Therapeutic Relationship

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Introduction

- **The doctor–client relationship is the foundation on which psychiatry is established.**
- **It is a relationship in which both participants must recognize each other as unique and important human beings.**
- **It is also a relationship in which mutual learning occurs.**
- ***Interpersonal communication techniques*** **(both verbal and nonverbal) are the "tools" of psychosocial intervention.**

Interpersonal skills

- Effective interpersonal skills include:

1. Listening and non-verbal communication
2. Paraphrasing
3. Summarizing
4. Questioning

1. Listening and non-verbal communication

- **Listening** is the most important skill and often the most challenging.
- The best and the most therapeutic thing to do are to say less and listen more.
- Listening to a client does not mean that you are doing nothing; instead, you are allowing a space for the person to talk.

Listening helps clients to:

- Feel cared about and accepted
- Feel significant and respected
- Feel heard and understood
- Connect with other people
- Establish a sense of trust with helper(s)

Continue…

- Feel less isolated and alone
- Make sense of their current situations and/or past experiences
- Ask for help
- Give feedback about their care
- Express emotions and release tensions
- Participate in their care planning.

Non-verbal behaviors include:

- **Facial expression:** Showing it in your face, for example facial expression, looking interested and concerned; maintaining good eye contact
- **Body movements:** Showing it in your body movements, for example nodding of head, leaning forward

2. Paraphrasing

- **Paraphrasing** involves expressing the person's core message in your own words.
- When using paraphrasing, essentially the meaning is not changed but the words are different. Paraphrasing is a valuable tool in that it demonstrates to the client that the psychiatrist is listening and has heard what s/he has said, which can feel very supportive and therefore therapeutic.
- Paraphrasing can also be used to check clarity and understanding rather than using questions

3. Summarizing

- This skill involves offering the client a summary of the information that s/he has given.
- Summarizing can be a very useful intervention, particularly if the person in distress has given you a lot of information.
- For the client, hearing a summary of what s/he has said can help to clarify and reassure them that the doctor has heard correctly. It also gives the client the opportunity to correct any misunderstandings, elaborate further as well as hear the main points of their story.

4. Questioning

- The most useful forms of questions are open ended and begin with ‘when’, ‘what’, ‘how’, ‘who’ or ‘where’.

- Asking an open-ended question invites a full descriptive response. For example, if you were exploring a person’s experience of hearing voices, you might use some of the following open questions.

Examples of open questions

- When did you first hear the voices?
- How many voices do you hear?
- What do the voices say to you?
- When are the voices loudest?
- Who knows that you hear voices?
- How do you feel, when the voices say . . . ?
- What were you doing when the voices became louder?
- What helps you to cope with the voices?

Unhelpful questions

1. Closed questions

Unhelpful questions include the closed questions, These are questions that limit the other person's options and often only give the option of a 'yes' or 'no' response, for example:

- Did you take your medication?
- Have you seen the doctor?
- Do you hear voices?
- Did you go to the hospital?
- Do you like your parents?

Unhelpful questions continue

2. Leading questions

- As the name suggests, these questions involve imposing your own perspective or being suggestive, for example ‘I don’t think you are very happy with your husband?’ rather than, ‘How do you feel towards your husband?’

Unhelpful questions continue

3. Multiple questions

- These involve asking two or more questions at once, for example ‘What did the doctor say when you told him about your panic attacks; did he suggest reviewing your medication and did he refer you to the anxiety management group?’
- It is not surprising that this can be confusing and unhelpful for the client. In addition, when the client answers, the psychiatrist will not know which question the client has answered.

Unhelpful questions continue

4. The 'why' question

The 'why' question tends to invite an answer rather than a description or an exploration

- *Examples*:

1. Why didn't you take your medication?

1. What stopped you from taking your medication?

2. Why did you take an overdose?

2. What made you take an overdose?

Why questions continue

3. Why did you discharge yourself from hospital?

3. What happened that led you to discharge yourself?

4. Why do you get anxious?

5. What do you think causes you to feel anxious?

6. Why did you say that?

5. What made you say that?

The Therapeutic doctor Client Relationship

- **Therapeutic Relationship :An interaction between two people (usually a caregiver and a care receiver) in which input from both participants contributes to a climate of healing, growth promotion, and/or illness prevention.**

The Therapeutic doctor Client Relationship

- **Therapeutic relationships are goal oriented. Ideally, the doctor and client decide together what the goal of the relationship will be.**

- **Most often the goal is directed at learning and growth promotion in an effort to bring about some type of change in the client's life.**

- **In general, the goal of a therapeutic relationship may be based on a problem-solving model.**

Conditions essential to the development of a therapeutic relationship

- **Several characteristics that enhance the achievement of a therapeutic relationship have been identified.**
- **These concepts are highly significant to the use of self as the therapeutic tool in interpersonal relationship development.**
  - **Rapport**
  - **Trust**
  - **Respect**
  - **Genuineness**
  - **Empathy**

Rapport

- **Rapport implies special feelings on the part of both the client and the doctor based on acceptance, warmth, friendliness, common interest, a sense of trust, and a nonjudgmental attitude.**

- **Establishing rapport may be accomplished by discussing non-health-related topics.**

Trust

- **Trust is the initial developmental task described by Erikson.**

- **If the task has not been achieved, this component of relationship development becomes more difficult. (That is not to say that trust cannot be established, but only that additional time and patience may be required on the part of the doctor).**

Respect

- **To show respect is to believe in the dignity and worth of an individual regardless of his or her unacceptable behavior.**

- **The attitude is nonjudgmental, and the respect is unconditional in that it does not depend on the behavior of the client to meet certain standards.**

Respect

- **Many psychiatric clients have very little self-respect because, as a result of their behavior, they have been rejected by others in the past.**
- **The doctor can convey an attitude of respect by:**
  - **Calling the client by name (and title, if the patient prefers)**
  - **Spending time with the client**
  - **Allowing for sufficient time to answer the client's questions and concerns**
  - **Promoting an atmosphere of privacy during therapeutic interactions with the client, or when the client may be undergoing physical examination or therapy**

Respect

- **The doctor can convey an attitude of respect by:**
  - **Always being open and honest with the client, even when the truth may be difficult to discuss.**
  - **Taking the client's ideas, preferences, and opinions into consideration when planning care.**
  - **Striving to understand the motivation behind the client's behavior, regardless of how unacceptable it may seem**

Genuineness

- **The concept of genuineness refers to the doctor's ability to be open, honest, and, "real" in interactions with the client.**

- **To be "real" is to be aware of what one is experiencing internally and to allow the quality of this inner experiencing to be visible in the therapeutic relationship.**

Genuineness

- **When one is genuine, there is congruence between what is felt and what is being expressed.**

- **The doctor who possesses the quality of genuineness responds to the client with truth and honesty, rather than with responses he or she may consider more "professional" or ones that merely reflect the "psychiatrist role."**

Empathy

- **Empathy is a process wherein an individual is able to see beyond outward behavior and sense accurately another's inner experience at a given point in time.**

- **With empathy, the doctor can accurately perceive and understand the meaning and relevance of the client's thoughts and feelings.**

- **The doctor must also be able to communicate this perception to the client.**

Empathy

- **This is done by attempting to translate words and behaviors into feelings.**
- **It is not uncommon for the concept of empathy to be confused with that of sympathy.**
- **The major difference is that with empathy the doctor "accurately perceives or understands" what the client is feeling and encourages the client to explore these feelings.**

Empathy

- **With sympathy the doctor actually "shares" what the client is feeling, and experiences a need to alleviate distress.**
- **Empathy is considered to be one of the most important characteristics of a therapeutic relationship.**
- **Accurate empathetic perceptions on the part of the doctor assist the client to identify feelings that may have been suppressed or denied.**

Phases of a Therapeutic doctor Client Relationship

- **The therapeutic interpersonal relationship is the means by which the psychiatric process is implemented.**
- **Through the relationship, problems are identified, and resolution is sought. Tasks of the relationship have been categorized into four phases:**

1. **Pre -interaction phase**
2. **Orientation (introductory) phase**
3. **Working phase**
4. **Termination phase**

The Pre-interaction Phase

- **The pre-interaction phase involves preparation for the first encounter with the client.**
- **It begins before the doctors first contact with the patient.**
- **A common first reaction is a feeling of panic from the patient; the most important tools are the ability to communicate.**
- **A common fear of doctors is related to the stereotype of psychiatric patient as a violent.**

The Pre-interaction Phase

- **Tasks include:**
- **Examining one's feelings, fears, and anxieties about working with a particular client.**

- **Obtaining available information about the client from his or her chart, significant others, or other health team members. From this information, the initial assessment is begun. This initial information may also allow the doctor to become aware of personal responses to knowledge about the client.**

- **doctors review general goal of therapeutic relationship and consider what they have to offer patient.**

The Orientation (introductory) Phase

- **During the orientation phase, the doctor and client become Familiar.**
- **Tasks include:**
  - **Creating an environment for the establishment of trust and rapport.**
  - **Establishing a contract for intervention that details the expectations and responsibilities of both the doctor and client (e.g. exchange name, purpose of the relationship, where will meet, how often and how long will the meeting be, confidentiality to be discussed).**
  - **Gathering assessment information to build a strong client database.**

The Orientation (introductory) Phase

- **Tasks include:**
  - **Identifying the client's strengths and limitations**
  - **Formulating psychiatric diagnoses.**
  - **Setting goals that are mutually agreeable to the doctor and client.**
  - **Developing a plan of action that is realistic for meeting the established goals.**
  - **Exploring feelings of both the client and doctor in terms of the introductory phase.**
- **Introductions often are uncomfortable, and the participants may experience some anxiety until a degree of rapport has been established. Interactions may remain on a superficial level until anxiety subsides. Several interactions may be required to fulfill the tasks associated with this phase.**

The Working Phase

- **Most of the therapeutic work of the relationship is accomplished during this phase.**
- **As the relationship develops, the patient being to feel close to the doctor, and attempt to move forward.**
- **The doctor help the patient to master anxiety, increase independence and self responsibility, and develop constructive coping mechanisms.**

The Working Phase

- **Tasks include:**
  - **Maintaining the trust and rapport that was established during the orientation phase**
  - **Promoting the client's insight and perception of reality**
  - **Problem-solving using.**
  - **Overcoming resistance behaviors on the part of the client as the level of anxiety rises in response to discussion of painful issues**
  - **Continuously evaluating progress toward goal attainment**

The Termination Phase

- **Termination of the relationship may occur for a variety of reasons: the mutually agreed-on goals may have been reached; the client may be discharged from the hospital; or, in the case of a student doctor it may be the end of a clinical rotation.**

- **Termination can be a difficult phase for both the client and doctor The main task involves bringing a therapeutic conclusion to the relationship.**

- **prepare the patient for termination by decreasing the number of visits, incorporating others into the meeting or changing the location of the meeting.**

The Termination Phase

- **This occurs when:**
- **Progress has been made toward attainment of mutually set goals.**
- **A plan for continuing care or for assistance during stressful life experiences is mutually established by the doctor and client.**
- **Feelings about termination of the relationship are recognized and explored Both the doctor and the client may experience feelings of sadness and loss.**

The Termination Phase

- Reaction to termination. Patient may react to
  - termination in a variety of ways:

- He/she may deny the separation, and impending separation perhaps causing the inexperienced doctor to feel rejection by the patient.

- Patient may express anger and hostility.

- Patient may view a termination as personal rejection and reinforce negative self concept.

- It is also common to see the patient regresses to an
  - early behavior pattern.

Boundaries In The doctor–Client Relationship

- **Material boundaries are physical property that can be seen, such as fences that border land.**

- **Social boundaries are established within a culture and define how individuals are expected to behave in social situations**

Boundaries in the doctor–Client Relationship

- **Personal boundaries are those that individuals define for themselves. They include physical distance boundaries, or just how close individuals will allow others to invade their physical space; and emotional boundaries, or how much individuals choose to disclose of their most private and intimate selves to others. (Changing the subject /topic).**

- **Professional boundaries limit and outline expectations for appropriate professional relationships with clients.**

Thank you