religious belief (22.8%) for not using contraception. (Table 4)

Table 4 : Reasons behind not choosing family planning methods (n=132)

Variables	Frequency	Percentage
Reasons behind not opting for contraception		
Husband's Disapproval	53	40.1
Lack of Knowledge	49	37.1
Religious Beliefs	16	22.8

Scores from WHOQOL questionnaires were obtained in five domains: the overall, physical, psychological, social and environmental domains. It was observed that all the domain scores of quality of life except environmental domain score were significantly higher among contraceptive users than the non-users. Similarly, significant scores in all the domains of quality of life were found among the respondents with knowledge of free availability of contraception in the health center. (Table 5)

Table 5 : Association between WHOQOL and contraception users and non - users (n = 350)

Domains	Yes	No	P value
	Mean (SD)	Mean (SD)	
Current Contraception Users			
WHOQOL domains			
Overall Domain	65.3 (12.3)	62.2 (8.5)	0.01
Physical Domain	9.7 (1.8)	8.6 (1.3)	< 0.001
Psychological Domain	10.3 (2.5)	10.0 (1.9)	0.19
Social Domain	10.8 (2.8)	9.7 (2.1)	< 0.001
Environmental Domain	9.8 (1.9)	9.9 (1.4)	0.825
Knowledge of Free availability of Contraception			
WHOQOL domains			
Overall Domain	62.4 (10.4)	66.0 (11.5)	0.003
Physical Domain	9.4 (1.7)	8.6 (1.7)	0.002
Psychological Domain	10.4 (2.3)	9.1 (1.6)	< 0.001
Social Domain	10.6 (2.6)	9.3 (2.1)	0.002
Environmental Domain	10.0 (1.7)	9.0 (1.4)	0.001

IV. Discussion

This study provided information about the knowledge, practice and quality of life of contraception adopters among the married women of reproductive age group in Bhutanese refugee population. Quality of life has been defined as an individual's perceptions of their position in life in the context of the culture and value systems in which they live in and in relation to their goals, expectation, standards and concerns (WHO).[18]

The mean age of our study was found to be 29.3 years which is also comparable to Nepal Demographic and Health Survey 2011.10Similarly, there was a predominance of Hindu by religion among the participants which was comparable to Nepalese society.[10] This shows that Bhutanese refugee population who are of Nepali origin had maintained their cultural and religious integrity despite of emigration long before. Almost thirty five percent of the respondents were illiterate which was lower than the literacy rate of eastern hills of Nepal.[10] This could possibly be due to lack of utilization of free education during the refugee status acquisition. Refugee populations were required to live in camp full time and utilize the resources provided by various programme implementing agencies. Work outside the camp is prohibited. Therefore around 85.1% of them were found to have unskilled occupation with predominance of housewives. This was further reflected by poverty status where 97.7% of them were below poverty line (Table 1).

Among them, all were aware about Depo-Provera, oral contraceptive pills and male condom which was similar to a study done in UAE by Ghazal – Aswad et al and NDHS report 2001, 2006 and 2012.[10, 11, 12] This could possibly be due to vigorous health information, education and communication programmes conducted within the camp by the health center. Though, all the services were provided free of cost for the refugees, it was surprising that, 13.1% of the participants were not aware about the contraception available free of cost in the health center. This was one of the noticeable feedbacks from user perspective. This clearly showed community health programmes haven't penetrated every segments of the refugee population. This would have never known to us from a study done from provider perspectives.

More than half were using Depo-Provera (57.3%) followed by oral contraceptive pills (23.3%) and male condom (11.0%). The reason behind Depo-Provera being a popular method could possibly be due to the fact that one shot of it worked for three months; privacy was ensured about the use, easily available and can be used even without the consent of husband or family members. This finding was also constitent in a study done by Bhattarai D where Depo-Provera was the most used contraception.[13] The type of contraception use showed that females were mostly the ones who used contraception to plan a family rather than the husband. Refugee population having a patriarchal society influenced by male child syndrome required females to use family planning methods as per the advice of their husbands and take the responsibility for the family; though the decision making right resided among the husbands. This predominance of husband's influence over their wives uptake of family planning method was also noted in studies by Family Health International and Poudel IS.[14, 15] Vasectomy wasn't reported in our study and this is relatively less among the families in south Asian region.[14] It clearly showed less male participation regarding the use of contraception which is common in south Asian communities where dominance of men over women is common. If men were supportive as equal partners and responsible partners better outcomes were expected in reproductive health indicators like contra-ception acceptance and continuation which is vital to improve overall maternal health.[7]

Husband's disapproval (40.1%) was found to be the main reason in our study for not using contraception. More than one fifth (22.8%) of the respondents didn't use contraception due to religious beliefs in (Table 4). This attitude against family planning was common and hinted the strong presence of traditional and conservative social practices and beliefs among some upper caste in Hindu religion. Use of contraception led to irregular bleeding which prevented them from performing scared religious rituals and sexual activities. These activities are absolutely prohibited during menstruation as women are considered to be 'impure' during these days. This type of practice was also observed in Islam countries where women weren't allowed to pray or participate in sexual activities during menstruation.[3, 8, 9]

It was observed that, quality of life was better among contraceptive users as compared to non-users and better among women with knowledge of availability of free contraception which is similar to the study done in India by Kameswararao, India.[6] This could be due to the absence of the fear of having unwanted pregnancies and gradual improvement overall maternal health. Consistent and proper use of family planning methods helped couple to plan a family and maintain financial and social stability gradually. Similar finding was also reported in the study done in by C. Egarter et al. among oral contraceptive users.16In a study done in Hong Kong, no adverse impact was noted by use of contraception upon the quality of life and sexual function of users.[17]

The major weakness of this study: the instrument of this study is based on consumer perspective's which is liable for subjective bias. To our knowledge, this was the first kind of study among the Bhutanese refugee population from consumer's persp-ectives. Consumer perspectives have an added benefit

of increased community participation and are essential for any program's success.[19]

V. Conclusion

Though all the participants were aware about contraception, more than one tenth of them weren't aware about the free provision of its availability within the health center in their respective camp. Lack of men's participation for adopting contraception led to more use of contraception among the females. Better quality of life was observed among contraception users possibly due to proper and consistent use of contraception which led to a well-managed family and life devoid of fear for unwanted pregnancies.

VI. Ethical Considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc) have been completely observed by the authors. No Competing interests among the authors.

VII. Acknowledgement

We would like to thank Association of Medical Doctors of Asia (AMDA) Primary Healthcare Project for Bhutanese Refugee for allowing us to conduct the study among the refugee population and the participants of the study without whom this study would not have been completed. The study was approved by the Institutional Ethical Review Board of B. P. Koirala Institute of Health Sciences, Dharan, Nepal. This article was a part of my MD thesis research.

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Teoría Del Reconocimiento: Aportaciones a La Psicoterapia

By José Ramón Boxó Cifuentes, Joaquín Aragón Ortega, Leonor Ruiz Sicilia, Orlando Benito Riesco & Y Miguel Ángel Rubio González

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Abstract- Based on a statement of the essential concepts that are part of the theory of recognition, we investigate its connections with various psychotherapeutic approaches sources. Then reflect on certain risks in its application to propose finally a structure interview based on their contri-butions.

Keywords: *self-esteem, recognition, psychotherapy.*

GJMR-K Classification : *NLMC Code: WB 556*

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Teoría Del Reconocimiento: Aportaciones a La Psicoterapia

José Ramón Boxó Cifuentes [α], Joaquín Aragón Ortega [σ], Leonor Ruiz Sicilia [ρ], Orlando Benito Riesco [ω] & y Miguel Ángel Rubio González [¥]

Resumen- **Partiendo de una exposición de los conceptos esenciales que forman parte de la teoría del reconocimiento, indagamos en sus conexiones con varias fuentes de planteamientos psicoterapéuticos. Posteriormente reflexionamos sobre ciertos riesgos en su aplicación para proponer finalmente una estructura de entrevista basada en sus aportaciones.**

Palabras Clave: *autoestima, reconocimiento, psicoterapia.*

Abstract- **Based on a statement of the essential concepts that are part of the theory of recognition, we investigate its connections with various psychotherapeutic approaches sources. Then reflect on certain risks in its application to propose finally a structure interview based on their contributions.**

Keywords: *self-esteem, recognition, psychotherapy.*

I. Introducción

La teoría del reconocimiento expresa la nueva base normativa mediante la cual Axel Honneth desarrolla la categoría de reconocimiento como la tensión moral dinamizadora de la vida social. El concepto de reconocimiento implica que el sujeto necesita del otro para poder construir una identidad estable y plena. La finalidad de la vida humana consistiría, desde este punto de vista, en la autorrealización entendida como el establecimiento de un determinado tipo de relación consigo mismo, consistente en la auto-confianza, el auto-respeto y la auto-estima. La identidad se fundamenta en la conciencia de sí mismo con que cuentan los elementos del sistema humano de relaciones intersubjetivas que, a diferencia de sistemas de otra naturaleza, se componen de personas y estas existen en el sentido que le atribuye Todorov cuando plantea la distinción entre *ser*, *vivir* y *existir*, a saber: la pulsión de ser la compartimos con toda la materia; la pulsión de vivir, con todos los seres vivos; pero la pulsión de existir es específicamente humana. Atribuye cualidad de cósmico al nivel de ser, de animal al de vivir y de social al de existir. Para los animales la vida predomina sobre la existencia, mientras que para el ser humano es lo contrario (1). La identidad, condición más o menos estable del self, depende en definitiva del reconocimiento, acontecimiento relacional de identify-cación y validación.

a) Tres esferas de necesidad y conflictividad

Irene Comins plasma el cierto acuerdo que existe hoy en día para distinguir tres fases de relación práctica consigo mismo a partir del cual se deducen las tres esferas de necesidad y conflictividad que distingue la teoría del reconocimiento (2):

1. Hay un primer nivel de auto-relación. En éste los sujetos se refieren a sí mismos de tal modo, que conciben sus necesidades físicas y sus deseos como parte articulable de la propia personalidad. La auto-confianza es la expresión de una correcta auto-relación del individuo en este nivel.
2. La segunda forma de auto-relación práctica consiste en la conciencia de ser un sujeto moralmente responsable de sus propios actos. De este nivel depende el auto-respeto.
3. La tercera forma de auto-relación se manifiesta en la conciencia de poseer capacidades buenas o valiosas. Esta conciencia genera la auto-estima.

La auto-confianza, el auto-respeto, la auto-estima serían respectivamente los distintos valores que favorecerían una correcta relación consigo mismo del individuo.

b) Los modos del desprecio

Al sentido personal de integridad humana se accede solamente por una vía negativa, por la vía indirecta de una determinación de los modos de humillación y del daño personal. Es decir, una vía negativa, que asigna primacía a la experiencia del daño, a su elaboración y a su definición y que explica, o intenta hacerlo, de manera derivada cómo formulamos nuestras ideas de lo que es un bien para nosotros (3). A las formas de auto-relación mencionadas se les puede asignar respectivamente tipos de ofensas morales que corresponden a grados de daño psíquico. La percepción de estas formas de desprecio puede motivar al sujeto a entrar en una lucha práctica o en un conflicto. Para llegar a una autorrealización lograda, el ser humano se encuentra destinado al reconocimiento

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intersubjetivo de sus capacidades y operaciones. Si en alguno de los escalones de su desarrollo tal forma de asentimiento social queda excluida, esto abre en su personalidad un hueco psíquico, en el que penetran las reacciones negativas de sentimientos tales como la vergüenza o la cólera. Por ello, la experiencia de desprecio siempre va acompañada de sensaciones afectivas que pueden indicarle al individuo que se le priva de ciertas formas de reconocimiento social (4). Es muy de destacar que el principio de la acción recíproca sea llamado también principio de la comunidad. En esta dirección las formas de desprecio expresan la frustración de la reciprocidad y la incapacidad de la comunidad humana para corregir el proceso del agravio moral en alguna de sus formas:

1. El primer tipo de desprecio concierne a la integridad física de la persona. Son aquellas formas de maltrato en las que la persona es forzosamente privada de la oportunidad de disponer libremente sobre su cuerpo. Representa el modo más radical de menosprecio personal, ya que el grado de humillación tiene un impacto más destructivo sobre la relación práctica del individuo consigo mismo. Lo definitorio de estas formas de maltrato físico, representadas por la tortura y la violación, lo constituye no el dolor corporal, sino el emparejamiento de este dolor con el fenómeno psíquico de sentirse indefenso frente a la voluntad de otro sujeto, hasta el punto de estar privado de todo sentido de la realidad (5). Todo atentado contra la integridad física destruye el principio de confianza en el mundo, la certeza de que nadie tocará mi cuerpo si no es de la manera, en el momento y el lugar que yo permita y que en caso de ser agredido se me permita defenderme o recibir ayuda de terceros (6). A través de la experiencia de este tipo de maltrato, la persona es privada de esa forma de reconocimiento que se expresa en el respeto incondicional al control autónomo sobre el propio cuerpo, una forma de respeto adquirida a través de la experiencia emocional del proceso de socialización. Este tipo de menosprecio daña la autoconfianza, ya que esa nace y se realimenta de la *otro-confianza*.
2. El segundo tipo de desprecio se produce cuando una persona es excluida estructuralmente de la posesión de determinados derechos dentro de una sociedad. Cualquier miembro de una comunidad tiene el mismo derecho a participar en su orden institucional. Si a una persona se le niegan sistemáticamente ciertos derechos de este tipo implica que no es merecedora del mismo grado de capacidad moral que los otros miembros de la sociedad. Este menosprecio viene representado por la negación de derechos y por el aislamiento social. La experiencia de tener ciertos derechos denegados está emparejada con la pérdida de la capacidad de relacionarse como miembro de interacción con posesión de iguales derechos que todos los otros individuos, lo que produce una pérdida del respeto de sí mismo, el segundo modo de autorrealización. La integridad social queda herida cuando somos desposeídos de nuestra segunda naturaleza, la que se constituye en las prácticas sociales humanas, en los conceptos y razones con las que se articulan nuestras acciones y que nos confieren una dimensión de ciudadanía. La exclusión nos deja al margen de una comunidad que reconoce y se opone al daño (7).
3. El tercer tipo de desprecio implica la degradación o menosprecio de los estilos de vida individuales o colectivos. La dignidad de una persona se valora por la aceptación social del método de autorrealización en un horizonte de tradiciones culturales dadas en una sociedad. El individuo que experimenta este tipo de devaluación social normalmente cae preso de una pérdida de autoestima, y, por consiguiente, de la oportunidad de poder entenderse como un ente estimado en sus capacidades y cualidades características (8).

En el origen de las experiencias de desprecio hemos de dirigir nuestra atención inicial al grupo básico de socialización que es el grupo familiar en el cual el valor significativo de sus componentes otorga especial relevancia a sus comportamientos relacionales. Los modos del desprecio no representan tanto una injusticia como una conducta dañina por la que las personas son heridas en la comprensión positiva de sí mismas que han adquirido por vías intersubjetivas (9).

c) Las formas del reconocimiento

La diferenciación de estas tres formas de desprecio nos facilita la llave para clasificar un idéntico número de relaciones de reconocimiento mutuo que se presenta como alternativa. A los distintos tipos de ofensas morales les corresponden, en sentido positivo, otras tantas formas de reconocimiento. Basta con seguir el hilo de las sensaciones afectivas que se asocian con formas de desprecio para establecer qué modalidad de reconocimiento es negada, qué lucha por el reconocimiento subyace a la acción de estas personas, aunque no puedan argumentarla. La comunidad es el lugar y resultado de la lucha por el reconocimiento: toda lucha por el reconocimiento de sí es una lucha por la comunidad. La adquisición del reconocimiento social se convierte en la condición normativa de toda acción comunicativa: los sujetos se encuentran en el horizonte de expectativas mutuas, como personas morales y para encontrar reconocimiento por sus méritos sociales. Según Honneth las luchas por el reconocimiento están desplazando las luchas para la redistribución económica teniendo como objetivo el mejoramiento de las condiciones de autonomía de los miembros de nuestra sociedad. Distinguimos

las siguientes formas de reconocimiento o de validación social:

1. En el primer caso de reconocimiento físico, el reconocimiento toma la forma de una aprobación emocional y un reforzamiento. Esta relación de reconocimiento depende de la existencia concreta y física de otras personas que se reconocen unas a otras con sentimientos específicos de aprecio que podríamos denominar *amor*. Por relaciones amorosas deben entenderse aquí todas las relaciones primarias, en la medida en que, a ejemplo de las relaciones eróticas entre dos, las amistades o las relaciones padres-hijos estriban en fuertes lazos afectivos (10). Estas actitudes, por lo general no se extienden a un amplio número de sujetos sino que son más bien restrictivas, expresándose preferentemente en los espacios de relación íntimos y privados.
2. El segundo tipo de reconocimiento implica que demos cuenta o respondamos unos de otros como portadores del mismo tipo de derechos. Tiene, por tanto, un carácter tanto cognitivo como emocional. Este tipo de reconocimiento esta comprometido con la *universalización* por dos razones: en primer lugar para incrementar la *legalidad* que garantice las libertades individuales, por otra, por las luchas históricas de los colectivos excluidos o marginados en la reclamación de sus derechos. La realización práctica es el respeto de sí por el cual el sujeto concibe su obrar como una exteriorización de su autonomía moral que es respetada por todos.
3. Finalmente, el tercer tipo de reconocimiento es la solidaridad con los estilos de vida de los otros. Introduce de nuevo elementos emocionales al componente cognitivo del reconocimiento de derechos: la *solidaridad* y la *empatía* por la singularidad de los proyectos de vida personales y colectivos de los otros. La identificación con el grupo social al que el sujeto pertenece, es experimentada como orgullo por su utilidad en relación a valores compartidos con la comunidad.

d) El reconocimiento como instrumento para la psicoterapia

La teoría del reconocimiento contiene los tres componentes necesarios que podemos exigir a un planteamiento terapéutico: primero, proporciona un modelo de organización de los datos biográficos para el análisis; segundo, aporta una forma de comprensión de la experiencia, es decir, una hermenéutica; y tercero, posibilita un acto de reconocimiento fundado en el valor simbólico del terapeuta. La aplicación de la teoría del reconocimiento a la psicoterapia encuentra antecedentes en planteamientos extraídos de varias fuentes.

Para el psicoanálisis evolucionado a partir de las observaciones de Donald Winnicott y Melanie Klein, los seres humanos solo estamos en disposición de desarrollar la autonomía si en el proceso requerido de independencia intersubjetiva, nos dejamos caer periódicamente desde de las fronteras del yo, alcanzadas hasta entonces, hasta la experiencia de fusión simbiótica con otro ser humano (11). La teoría psicodinámica que contempla al yo como algo más que un simple órgano de adaptación, evolucionó hacia la consideración de que su objetivo final no es tan solo la supervivencia física sino la preservación de la integridad de la persona y la defensa de sus valores. En el estudio del ser humano, el concepto de adaptación se sustituye por otro de mayor complejidad, el de una relación significativa en términos de valores. Las relaciones personales con los objetos son esencialmente bilaterales, recíprocas por el hecho de ser personales e implican una mutua valoración, una comunicación, la participación de cada ser humano en la vida de los demás (12). En la interpretación que realiza Heinz Kohut sobre el dinamismo psicológico del ser humano, establece dos direcciones, una que denomina el *hombre culpable* cuyas metas apuntan a la actividad de sus impulsos de modo que predomina el modelo adaptativo impersonal, y una segunda, que para nuestro análisis es de mayor interés, el *hombre trágico* cuyas metas apuntan al desarrollo del sí mismo y que solo alcanzará en su afirmación personal dentro de un medio social en el que se sienta realizado (13). En resumen, la madurez del sujeto no se mide por su capacidad de control de las necesidades y del entorno, sino por la capacidad de apertura a las múltiples facetas de su propia persona expresadas en la interacción comunicativa. Las versiones más avanzadas del psicoanálisis han seguido esta línea de desarrollo de modo que Honneth puede hablar de un psicoanálisis entendido desde la teoría del reconocimiento (14).

Tal como adelantábamos en nuestra introducción, Todorov plantea la necesidad de existir como cualidad exclusiva de lo humano en comparación con el resto de seres vivos. Esta es solo alcanzable a través de la interacción con el otro, que se hace significativo en la relación, en la medida en que nos proporciona la posibilidad de tomar conciencia de nuestra propia existencia; un proceso que se inicia en el niño a través de la mirada de sus progenitores: una vez dominados sus ciclos biológicos fundamentales, el niño puede ocuparse más del mundo circundante. El niño ya no se conforma con mirar a su madre o a su padre, busca atraer y captar sus miradas. Quiere ser visto y no solo ver, convirtiéndose la mirada de la madre o del padre en el primer espejo con el cual el niño se ve: este momento decisivo marca el nacimiento simultáneo de su conciencia del otro (aquel que debe mirarlo) y de sí mismo (aquel a quien el otro mira) y, por lo mismo del nacimiento de la conciencia.

El concepto de *incompletud* original de Rousseau es asumido por Todorov para explicar cómo esta necesidad de existir nunca puede ser colmada

definitivamente, algo que convierte a la *incompletud* en constitutiva, de tal manera que la disparidad entre su reclamo infinito y su satisfacción, forzosamente parcial y provisional, es algo que nace poco después de nuestro nacimiento físico y solo se aplaca en la inconsciencia que precede a la muerte. De esta forma Todorov desarrolla su tesis acerca del reconocimiento como amalgama de continuidad ente los humanos; no se trata de una necesidad para la sana configuración del ser humano exclusiva de sus inicios, ya que mientras que la madre busca concederle el reconocimiento a su hijo, asegurarlo de su existencia; al mismo tiempo, siempre sin darse cuenta, se encuentra ella misma reconocida en su papel de agente del reconocimiento por la mirada solicitante de su hijo (15). El terapeuta asume la representación de una continuidad simbólica de la comunidad humana que concede el reconocimiento negado en la experiencia del paciente. El reconocimiento en terapia familiar tiene una dificultad añadida que no parece existir en la terapia individual. En esta la función simbólica del terapeuta es determinante, pero en aquella, la simbología se difumina ante el papel real de los miembros de la familia que son los que tienen que conceder el reconocimiento. El terapeuta representa a una comunidad mediadora, el espacio público, pero la familia es la comunidad reconocedora. No puede ser sustituida por el terapeuta porque donde hay presencia real, la simbología toma otras dimensiones secundarias. Para Linares, en un contexto de terapia familiar, el reconocimiento y el consuelo pueden revestir formas más elaboradas, que los integran en el conjunto de una intervención coherente con el objetivo de modificar la narrativa dominante y propiciar la nutrición emocional (16).

Dentro de las contribuciones de la teoría de la comunicación humana, el grupo de Palo Alto, enfocaba la comunicación como el interminable proceso de construcción y validación de los self de cada sujeto, por tanto de reconocimiento de una identidad ofrecida al intercambio intersubjetivo. Esto es parte del compromiso profesional de la ayuda psicológica: la cooperación en esta construcción. La comunicación como compromiso, establece un grado de responsabilidad mutua entre los que interactúan en un contexto. Toda conducta es siempre un mensaje de solicitud o evitación de validación del self, una propuesta de compromiso en el reconocimiento. En este compromiso podemos fluctuar entre varias posibilidades de manifestar nuestra actitud respecto de la propuesta de self:

a. Desconfirmación: es el no ser visto, no ser tenido en cuenta, sería el desprecio.
b. Confirmación: es un factor de estabilidad sólo si lo es en su valoración positiva.
c. Rechazo: no es aceptada la imagen que se propone (17).

El oyente, en su atención, *reconoce* al hablante y tiene la capacidad de hacerlo ser, de colaborar con él en la construcción de su persona, en su individualización. Para Hannah Arendt no existe nada ni nadie en este mundo cuya misma existencia no presuponga un espectador (18). El terapeuta se convierte en el espectador comprometido con el que puede contar el paciente en tanto portador del sufrimiento generado por el discurso social. Nadie existe en singular desde el momento en que hace su aparición; está destinado a ser percibido por alguien. Existir significa estar movido por una necesidad de apertura, de mostrase, que en cada uno se corresponde con su capacidad de aparecer.

Una consecuencia de la apertura a la relación interpersonal es *el self*. En toda comunicación existe una propuesta de relación sobre la base de una identidad. Para Castilla del Pino el self es la imagen instrumental con la que el sujeto se presenta en y para la situación; un intermediario del sujeto para la situación. Es la representación con la cual el sujeto se propone obtener de los demás la mejor de las imágenes posibles, cara a la interacción y a la satisfacción desiderativa derivada de ella, en suma, un mensaje mediante el cual pretende que el otro, por una parte, se forme la imagen que él anhela provocar y, por otra, que acepte su propuesta (19). Aparecer en el mundo de los humanos implica siempre parecerle algo a otros, y este parecer cambia según el punto de vista y la perspectiva de los espectadores.

El *sí mismo*, la identidad de uno, quién es el que uno es, cómo se valora y cómo le valoran a uno es una *formación mental funcional e imaginaria*, una inferencia que el sujeto obtiene de la idea que tiene de sí mismo y de la idea que cree que los demás tienen de él (20). El sí mismo es un yo que habla de sí, una identidad narrativa al que se accede por la hermenéutica al hablarle a un tú. El *self* es la totalización de la idea que tengo de mí mismo en esa esfera de mis acciones concretas de ahora, más la idea que los demás tienen de mí, más la idea que yo me formo de lo que los demás piensan de mí (21). El acto de adquirir una identidad se difracta en todos los textos en los que aparece y somos de esta manera, muchos. Esta quiebra puede hacernos soñar en un lugar unitario de significación donde ser alguien, no muchos (22). Además de la necesidad de auto- exhibirse, los humanos también se presentan de obra y palabra mediante la acción y el discurso, y así indican cómo desean aparecer, es decir, realizan una elección deliberada de lo que se puede mostrar y de lo que hay que ocultar. Siempre se es el mismo yo pero no la misma persona que es un proceso de creación. La ansiedad y la depresión expresan la alarma o la herida en el self y, en última instancia, remiten a él.

Mediante la acción y el discurso los seres humanos muestran quienes son, revelan activamente su personal e única identidad, y hacen aparición en el

mundo humano. El desvelamiento de quién en lugar de qué, está implicado en todo lo que dice y hace. Pero su revelación casi nunca puede realizarse como fin voluntario, como si uno poseyera y dispusiese de este quién de la misma manera que de sus cualidades. Por el contrario, es más probable que el quién que se presenta tan claro e inconfundible a los demás, permanezca oculto para la propia persona. Esta quiebra en la modalidad de la presentación define el espacio que puede cubrir el terapeuta ya que, desde una relación intersubjetiva establecida en un marco ético, está en condiciones de colaborar en una construcción saludable de la personalidad.

Mientras que con el conocimiento de una persona nos referimos a su identificación como individuo, con el reconocimiento podemos designar el acto expresivo mediante el cual es conferido a aquel conocimiento el significado positivo de una apreciación, es decir, un medio lingüístico que permita la emergencia en la realidad social de hechos no percibidos hasta entonces (23). Hannah Arendt con su exquisito sentido del otro, señala que, dado que las personas aparecen en el mundo de las apariencias, necesitan espectadores, y aquellos que acuden como espectadores a la fiesta de la vida tienen numerosos pensamientos de admiración que se expresan en palabras. Sin espectadores, el mundo sería imperfecto; el participante, absorto como está en cosas concretas y apremiado por actividades urgentes, es incapaz de ver cómo las cosas del mundo y los acontecimientos particulares de la esfera de los asuntos humanos se adaptan y producen una armonía que, en sí misma, no se da a la percepción sensible, y este invisible en lo visible permanecería desconocido para siempre si no hubiera un espectador que lo cuidase, lo admirase, ordenase las historia y las pusiese en palabras (24). Esta reflexión expresa el posicionamiento narrativo propio de un terapeuta orientado al recono-cimiento.

e) Los reconocimientos espurios

Tras esta propuesta se oculta un problema crucial de las formas modernas de relato del yo: las contradicciones o disimetrías pragmáticas que se introducen al narrarnos a nosotros mismos, las que existen entre el texto y el contexto; en suma el problema de la verdad y el problema de la falsedad de todo relato del yo. Hay una distancia entre el yo que narra y el yo del relato. La intención del yo que narra es establecer un sentido para el presente desde la constitución actual de su identidad (25). Partimos pues, de la constatación de la resistencia que opone a la idea de reciprocidad la disimetría originaria que se abre entre la idea del uno y la idea del otro. Este conflicto nos enfrenta con el problema de los reconocimientos espurios consec-uencia de la intranquilidad generada por la auto-representación permanente. Porque por el miedo de no poder corresponder a las expectativas intersubjetivas, cada persona se esfuerza en conseguir una presentación de sí mismo que promete más de lo que es capaz de cumplir de hecho, esperando conseguir un grado más amplio de reconocimiento social, convirtié-ndose en víctima de la externalización de sus orienta-ciones de acción al sucumbir a la presión de presentar una imagen sobrevalorada de sí mismo (26). A esta limitación se incorporan las dudas sobre que las prácticas de reconocimiento no efectúan un fortalecimiento de los sujetos sino, al contrario, su sometimiento: mediante procesos de reconocimiento mutuo, así se deja resumir la objeción, los individuos son ejercitados en una determinada relación consigo mismos que los motiva para una asunción voluntaria de tareas u obligaciones socialmente útiles (27).

f) Fuentes del reconocimiento

Llegado este punto el terapeuta se pregunta ¿Cómo pues reconocer terapéuticamente? Las fuentes de reconocimiento difieren hasta el punto de ser opuestas. De un lado hemos visto que se encuentra el asombro admirativo ante el espectáculo de la vida, pero no olvidemos otra fuente quizá más oscura, el terrible extremo de haber sido arrojado a un mundo cuya hostilidad resulta abrumadora, del que el ser humano hace todo lo posible por escapar. La mirada entonces debe dirigirse a las prácticas de humillación o envilecimiento a través de las cuales les es escatimada a los sujetos una forma fundada de reconocimiento social y con ello una condición decisiva de la formación de su autonomía. El reconocimiento de sí por parte de la persona actuante y sufriente se caracteriza como saberse capaz de ciertas realizaciones. La posición activa del terapeuta estriba en su comportamiento racional con el que puede reaccionar a las cualidades valiosas de una persona y saber explicitar esa capacidad de acción en el encuentro clínico mediante una perspicaz percepción de los valores del paciente.

Paul Ricoeur en su desarrollo de la fenome-nología de la persona capaz (28) nos propor-ciona excelentes pistas a partir de las cuales connotar minimizando los riesgos de una validación espuria. Destaca cinco capacidades que podemos reconocer en las personas:

a. Poder decir. Hablar es hacer cosas con las palabras y podemos connotar lo dicho y cómo se ha dicho. En lo verbal, darse a conocer, hacerse reconocer es, ante todo, suscitar una confusión y, luego, sacar del error. Se presenta en la descripción de la peripecia, trastocamiento de la acción en sentido contrario que permite pasar de la ignorancia al reconocimiento.
b. Poder hacer. Designa la capacidad de hacer que ocurran acontecimientos en el entorno físico y social del sujeto actuante.
c. Poder contar y poder contarse. La concentración de la vida en la forma de un relato es capaz de dar un punto de apoyo al objetivo ético de la vida buena. Aprender a contarse es también aprender a

contarse de otra manera. Una historia de vida se mezcla con la de los otros, de modo que el enmarañamiento en historias, lejos de constituir una complicación secundaria, debe considerarse la experiencia principal de la materia. Es en la prueba de la confrontación con otro, ya se trate de un individuo o de una colectividad, donde la identidad narrativa revela su fragilidad, donde los recursos de configuración se pueden convertir en recursos de manipulación.

d. Imputabilidad y responsabilidad. Para Ricoeur, con la imputabilidad, la noción de sujeto capaz alcanza su más alta significación. Es considerado imputable el sujeto que debe reparar los daños y sufrir pena. La idea de responsabilidad sustrae la de imputabilidad a su reducción puramente jurídica. Su virtud primera consiste en subrayar la alteridad implicada en el daño o perjuicio más que el solo precepto que se transgredió. En la responsabilidad no se oculta el sufrimiento primero que es el de la victima. En virtud de este desplazamiento del énfasis, la idea de prójimo vulnerable tiende a remplazar a la de daño cometido. Estos dos principios deben guardar un equilibrio pues la inflación de alguno de ellos podría girar hacia la indiferencia de los dañados o hacia la anulación del carácter propio de la acción. La persona sigue siendo el autor de esta acción íntima que consiste en evaluar sus actos, singularmente en la condición de retrospección. La misma persona sufriente es la que se reconoce como agente en una intención de vida realizada que se ha visto truncada. Al distinguirse las decisiones intencionales, se distinguen las virtudes que posee la persona y que son, en definitiva, el meollo del acto de reconocimiento. Sin embargo en la historia de cualquier vida existe el peso de lo que se hizo, y no sólo de lo que se hizo intencionalmente.

e. El mantenimiento de la identidad: la promesa. La promesas se presenta como una dimensión nueva de la idea de capacidad y como la recapitulación de los poderes anteriores: poder prometer presupone poder decir, poder actuar sobre el mundo, poder contar y formar la idea de la unidad narrativa de una vida, en fin, poder imputarse a sí mismo el origen de sus actos.

g) El momento de la devolución

Estos aspectos remarcados por Ricoeur, nos permiten llenar de contenido pertinente la devolución terapéutica que el paciente espera y de la que el profesional se ha hecho deudor en el contrato terapéutico. Una devolución bien construida inspirada en la teoría del reconocimiento debiera incluir estos contenidos:

1. Explicitación del modo del menosprecio elaborado en la narración del paciente que el terapeuta ha creído detectar y su consenso con el paciente ya que el punto de apoyo esencial es el malestar o la protesta del afectado.
2. Explicitación del derecho a la queja y al síntoma ante una situación de dominio social que solamente permite exponerlo en ámbitos restringidos como la consulta. El malestar es la forma de protesta posible para muchas personas que experimentan el menosprecio en alguna de sus formas.
3. Connotación positiva elaborada de acuerdo a los elementos de la narración que permitan el acceso al reconocimiento. La connotación positiva es el instrumento verbal más elemental del que disponemos. Pero no debemos confundir su característica de recurso primario como si de un instrumento inocuo se tratara. La connotación positiva, instrumento de marcada raíz cognitiva utilizado en múltiples procedimientos de terapia individual o familiar, en este contexto de validación, es un juicio positivo de valor, una interpr-etación favorable de un rasgo de la persona. Surge de una apreciación aparecida en la escucha clínica, en el despliegue de la historia. No es una adulación ni un consuelo. Realza un valor de la persona puesto en acción como consecuencia de la crisis. No se da valor a la crisis misma sino a la persona agente o sufriente de la crisis. Pretende un reconocimiento y validación positiva del self. Su elaboración requiere un enorme esfuerzo de atención en el terapeuta para que sea digna de crédito por parte del paciente (29). Su construcción implica una sujeción realista: debe referirse de forma significativa a capacidades efectivamente manifestadas en el relato del paciente. Otro aspecto importante en su construcción es que se refieran a valores morales actuales, vivos en el conjunto de la sociedad. Por último debe incluir una faceta de racionalidad, es decir, de argumentación convincente para el paciente al realizar otra lectura de la historia a la que abocó.
4. Exposición de los enigmas sobre lo que el paciente hará en su comunidad social con el conocimiento de sí y de las patologías sociales que han intervenido en la gestación de su malestar. Se establece una tensión entre normalización como comprensión de una respuesta adecuada al agravio sufrido e individualización como ser humano que ha adquirido una visión crítica del sufrimiento.

II. Conclusiones

La psicoterapia basada en el reconocimiento proporciona la integración de principios bioéticos en las entrañas mismas del proceso de análisis del sufrimiento y en las líneas de resolución de conflictos.

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The Phenomenology of Aesthetic Event

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Abstract- An aesthetic event represents the conjunction of the subjective knowledge and of the primordial objective reality, conjunction that is crucial to signify the presence and the role of the human being in the natural existential context and to clarify man's relationship to the universe. In this context the rules of the general system theory can be used to analyse the dynamics of the aesthetic work. We try to show how the expression of any aesthetic event, through its own structure and by its intentionality, unifies and harmonises the objective beauty. Thus the ineffable reality is revelead to human beings.

Keywords: *aesthetics, event, intentionality, phenom-enology, system, cybernetics, sequential process, innate.*

GJMR-K Classification : *WZ 348, W 20*

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The Phenomenology of Aesthetic Event

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I. Introduction

In existential reality an event is an object in time. Aesthetics[1] can be defined as a reflection on art, culture and nature. By aesthetic event we mean an intentional work[2] in search of the Beauty. In a large acceptance, Truth and Beauty can be seen as synonymous. The intentional work is a natural process that evolves in accordance with the logic and the rules of Natural Equilibrium. It is a spiritual process defined as a metaphysical phenomenon of existence. Baumgarten, the father of aesthetics, defined art as a way of "thinking in beauty". An aesthetic event is a spiritual witness of the human being's presence in the natural context of existence. The functional laws of Nature[3], the fundament of Natural Equilibrium, can be seen as an aesthetic norm[4]. Any authentic artistic work, by a profound observation and imagination, expresses the vital strength of Nature, nature which is present in the human mind and which determines the feeling of life. The present study is an interdisciplinary approach that tries to show the global structure of an aesthetic event and its dynamic evolution. In this way we apply the principles and the conclusions of the theory of complex systems.

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Why a phenomenological analysis?

Phenomenology is not a doctrine but a method which helps to discover the "Being" (German "Sein") in the quality of "existence" (Dasein) [5]. The transcendental vision of the phenomenology of aesthetic experience considerably enlarges the ontological dimension of the human spirit.

In Heidegger's book Being and Time (Sein und Zeit) we find his vision on the Dasein ("there being") concept. According to this point of view the human subject had to be reconceived in an altogether new way, as "being-in-world". Because this notion represented the opposite of the Cartesian "thing that thinks" (res cogitans), the idea of consciousness as representing the mind's internal awareness of its states had to be dropped. With it went the assumption that specific mental states were necessary to place in existentialism. Heidegger sought to use the concept of Dasein to uncover the primal (?) nature of "Being" (Sein), agreeing with Dilthey theory. The Dasein is always a being engaged in the world: neither a subject, nor the objective world alone, but the coherence of Being-in-the-world. Being (Sein) is always the being of an entity. Establishing this difference is the general motif running through Sein und Zeit. The Aesthetic work, as a result of intentional behavior, is specific for a man engaged in the dynamical mechanism of Nature. The human being is integrated in the World by his aesthetic product that extends the boundaries of his ontological capacity.

In this way to study the phenomenology[6] of any practical experience, one has to start by analyzing the

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[1] "Aesthetics" is derived from the Greek **αίσθάνομαι** (*aisthanomai*, meaning "I perceive, feel, sense") and **αίσθητικός** (*aisthetikos*, meaning "aesthetic, sensitive, sentient"). The new meaning of "aesthetics" (in the German form Æsthetik, with its modern spelling Ästhetik) was defined by A. Baumgarten in 1735.

[2] The intentionality (from the Latin *intentio*) can be seen, in the most general sense, as the desire to know , which is engraved on our natural constitution as an original structure and which confirms our capacity to reach the transcendence by our innate, ante-predicative knowledge. Intentionality is an intrinsic feature of acts such as thinking and hoping. The phenomenology of intentionality is important in the description and classification of mental acts, such as aesthetic works. Husserl and his Gottingen students have developed a large phenomenological analysis of mental life and its products.

[3] There are several aspects of the concept of Nature: 1. the "objective" Nature can be seen as empirical and ideal (Platonic) reality; 2. The "essential" Nature can be understood as the system of the primordial truth and essential relations; 3. The "subjective" Nature determines the perpetual relations in private life; 4. The "psychological" Nature expresses the freedom of rules and conventions, without traditional, artificial behavior.

[4] Arthur O. Loveloy, "Nature as Aesthetic Norm", in *the Great Chain of Being: a Study of the History of an Idea*, Cambridge (Mass.), 1936.

[5] Dasein is a German word which means being there or presence (German: da - there; sein - being) often translated in English by the word "existence". German philosopher Heidegger in his existentialism philosophy uses the expression Dasein to refer to the experience of being that is peculiar to human beings. Thus it is a form of being that is aware of and must confront such issues as personhood, mortality and the dilemma or paradox of living in relationship with other humans while being ultimately alone with one self.

[6] Phenomenology (from the Greek *phainomenon*, "that which appears"; and *logos* "study, science") is the natural study of the structures of experience and consciousness. As a philosophical approach it was founded in the early years of the 20th century by

genesis and the structure of the object of that experience. The phenomenological method is rooted in the notion of intentionality. Aesthetic work springs from a primordial necessity whose origins are to be found in the ante-predicative layers of human spirituality. It is a fundamental basis of existence. It is a perennial source of life. Through aesthetic expression, man goes from the world of essences to the existential world. He discovers the mystery of the context "space-time" in which he lives, the mystery of existence, and ultimately the mystery of "The One". In this sense we can speak about reality as a potential description of a singularity waiting to be revealed in the sensible world[7].

The phenomenological study of the aesthetic experience leads to finding reliable answers to questions that concern the essence and the evolution of the aesthetic concept in the natural space where it manifests itself. An aesthetic work results from the symbiosis of two essential elements: the initial idea and the act of reflection.

The initial idea, as a result of the dynamics of consciousness' pre-reflexive activities, represents the starting point from which aesthetic discourse gets configured and structured. For Schoenberg[8] "the musical idea" was the most important element in a piece of music.

The second essential element, the act of reflection, has to be understood in its most general sense as the process through which all the conscious forms of human inner life are activated; this process supports dynamically any voluntary manifestation of man. The act of reflection arises, in an immanent way, as the motor of the initial potentialities which were "homologated at the world's birth" (after Mircea Eliade's expression) [9].

The deep rhythm which is the fundament of the universal context "space-time" (Messiaen[10] asserts that "the world's substance is the polyrhythm") shapes the immanent relationship between the musical idea and the act of reflection. Through aesthetic expression, man goes beyond the essences of the world so that he can define his own presence in the existential universe. He creates a new context, which we call "real-symbolic", specific to his own spiritual manifestations, which evolves simultaneously with the universal context "space-time" governed by natural phenomenology[11]. The authentic aesthetic work, as the inexorable product of aesthetic experience, arises as a symbol of primordial truth's immanence, as a symbol of sacredness understood in the sense of an absolute and immutable value. Thus the reason for a work of aesthetic existence is to put in evidence, in the sensible world, the extraordinary beauty of the functional interdependence between Nature and Spirit. This relation is defined by a perpetual movement of "entry in oneself" to "exit out of oneself", movement which generates the aesthetic existence of the human being.

II. The Global Vision of the Aesthetic Event

In its essence, aesthetics is the art of movement. It is implicated in the transcendental movement of the conscience. It represents an intentional object as much as the transcendental intention is the way of being of the conscience. The aesthetic work is not a harmonization, it is the source of harmony, it is a fundamental existential principle. By the aesthetic phenomenon, man transcends his condition of a sensible being in order to obtain the understanding of the world of essences, the world of the truth. The present study, by its approach of the aesthetic event, tries to highlight the a priori potentialities that are offered by aesthetics to the human being in his existential search. For Friedrich Schiller aesthetic appreciation of beauty is the most perfect reconciliation of the sensual and rational parts of human nature. Modern approaches of aesthetics mostly come from the fields of cognitive psychology and neurosciences.

An aesthetic work can be considered as a global intentional process. Within this process a mental act creates a relationship between an intentional act and real happenings in the "space-time" world. All the happenings of the "space-time" universe determine the general context of aesthetic phenomena. In a broad sense it is a matter of a natural or artificial (human-made) system[12] in which the components form a

Edmund Husserl and was later expanded upon by a circle of his followers at the Universities of Göttingen and Munich in Germany. It then spread to France, the United States, and elsewhere.

[7] The French sculptor Brancusi said: "when I work I put in the light the forms hidden into the stone".

[8] Arnold Schoenberg, an Austrian composer and painter associated with the expressionist movement in German poetry and art was one of the leaders of the Second Viennese School. In the 1920s, he developed the twelve-tone technique, an influential compositional method of manipulating an ordered series of all twelve notes in the chromatic scale.

[9] M. Eliade, *the Sacred and the Profane*, New York, Harcourt Brace, 1959. He was a known philosopher of the religions.

[10] Olivier Messiaen was a French composer, one of the major composers of the 20th century. His music is rhythmically complex as he was interested in rhythms from ancient Greece and from Hindu sources.

[11] In 1967 Gordon Epperson, in his study *The Musical Symbol, a Study of the Philosophic Theory of Music*, brought into relief the importance of the symbol in musical events.

[12] The term "system" comes from the Latin word *systēma*, in turn from Greek σύστημα, *systēma*, that signifies a whole compounded of several parts or members. One system can be formed by two types of functional structures: somatic and constituent. The somatic structure can be understood as a sum of independent elements, whose general characteristics are obtained by the sum of characteristics of each independent component. In the constituent structure there are

coherent transcendental entity. The structure of the global system is constituted by several interdependent sub-systems. Each sub-system has its own structure and its own way to reach its own aim, but their interdependent working follows the way of the global aim. The working and the evolution of this system is determined by the state parameters (f_{e1}, f_{e2}, f_{e3}…….f_{en}) of the external existential context and the state parameters (f_{i1}, f_{i2}, f_{i3}…….f_{in}) that characterize the internal dynamic of the aesthetic process (Fig. 1).

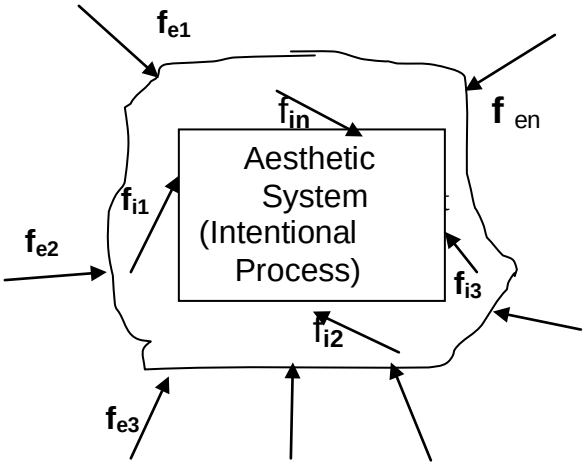

Fig. 1 : Schematic model of an aesthetic process

specific functional relations between the constituent elements; to understand this type of structure one has to know the identity and the nature of the constituent components as well as their functional interrelations.

The influence of these parameters can have a random, chaotic behavior or can follow deterministic laws. Their actions on the process follow the specific rules of dependence which determine the relations between the components of the global system.

According to A. Koestler[13], the general principle of such psychological system is the principle of hierarchical structure. He develops a coherent way of organizing knowledge and nature all together. Everything we can think of is composed by an Holon (simultaneously both part and whole). Each Holon is always a constituent of a larger one and yet also contains other Holons that are constituents of a lower level system within. Every Holon is like a two-faced "Janus", the Roman God: one side (the whole) looks down (or inward); the other side (the part) looks up (or outward). Each whole is a part of something greater, and each part is in same time an organizing whole of the elements that constitute it.

The concept of hierarchical structure on several levels closely connected with the theory of complex systems as it was developed by Ludwig von Bertalanffy[14]. The Koestler's ideas put together one of the first broad based arguments for incorporating the theory of complex systems into the philosophy of science and epistemology. The Bertalanffy's General System Theory and the Koestler's Holon theory are an interdisciplinary practice that describes systems by the interacting components, applicable to biology, cybernetics, socio-logy, art and other fields. Bertalanffy's opinion is that the classical laws of thermodynamics applied to closed systems but not necessarily to "open systems" such as a spiritual processes or living things. We can now try to apply the information theory and the principles of cybernetics to our object of study, the phenomenology of aesthetic experience. The term "Cybernetic" was introduced in 1948 by Norbert Wiener in his fundamental work Cybernetics or control and Communication in the Animal and the Machine[15].

Cybernetics is a phenomenological approach to the structure of information and its function in the interactive systems. It is the general science of the regulation and communication in the natural and artificial systems. Cybernetics is a means of knowledge to study the information in the physical context which in Wiener's vision is a measure of organization just as the entropy is a measure of disorder. The concept of interaction is founded on the feedback notion. A process that has a desired aim compares anytime the Output parameter with the desired aim through the feedback action. If the result of the comparison is not significant the process is stable in desired state, if not the process is in transitive state and the sequences of comparison continue.

The schematic model of any process with feedback action is represented below (Fig. 2):

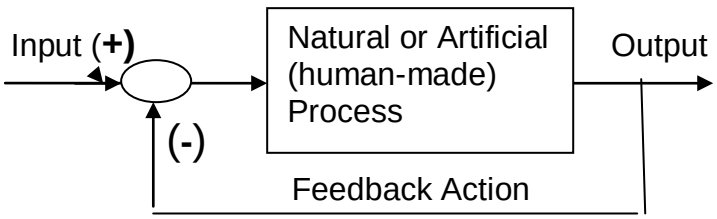

Fig. 2 : Feedback model

[13] *A. Koestler, Janus: A Summing Up, 1978.*

[14] L. von Bertalanffy, *General System theory: Foundations, Development, Applications*, New York, 1978. Today Bertalanffy is considered to be a founder and one of the principal authors of the interdisciplinary school of thought known as general systems theory.

[15] N. Wiener, *Cybernetics or Control and Communication in the Animal and the Machine*, New York, 1948. Wiener is considered the originator of cybernetics, a formalization of the notion of feedback, with implications for engineering, systems control, computer science, biology, philosophy, and the organization of society.

III. Aesthetic Work as a Sequential Process

One of the fundamental problems in the knowledge of the aesthetic process as a system is to establish the identity of the process which characterizes the engendering and evolution of its events. We can globally represent an aesthetic work as a sum of interactive elements that define a dynamic phenomenon of the human spiritual activity. If we represent the aesthetic phenomenon as a spiritual transformation point, its identification supposes the cognition of the relation Y = F(X, R, P) (Fig. 3).

If we note, in the model of the aesthetic phenomenon, by the vector "X" the entry context, by the vector "Y" the exit context, by the vector "P" the external perturbation, and by vector "R" the final goal of the process (which is in the mind of the creator of aesthetic event), then the function "F" is the transfer function that identifies the transformation of the "X" towards the "Y". The structure of the vectors X, Y, P, and R, is determined by the state parameters (f_{e1}, f_{e2}, f_{e3}……f_{en}), (f_{i1}, f_{i2}, f_{i3}……..f_{in}) as seen above (fig. 1).

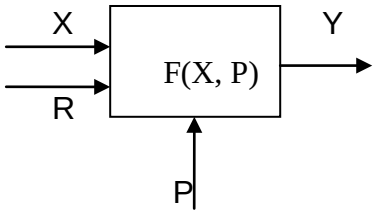

Fig. 3 : Model of the aesthetic phenomenon

The values of the state parameters reflect, also, the natural and existential context of the aesthetical events. In the process of artistic creation, the aesthetic reality has three aspects: present of the past since there is a conscience and a memory, present of the present by attention and, finally, present of the future since the conscience is in the state of expectation. This triple aspect of time determines the natural and existential context of the aesthetical events defined by the parameters (f_{e1}, f_{e2}, f_{e3} ……f_{en}), and (f_{i1}, f_{i2}, f_{i3}……..f_{in}).

It is matter of a process that evolves from an unstable state to a stable state that is defined by the final aim or reference ("R"). By reference "R" we understand here the ideal author's vision on the final of the artistic product. The reference "R" is the result of an intentional process that is present in the mind of the author as an innate property. Jacque Monod[16] (Nobel prize in Physiology and Medicine - 1965) wrote that the intentionality as a human tendency to know is acquired through experience according to an innate program which follows a certain pre-established pattern defined by the species' genetic patrimony. It is a transcriptional regulation system. He believes this understanding will enable the mankind to eliminate the dualism of the brain and the mind.

This new understanding will also enable us to understand that "to give up the illusion that sees in the soul an immaterial "substance" is not to deny its existence, but on the contrary to begin to recognize the complexity, the richness, the unfathomable profundity of the genetic and cultural heritage and of the personal experience, conscious or otherwise, which together constitute this being of ours".

A correct and complete structure for the vectors X(x', x", x'''…), Y(y', y'', y'''…), P(p', p'', p'''….) and R(r', r'', r''''…) offers a further chance for the F(f', f'', f'''…) to really represent the identity of the process, that is to say the knowledge of it. The evolution of the aesthetic process is determined by a feedback mechanism that allows realizing a synthesis between the functions and the significance of the vectors X, Y, R and P. In this sense the initial idea, as a result of the consciousness' pre-reflexive activities, represents the starting point of the aesthetical process and determines the structure and the configuration of the elements X(x', x'', x'''…) and the elements R(r', r", r'''…..).

The evolution of the process is determined by the act of reflection, the second essential element necessary for the generation of an aesthetic event. This global process generates the aesthetic expression and is in fact the aesthetic existence of man. The aesthetic work accompanies faithfully the smallest oscillations of the hidden order in the world and thus the phenomenological vision of aesthetic event greatly expands the ontological dimension of the human spirit. By then, man understands better his rationale existence and, ultimoately, his own human nature. The core mission of artistic effort is to reveal the nature of things, to highlight the intrinsic reality, the real immutable and timeless, and the absolute. Plato's beauty is a timeless essence, an Idea, but for Aristotle, on the contrary, beauty lies in the objective, that is to say in the internal order that governs the creation of something or someone alive. The correctness of proportion equally aims at the sensible and at the reason.

[16] J. Monod, *Le Hasard et la nécessité: essai sur la philosophie naturelle de la biologie moderne*, Paris, 1970. The author believes that we contain an inborn genetic need to search out the meaning of existence and that is responsible for the creation of myths, religion, and philosophy. He implies that this genetic component accounts for religion being the base of social structure and the reoccurrence of the same essential form in myths, religion, and philosophy. The book's title was inspired by a line attributed to Democritus, "Everything existing in the universe is the fruit of chance and necessity."

Because of its complexity, its continuous and deep transformations, and its dialectical features, the aesthetic work can be seen as a living structure telling truth, as a powerful and scalable system in the mind of a clearly defined end[17].

That purpose is an internal necessity within the spirit, a necessity which has the force of the innate. We can consider the entire aesthetic work as a global dynamic category in which forces of attraction and rejection are growing as well as in the natural dynamic processes. The aesthetic discourse is indeed a scalable system with a strong feedback mechanism that allows itself to correct errors of expression and analysis on the way to the desired final expression. All this process is a sequential process within which the vectors X and Y evolve step by step under the influence of the vector P and the feedback action vector FB (Fig. 4).

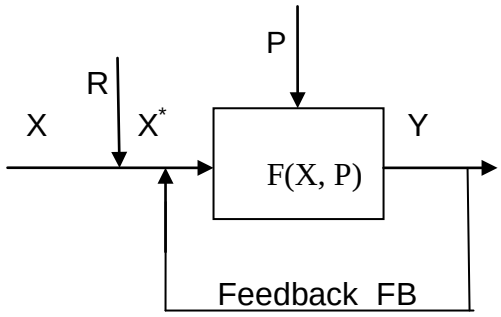

Fig. 4 : Theoretical model of an aesthetic discourse

The mechanism of feedback, as a spiritual retroactive mechanism is the result of the symbiosis between two psychological elements: the spiral of intuition and that of reason. This harmony is always present in the mind of the artist. The sequential process creates each movement as a result of the movement that precedes it. Each step is validated by a decisional comparison between the two vectors: vector X* (composed of the entry vector X and reference vector R) and feedback action vector FB. The reference vector R is a result of an intentional process which takes place in the mind of the aesthetical event's author[18] and describes the intention of the author, his global vision of the original idea. This comparison determines the global structure of the entry in the sequential process. The iteration ends when the aesthetic work arrives at the qualities required by the context « idea-form », by the natural logic of Equilibrium and Beauty, by the ideal intentionality.

Normally, the natural evolution of this system determines the convergence of intermediate steps towards a stable form, permanent and unique, a unit of perception. The dynamics of the aesthetical work as a system introduces time in the sensitive reality, because it directs the creative pulse of the mind in a manner entirely consistent with the time of nature[19]. Here we find Aristotle's conception of time, which states that "the before and after are in change, and time is these in so far as they are countable". [20]

This conception is the fundament of his use of the word idea (ιδεα), as:

- the shape of perception of elementary things of the sensible world, perception which is directed to an intentional object,
- the product of the abstraction process that offers an account of the content of mental states in order to guarantee a correspondance between the content of one's mental state and the objects from which it arises.

The spirit by its aesthetic work modifies the "real-symbol" context which, following the natural rules, in its turn modifies the spirit within a sequential process. In its essence an aesthetic event is the expression of the movement. It is implicated in the transcendental movement of the conscience. It represents an intentional object as much as the transcendental intention is the way of being of the conscience. Bergson in his work Essay on the Immediate of Consciousness considers this way as the intimate experience of time. The aesthetic work is the final product of the transcendental movement of conscience. Bergson has compared the temporary unity of conscience with a musical structure where each pitch is depending on the previous pitch and determines, in its turn, the future pitch. The result is that the real-life (factual experience) becomes an intimate interior melody, the source of the aesthetic event[21].

IV. Mathematical Approach of Temporal Evolution of The Aesthetic Process

Now let us suppose a system where the constituent elements "p_i" are bound by the relations "R_i", forming a couple (p_i, R_i) and an another couple with the same elements "p_i" but other relations "R_i", (p_i, R_i). If the behavior of the couple (p_i, R_i) is different from that of

[17] P. Eykhoff, *System Identification*, John Wiley Sons, London-New York, 1982.

[18] P. Jacob, *What Minds Can Do ? Intentionality in a Non-Intentional World*, Cambridge University Press, Cambridge, 1996.

[19] According to Plato, things exist only if their *nature* is necessary and intelligible. The physical being does not really exist because it does not remain identical in two succesive moments. To eliminate this ambiguity, Plato has developed the *Idea* concept. He defines Idea as the eternal essence and unitary intelligible of the sensible things which are temporary accidents. On this concept of *Idea*, he has built an existential system in which the ideas are essential descriptive principles. This is the platonian's essence of the reality.

[20] Aristotle, *Physics*, IV, 223 a 28.

[21] S. Gallagher, *How the Body shapes the Mind*, Oxford University Press, 2005.

the couple (p_i, R_i), the components of the system are in interaction, otherwise these components operate independently. According to its state, a process can be stable, unstable, in evolution, or explosive. It is stable if in a presence of an external perturbation the system remains in equilibrium i.e. unchanged. It is unstable if the system loses its equilibrium. The system evolves if adaptation is possible; on the contrary case it is explosive. An aesthetic process, according to the evolution of the character of the state parameters (f_{e1}, f_{e2}, f_{e3}…….f_{en}), (f_{i1}, f_{i2}, f_{i3}…….f_{in}) can be in one of the states enumerated above. The system, under the action of external perturbation "P", changes its state from the state "S1" to the state "S2" which can be reached either quickly or after a significant delay "T" (Fig. 5).

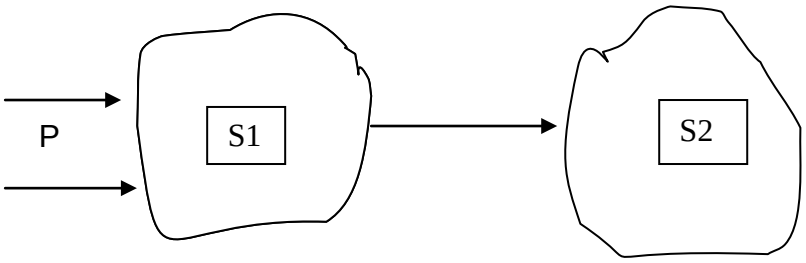

Fig. 5 : Theoretical model of change from state S1 to state S2

The speed of the passage from the state S1 to the state S2 depends of the nature and of the source of the transformations within the intentional aesthetic process (fig.6). In the case a) the time of this passage is virtually zero, but in the case b) this time has a significant value.

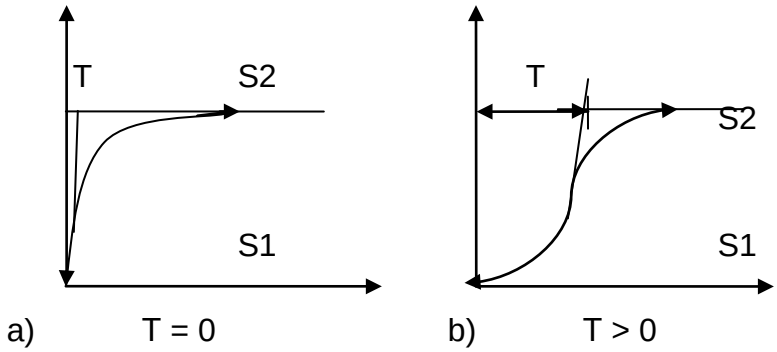

Fig. 6 : The diagram of the passage from the state S1 to the state S2

The temporal evolution of the aesthetic process from the state S1 to the state S2 can be described by a set of simultaneous differential equations. If we suppose that "Q"$_i$ (i = 1, 2, 3…….n) is a measure of the element p_i, the evolution of process is described by a mathematical model where the functions ϕ*1*, ϕ*2*, ϕ*3*…..……ϕn describe the dependence relations between the measures Q_1, Q_2……Q_n. Thus we can write the set of differential equations:

$$\frac{dQ1}{dt} = \varphi 1(Q_2, Q_3, \ldots\ldots\ldots\ldots Q_n)$$

$$\frac{dQ2}{dt} = \varphi 2(Q_1, Q_3, \ldots\ldots\ldots\ldots Q_n)$$

$$\frac{dQ3}{dt} = \varphi 3(Q_1, Q_2, \ldots\ldots\ldots\ldots Q_n)$$

……..

$$\frac{dQi}{dt} = \varphi i(Q_1, Q_2, \ldots\ldots\ldots\ldots Q_n)$$

……..

$$\frac{dQn}{dt} = \varphi n(Q_1, Q_2, \ldots\ldots\ldots\ldots Q_{n-1})$$

In the interactive system the variation of one of the measures "Q"$_i$ depends on all others "Q"$_i$. The set of equations written above is the simplest mathematical model, but if we want to take into consideration the spatial and temporal conditions, the set of equations will be a set of partial derivative equations. Finally, for a more precision the set of equations becomes a set of integral-differential equations. Even so, with the set of equations above described, one can find the stationary states of the process. To find the stationary state it must cancel the derivative values "dQi/dt", in other words ϕ1 = ϕ2 =…..= ϕn = 0. We obtain a set of classical equations with the roots Q_1*, Q_2*…….Qn* that are

the values of the stationary state. Depending on these values, there are several stationary states: some of them are stable, others are unstable. The process can have in time several kinds of evolutions: 1. - an asymptotical evolution to the stable stationary state, 2. - a periodical oscillation around a stationary state, 3. - a process never reaching the stationary state.

In the case when the process tends to a stable state the variations of the measure "Q_i" can be expressed in function of the distance to the value of the stable state. Here we find the concept of finality. There are two types of finality: static finality when the process is useful for a certain goal that is always the same and dynamic finality that signifies a predetermined orientation of the process. There are several kinds of dynamic finality. In one of them the final aim is to realize a wanted result. It is the case of the biological process that conserves the material and energetic equilibrium of the human being; or in another case to manage of the human body's temperature, or to conserve of the osmotic pressure, and so on. Another type is the equipfinality: the same final state can be reached in different ways, starting from different initial conditions. Aesthetic process brings into relief the true finality or destination. In this case the actual behavior is determined by a foresight of the goal. It supposes that the final aim exists in the mind of the author and that it leads the present action. The true finality is characteristic of human behavior and its development depends on the evolution of the symbolic concepts. Artistic creation of the Beauty is a feature of human being behavior, but the spiritual activity that gives rise to it remains a major problem of cognitive processing and of neurosciences in general.

V. By Way of a Conclusion

To study of any aesthetic experience, as expression of movement, we must analyze the natural dynamics of the aesthetic phenomenon in its manifestation context. We think that the phenome-nological approach, by its concepts, is the best way to search the implication of aesthetic event in the transcendental movement of the conscience. Aesthetic experience is the way of being of the conscience; it is a phenomenological existential principle. For Friedrich Schiller aesthetic appreciation of beauty is the most perfect reconciliation of the sensual and rational parts of human nature.

An aesthetic work appears as a global intentional process that defines the presence and the role of the human being in the dynamics in the natural existential context. Its structure and its functional evolution are governed by the lows of the complex systems. The aesthetic phenomenon becomes a spiritual transformation point, where the contextual parameters through a sequential process build the functional relation Y = F(X, R, P). In our analysis the definition of the vectors X, Y, P and R is crucial to understand correctly the aesthetic event's dynamic description. Today this definition is currently set up by the enlargement of experimental aesthetic discipline and by mathematical approach of temporal evolution of the aesthetic process. Thus the new phenomenological vision on the aesthetic event tends to penetrate, as thinly as possible, into the details of artistic creation process. The creative pulse of the mind, the fundament of dynamics of the aesthetical work as a system, introduces the metaphysic time of nature in the sensitive reality as a movement from "the before to after which are in change and time signifies these numerical (sequential) process of the spiritual activity. It is matter of a perpetual movement of "entry in oneself" to "exit out of oneself", movement which is the fundament of the human aesthetic existence. Thus the aesthetical process becomes a real witness of the functional interdependence between Nature and Spirit and so the ineffable reality is revelead to human beings.

All these problems come from a new concept of the artwork, a concept initially determined by the artistic practice and then enriched by new mathematics, philosophy, and media conquests. In this way we remind Stravinsky's words "more the art is controlled, limited, worked, more it is free"[22]. In fact, the purpose of any aesthetic discourse is to create, in any human being, the essential ideas of the human permanence.

The aesthetic experience brings the original reality, that is Truth, into the subjective reality. The authentic aesthetic work becomes the symbol of the immanent truth, a symbol of the immutable sacredness. The ultimate aim of an aesthetic event is to clarify man's relationship to the universe, to move away the contemporary existential doubts.

[22] I. Stravinsky, *Poétique musicale*, Paris, 1952.

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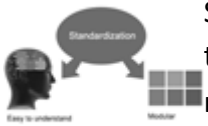

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· Present your points in sound order

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- Fundamental goal
- To the point depiction of the research
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- Center on shortening results - bound background information to a verdict or two, if completely necessary
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Approach:

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	A-B	**C-D**	**E-F**
Abstract	Clear and concise with appropriate content, Correct format. 200 words or below	Unclear summary and no specific data, Incorrect form Above 200 words	No specific data with ambiguous information Above 250 words
Introduction	Containing all background details with clear goal and appropriate details, flow specification, no grammar and spelling mistake, well organized sentence and paragraph, reference cited	Unclear and confusing data, appropriate format, grammar and spelling errors with unorganized matter	Out of place depth and content, hazy format
Methods and Procedures	Clear and to the point with well arranged paragraph, precision and accuracy of facts and figures, well organized subheads	Difficult to comprehend with embarrassed text, too much explanation but completed	Incorrect and unorganized structure with hazy meaning
Result	Well organized, Clear and specific, Correct units with precision, correct data, well structuring of paragraph, no grammar and spelling mistake	Complete and embarrassed text, difficult to comprehend	Irregular format with wrong facts and figures
Discussion	Well organized, meaningful specification, sound conclusion, logical and concise explanation, highly structured paragraph reference cited	Wordy, unclear conclusion, spurious	Conclusion is not cited, unorganized, difficult to comprehend
References	Complete and correct format, well organized	Beside the point, Incomplete	Wrong format and structuring

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