The Therapeutic Relationship
Part 1: The Helping Relationship

Almahdi Wardami Alamen,* Mutwakil Gamal Ahmed,*

Objectives:
After completing the series of articles, the reader will be able to:
- Evaluate values of clarification as a prerequisite to effective health promotion.
- Examine the elements of and process of communication.
- Analyze differences between functional and dysfunctional communication.
- Develop strategies to promote therapeutic relations with diverse populations across clinical settings, contexts, and physician roles.
- Synthesize knowledge of the therapeutic relationships as an essential component of health promotion.

Relating to patients offers many challenges and rewards for clinicians. Although some aspects of this work are predictable, each person and family is unique and provides a chance for the clinician to learn, grow, and help in new ways. The series of articles provide guidelines for developing therapeutic relationships, but these guidelines do not guarantee success or an easy job. The desire and skill of the individual clinician bring this information to life. The blend of the clinician's artistry, humanity, knowledge, skill, and ethics sparks concern and the ability to help another human being communicate effectively – essential components of the clinician-patient relationship.
The therapeutic relationship is the priority arena for health promotion. Values clarification, communication, and the helping relationship are its core components. Applying this knowledge to their varied clinician roles is essential to promoting quality care.
Rising use of technical and mounting pressures for cost-effective care are here to say. In this climate, the importance of therapeutic relationship is underscored. Without a relational con txt, the care dimension in health care is lost, and health promotion is reduced to standardized, recipe-like prescriptions. Effective health promotion directed to the needs of individuals, families, and communities requires reflection on the value of caring, effective communication, and a helping relationship.
Key terms: Communication process; empathy; feedback; health literacy; therapeutic relationship; output; reflection; self-concept; self-esteem; self-disclosure; values; clarification; tele-health; verbal; nonverbal; meta-communication.

Introduction:
"'… the interview is potentially the most powerful, sensitive instrument at the command of the physician." In these days of high-technology medicine this statement, made by George Engel in 1973, may surprise you. But the medical interview is still powerful and is likely to remain so.[1] What is it that happens between doctor and patient that can make the interview such a powerful instrument?
A patient brings to the doctor his problems usually in the form of symptoms and complaints, his anxieties about his problems and, his concerns about other aspects of his life. He also has expectations about how the doctor will deal with him as a patient. The interview between the patient and doctor is the cornerstone of the problem-solving process. The doctor's role is to gain as accurate a picture as possible of the patient's problems. This information must then be processed in such a way that will enable the doctor, ideally in collaboration with the patient, to develop a plan for managing the problem.

How this is done?
- Establish a therapeutic relationship with the patient
- Gather information (history, physical examination, & investigations)
- Make a diagnosis
- Formulate a management plan
- Explain and discuss this with the patient

*) Department of Medicine; Faculty of Medicine; University of Sebha, Sebha, Libya.

The therapeutic relationship is the milieu in which clinical care occurs. A helping or therapeutic relationship is a process through which one person promotes the development of another person by fostering the latter's maturation, adaptation, integration, openness, and ability to find meaning in the present situation.[1] The therapeutic relationship emerges from purposeful encounters characterized by effective communication. In this relationship, the clinician respects the individual's values, attends to concerns, and promotes positive change by encouraging self-expression, exploring behavior patterns and outcomes, and promoting self-help.[2] This helping relationship is created by the clinician's application of scientific knowledge, his understanding of human behavior and communication, and his commitment to the individual.

In every situation, techniques, technology, interventions, and context vary, but the relational aspect of clinical practice produces a cohesive unity, allowing each clinician to see people holistically and as unique individuals. No perfect profile or personality of a helping person exists. However, certain traits can be nurtured without thwarting the clinician's unique personality. These characteristic enable the clinician to be an agent of therapeutic care.[3]

Characteristics of therapeutic relationship:
No recipe is available for a successful therapeutic relationship. Techniques and concepts serve only as tools. As a clinician develops and evaluates a helping relationship, the following guidelines may be useful.
Characteristics associated with therapeutic effectiveness:
1. Self-awareness and self-reflection
2. Openness
3. Self-confidence and strength
4. Genuineness
5. Concern for the individual
6. Respect for the individual
7. Knowledge
8. Ability to empathize
9. Sensitivity
10. Acceptance
11. Creativity
12. Ability to focus and confront

Purposeful communication:
Purposeful communication means that the clinician focuses communication for a particular aim. Social chitchat, communication without a goal, should not make up the bulk of therapeutic without a goal, should not make up the bulk of therapeutic interaction. This does not mean that the clinician should never discuss a social topic; nonetheless, there should be some purpose. For example, discussing the weather with a somewhat disorientated elderly individual serves the purpose of orienting that person to the environment. Goals guide the clinician in focusing communication.[5-7]

Rapport:
Rapport is a harmony and an affinity between people in a relationship. The clinician is responsible for establishing an atmosphere in which rapport can develop, by using many of the traits listing for a helping person. To let the person know that his concerns interest the clinician and that working together may alleviate some of his difficulties and encourage growth, it is important to be genuine, open, and concerned.

Trust:
Trust is a necessary component of any helping relationship. Trust is the reliance on a person to carry out responsibilities and promises, based on a sense of safety, honesty, and reliability. Trust is an important of partnership.[7-13] The clinician promotes trust by modeling and structuring the relationship appropriately. Strategies that promote trust include:
1. Trusting the individual to do as promised
2. Clearly defining the relationship parameters and expectations, particularly the purpose and specifics of time, place, and anticipated behavior
3. Being consistent
4. Examining behaviors that interfere with trust

Empathy:
Empathy is the ability to understand another's feelings without losing personal identity and perspective. Empathic clinicians draw on emotions and experiences that enable them to place themselves in the other person's sense that the clinician is understanding and accepting increases, the individual's distress decreases.[14-16] Outcome from research studies are building knowledge about the role that empathic clinical care plays in outcomes. During a phenomenological study to explore the experience of being nurtured while depressed, interviews with hospitalized

participants revealed the importance of nursing presence that included spending time listening and assisting participants to discuss problems, fears, and anxieties. Furthermore, participants described their disappointment when nurses distanced themselves by attending only to physical needs and by limiting contact.[17]
Clinicians can learn behavioral approaches that enhance empathic relations with people through supervised experiential learning. They have to use their clinical and personal experience to appreciate the individual's feelings and experiences. Using personal understanding while maintaining boundaries, is the essence of empathy in the helping relationship. With empathic understanding, the clinician acknowledges the affective domain of personal experiences and uses this knowledge to appreciate the person's reactions. Empathy enables the listener to share human experiences as the basis for providing care.

Goal Direction:
A helping relationship is special in its goal-directed nature. Although most human relationships focus on mutual benefit, a helping relationship exists solely to meet some need or to promote the growth of the recipient. Although the clinician may benefit from the interaction, the relationship is centered on the recipient.
Goals are formulated as desired individual behaviors. Short-term goals are likely to be achieved within 10 days to 2 weeks; all other goals are long term. All goals should be stated in measurable terms and should focus on a positive change or on the decrease of problematic behavior. Ideally, a person works with the clinician to establish goals. However, some individuals, such as those who are seriously ill, depressed, psychotic, or cognitively impaired, are unable to establish goals. When an individual is unable to negotiate appropriate goals, the clinician establishes realistic goals and shares them with the person, who is free to participate or to reject efforts to reach these goals.[18]

Ethics in communicating and relating:
Ethical decision making is closely linked with the goal directed nature of helping relationships. Ethical issues are present in human interactions whenever behavior may affect others, whenever actions involve conscious choices of methods and ends, and whenever actions can be evaluated in reference to standards of right and wrong.[19,20]

Guidelines for ethical interpersonal communication consist of:
1. Being aware and open to changing concepts of self and others
2. Attending to role responsibilities, individual sacrifice, when it is required to make a "good" decision, and emotions, when guarding against letting emotions be the sole guide of our behavior
3. Sharing personal views candidly and clearly
4. Communicating information accurately, with minimal loss or distortion of intended meaning
5. Communicating verbal and nonverbal messages with congruent meanings
6. Sharing responsibility for the consequences among communicators
7. Recognizing the multicultural context of all communication
8. Respecting the dignity of every person
9. Avoiding coercion and use of power in communicating
10. Being sensitive to gender and cultural contexts of communication and interpretation
11. Eliminating any elements of your communication that designate, stereotype, or devaluate.

Unethical communication involves:
1. Purposefully deceiving
2. Intentionally blocking communication, for example changing subjects when the other person has not finished communicating, cutting a person off, or distracting others from the subject under discussion
3. Scapegoating or unnecessary condemning others
4. Lying or deceiving that causes intentional or unintentional harm
5. Verbally "hitting below the belt" by taking advantage of another's vulnerability

Frequently the clinician may wish to set goals that the individual does not want to reach; the clinician must remember that the problem belongs to the person, as does the choice of care alternatives. The clinician assists the individual to in decision making, with the decision based on the individual's value system. However, the clinician should not take a laissez-faire approach and avoid assisting the person. The clinician's responsibility is to help the individual to examine values, identify conflicts, and prioritize goals and desired health care outcomes. Action follows from

understanding values and the best available information. Both the individual and the clinician must bring interpreted facts and personally clarified values to the interaction to establish goals. Recognizing this interplay, the clinician must clarify personal values, subsequently respect the individual's rights, and act to support and protect the integrity of the person and the family.

Therapeutic techniques:
Occasionally, clinicians who are novices in establishing helping relationships assume that they are bound to "say the wrong thing" and cause terrible damage to the person, or that they will learn some magical phrases and questions to create instant rapport. No clinician is so powerful that a "wrong word" will destroy the individual's elf-concept or self-esteem. Even people with physical and emotional problems are resilient and have coped, at least to some degree, with a lifetime of stresses. Alternatively, no magical saying exists that the clinician can always plug into an interaction to communicate successfully. Although some techniques often are useful, they must be applied with purpose, kill, and attention to the individuality of each person and to the context of the interaction. The following technique should be viewed as guidelines, rather than prescriptions, for effective shaping of the therapeutic relationship.

Focus on the Individual
The first step to therapeutic communication is focusing on the individual and why the interaction is occurring. The clinician is not the focus; the person is. Although an overly businesslike style fails to communicate concern and support, delving into one's own personal life to the extent that it diverts attention from the other person's concern is also problematic. Avoiding clinician-directed conversation can be difficult; a useful rule of thumb is to answer or respond to obvious questions and to switch the focus back to clinical concerns when other questions are asked.

Keeping focus on the person's concerns includes identifying the portion of the message that is clear and relevant to the purpose of the interaction, seeking validation, and helping the individual to clarify the rest of the message.[2]

Help to Describe and Clarify Content
Too often the clinician rushes to offer an interpretation of the nature of the problem and quickly follows up by suggesting a solution. Solving problems efficiently makes the clinician feel effective, important, and powerful; however, the person's needs may not be met. A crucial step in using the therapeutic relationship effectively is to assist the individual to describe a particular experience or concern. Description is enhanced when the clinician prompts the person to clarify the description and interpret its meaning.

Use of who, what, where, and when questions helps to clarify and expand the content and meaning of what is communicated. Phrases such as "tell me," "go on," "describe to me," "explain it to me," and "give me an example," also are likely to elicit description of important content and to diminish distracting generalizations and abstractions. By seeking feedback, the clinician helps the individual to explain the meaning further. In clarifying, the clinician should avoid threatening, detective-like questions. Questions that begin with "why" often increase the person's anxiety because they demand reasons, conclusions, analysis, or causes. Reforming questions to obtain data first and then helping the patient to analyze links among events, thoughts, feelings, actions, and outcomes is generally a more helpful approach.[1]

Reflection:
Reflection is the restatement of what the individual has said in the same or different words. This technique can involve paraphrasing or summarizing the person's main point to indicate interest and focus the discussion. Effective use of this approach does not include frequent, parrot-like repetition of the individual's statements. Instead, reflection is the selective paraphrasing or literal repetition of the person's words to underscore the importance of what has been said, to summarize a main concern or theme, or to elicit elaborated information.[2-3]

Constructive Confrontation:
Confronting an individual means that the clinician points out a specific behavior and then helps the person to examine meaning or consequences of the behavior. This type of confrontation is not an angry exchange, but a

Nouns and Pronouns:
Some individuals have difficulty separating themselves from others or specifying the object or subject in their language. These individuals misuse pronouns by referring to we, us, they, she, he, him, and her, without clearly identifying the referent, and by making vague statements such as ‘’they don’t like me. They told me I was useless.’’ Others may use general nouns, such as everyone, people, doctors, and nurses, to avoid clear communication about specific persons. The clinician can clarify by asking, “Who are they?” or “To whom are you referring?” Additionally, the clinician must be careful to use separate pronouns when speaking of himself and the individual, particularly when the patient has disordered thinking. For example, when communicating with an individual who is confused or exhibits disordered thinking, the clinician should say you and I, rather than us or we, to promote clear thinking and communication and to assist the individual to maintain personal boundaries.[1,22]

Silence:
Allowing a thoughtful silence at intervals helps the individual to talk at his own pace without pressure to perform for the clinician. Silence also permits time for reflection. Particularly helpful to the depressed or physically ill person, silence can reduce pressure and conserve energy. After several moments, the clinician can ask the person to share some thoughts. For example, “Try putting your thoughts into words,” “Tell me what are thinking or feeling now,” or “I will be here when you feel ready to talk.”[22-24]

Accept Communication:
Acceptance of the person’s mode of communication is an important ingredient in a helping relationship. Allowing the person to communicate verbally and non-verbally in a personal fashion promotes feelings of safety and respect. Nevertheless, acceptance of communication does not mean that the clinician always agrees with the individual or tolerates inappropriate behavior within the established limits of the setting, such as verbal or physical abuse. Rather, accepting communication involves effective use of patient-centered communication.[22-26]

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