CLINICAL REVIEW

Therapeutic Aspects of the Clinical Encounter

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THE MODERN ERA in medicine has brought a turning away from a quality of doctor-patient interactions that had persisted over centuries. When there were few efficacious remedies, doctors relied upon the healing power of the doctor-patient relationship. Hippocrates observed, "The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician."[1] More recently, Balint reaffirmed the importance of doctor-patient interaction, asserting that by far the most frequently used drug in medical practice is the doctor himself.[2]

With its potential impact on patient outcomes, it would seem that the doctor-patient relationship should be taken seriously in its own right. Yet, with modern diagnostic and therapeutic techniques, the healing potential of this relationship has been de-emphasized, as if it were a relic of an unscientific past. There are other reasons for the de-emphasis of the importance of the doctor-patient relationship. Engel argues that the biomedical model, the basis for practice of Western medicine, limits our thinking about the causes and cures of disease to biological, quantifiable variables.[3] Almy points out that present fee schedules offer physicians excessively strong incentives to furnish technical services and discourage performance as the patient's advisor, counselor, and health advocate.[4] Jenson has identified the "dehumanizing process of medical education" as discouraging physicians from awareness of their own and their patients' needs.[5] Medical students for the most part learn patient care in tertiary care institutions, where the healing effects of their relationships with patients are less evident. Though some progress has been made, there are many deficiencies in the teaching of doctor-patient communication in medical schools and residency programs.[6]

Physicians use their relationships with patients to enhance therapy. Few pause, though, to identify the therapeutic elements of their patient encounters, explaining their effectiveness by their use of the "art of medicine." Yet if using the healing power of the doctor-patient relationship is an art, physicians could become more skillful artists: By identifying the therapeutic elements of their clinical encounters, they might use them more consistently and appropriately. Also, in teaching medical students and residents it is useful to have a conceptual framework and an organized approach. Much of what is therapeutic about doctor-patient interactions has been identified, but in a diverse literature. In this report I review this literature, discuss therapeutic aspects of clinical encounters, and present strategies relevant to practicing physicians.

UNDERSTANDING THE THERAPEUTIC EFFICACY OF THE PHYSICIAN-PATIENT RELATIONSHIP

Several concepts are central to understanding the therapeutic efficacy of the physician-patient relationship: the essential unity of mind and body, the importance of symbols and the manipulation of their meaning, transference in the physician-patient relationship, and the definitions of and relationships between disease and illness.

Though for historical and scientific reasons it has been useful to separate the concepts of mind and body, the many advances of psychosomatic research have demonstrated their essential unity. One way to understand this unity is to reflect that thought, feelings, and abstract reasoning are also neurobiologic processes. While you are reading this, neurochemical processes are being stimulated in your brain. Basic changes in messenger RNA and neurotransmitter metabolism are occurring as new information is being processed. If your feelings are aroused, neuroendocrine mechanisms are affecting other bodily processes. All of which can, in turn, affect your behavior. Engel and Weiner elegantly summarize research that demonstrates the unity of mind and body.[7,8]

A second central concept is the notion of the importance of symbols and the manipulation of their meaning in therapy. Our lives depend on symbols. We communicate through the symbols of language. Our self-concepts, attitudes, and assumptions about the world are encoded in symbols such as parent, family, doctor, and country. Healers often depend on manipulation of the meaning of symbols. A change in the symbolic meaning of a diagnosis may restore hope and hasten physical recovery. If, for example, a patient feels that the diagnosis of cancer

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means a death sentence, he is likely to become depressed, eat poorly, and become less motivated to cooperate with treatment. If the physician, through his or her manner, words of encouragement, and giving of new information, changes the symbolic meaning of the diagnosis, the patient may regain hope, feel better, and become more compliant.

A third central concept is the notion of transference phenomena in physician–patient relationships. That is, patients may project onto their physicians conscious and unconscious expectations, determined by their life experiences. Especially when illness heightens needs for reassurance and understanding, patients may act as though their physicians were parental figures. Physicians can be empowered, and their interventions made more effective, by their awareness and use of patients' positive transference.[9]

A fourth central concept is the notion of the differences and relationships between disease and illness. Disease and illness are, respectively, objective and subjective phenomena. Disease can be identified by a laboratory test or a microscopic examination. Illness is a sense of dis-ease, a sense of distress, related to a patient's perceptions and feelings. There can be disease without illness (e.g., hypertension), and illness without disease (e.g., hypochondria). Many patients have a disease, and a sense of illness determined not only by the severity of the disease, but also by a host of psychological and social factors.[10] For the most part, patients come to physicians seeking relief from illness. In contradistinction to curing disease, which may be accomplished with a scalpel or a drug, to heal illness the physician must often attend to psychosocial issues.

If psychosocial factors weigh heavily in illness, and physicians' communication can help alter them for the better, there is great opportunity for physicians to heal illness: One third to half of cases in general medical practice have a significant emotional or behavioral component.[11] In this country generalists see the majority of patients with psychiatric diagnoses, most of whom seek treatment because of somatic symptoms.[12] These studies suggest that for physicians to be maximally effective they need to be equally skilled in the treatment and cure of disease, and in the healing of illness.

A key therapeutic process by which physicians' communication can effect healing of illness is the reduction of patient anxiety and depression. Significant levels of anxiety and depression are found in as many as 35% of patients visiting clinicians for physical complaints.[13] It is well known that anxiety and depression have a number of deleterious effects. At a biologic level, the neural and neuroendocrine factors associated with anxiety can increase blood sugar in the diabetic, increase gastric acid in the patient with an ulcer, or increase cardiac work and tip the compromised heart into congestive failure or a fatal arrhythmia.[8] Grief and depression are associated with depressed immune function, which could predispose to infection or neoplasia.[14] At a psychologic level, the somatic symptoms of anxiety and depression (e.g., tremor, palpitations, loss of appetite, impotence) may prolong illness and confuse assessment of recovery. Depression is associated with self-defeating thoughts and negative cognitions (e.g., "I'm no good, I'll never get better") that may diminish patients' compliance. At a social level, these affects may undermine relationships with physicians, family, and friends, increasing patients' isolation and sense of illness. Thus, to the extent that their interventions relieve anxiety and depression, physicians reduce the negative influences of these affects. With less anxiety and depression, patients begin to feel less ill, and are more amenable to the physicians' efforts in promoting positive attitudes and compliance.

FACTORS CONDUCIVE TO EFFECTIVE THERAPY

Certain factors are conducive to effective therapy, including the clinical setting and physician attitudes, knowledge, and skills.

Clinical Setting

Before patients enter a physician's examining room they have already had much contact with the physician's clinical setting. The parking facilities, waiting room, administrative procedures, and waiting times affect patients' initial impressions of the physician. The attitudes and practices of receptionists, nurses, and ancillary personnel can put patients at ease or heighten their anxieties (e.g., a recent patient of mine did not want to discuss her personal life because she had seen the receptionist leafing through another patient's chart). A busy practice setting with many interruptions can restrain communication. A setting that is comfortable, unhurried, and puts the patient at ease is conducive to effective communication and therapy.[15]

Physician Attitudes and Personal Qualities

Certain attitudes facilitate effective therapy. Accepting the importance of psychosocial factors in illness produces more scientific evaluations, since relevant psychologic and social data are included.[3] As another benefit of this approach, the physician's active concern for psychologic and social issues may convince patients of the physician's caring.

Peabody advised, " . . . the secret of the care of the patient is in caring for the patient."[16] Patients want their physicians to be warm and caring. Patients' perceptions of these qualities are related to

TABLE 1

Therapeutic Strategies

Cognitive strategies
1. Negotiation of priorities and expectations
2. Giving an explanation
3. Bringing patient to a crossroads
4. Suggestion
5. Patient education
6. Giving a prognosis
Affective strategies
1. Empathy
2. Encouragement of emotional expression
3. Encouragement
4. Offering hope
5. Touch
6. Facilitation of self-forgiveness
7. Reassurance
Behavioral strategies
1. Emphasis of patient's active role
2. Praising desired behaviors
3. Suggesting alternative behaviors
4. Attending to compliance
Social strategies
1. Use of family and social supports
2. Use of community agencies and other health care providers

their evaluations of their physicians' general competence, and their satisfaction and compliance with medical visits.[17] Rogers identified an attitude of unconditional positive regard toward patients as the most important of the necessary and sufficient conditions for therapeutic personal change.[18] This attitude implies a nonjudgmental approach, respect for a patient's individuality, and the ability to offer warmth and genuineness. Truax concluded that the abilities of clinicians to offer empathy, warmth, and genuineness were characteristic of therapeutic encounters that change patients for the better.[19] Conversely, if a physician dislikes a patient, or feels that a patient is a "crock," these attitudes are likely to be communicated and to have a detrimental effect on therapy.

Several authors have commented on the necessity for physicians to have tolerance of ambiguity, uncertainty, and stress in the clinical setting.[20] With all the uncertainty in clinical medicine, this tolerance prevents injudicious use of procedures and laboratory tests, and physician anxiety, which could undermine patient confidence.

Basic Knowledge and Skills

In addition to biotechnical knowledge and skills, the physician needs to master certain psychosocial knowledge and skills.[21] Examples of key knowledge areas are the somatiform disorders, such as psychogenic pain disorder and conversion disorder, the phenomenology and treatment of depression and anxiety, and the importance of stress and life change in the development of illness. Examples of key skills are the ability to perform an effective patient-centered interview, the ability to interpret and use nonverbal behavior, the ability of physicians to recognize and use their emotional reactions to patients as data, and skills in patient education and behavior modification techniques.

THERAPEUTIC STRATEGIES

The therapeutic process begins with the patient's decision to seek help. The physician's personal contributions to this process begin with the first interview, attentive listening possessing great therapeutic value in itself.[2] A comprehensive diagnosis guides selection of appropriate therapeutic strategies. This diagnosis involves understanding the contributions of biologic, psychosocial, and personality factors to the onset and maintenance of the illness.[22]

For people to change, they must change the way they think, feel, or behave in their social contexts. Major changes in any of these spheres change the whole person. Interventions, then, are presented in four categories: cognitive, affective, behavioral, and social (Table 1). Though they are categorized for heuristic purposes, there is great overlap in these interventions and in their effects (e.g., receiving an explanation often changes the way a person thinks, feels, and behaves). Many of these strategies and interventions have proven useful, as evidenced by their common presence in diverse healing disciplines.

Cognitive Therapeutic Strategies

A patient's thoughts, perceptions and attitudes are involved in the illness process, and can be addressed directly.

Negotiation of priorities and expectations. Lazare, Quill, and others have discussed the value of a negotiated approach to patient care.[23, 24] This approach recognizes the critical importance of eliciting and attending to the patient's perspective, which begins by asking, "How do you hope that I can help?" Physician and patient then negotiate some agreements about the nature of the patient's problems, the patient's requests and expections, and the goals, methods, and conditions of treatment. While it may seem obvious that the physician and the patient must agree on the problems to be addressed, studies show that physician–patient concordance is often low. In a study of 439 patient visits to a medical clinic, physician and patient were fully concordant in the identification of the principal problem in only 208 of cases (47%).[25] Patients often have hidden reasons for visiting doctors,[26] and physicians often do not elicit patients' chief concerns by focusing too early on chief complaints.[27] Patients report better outcomes

when there is physician–patient agreement about problems.[28] In addition to improving physician–patient concordance on a variety of therapeutic issues, the negotiated approach helps both physician and patient to share the responsibility for therapy, and prevents unrealistic patient expectations of the relationship.

Giving an explanation. All healing disciplines give explanations to patients about causes of illness.[29] Patients have intense needs for information and explanations about the causes of illness, and are dissatisfied when these are not given.[30] Confusion and uncertainty about diagnosis are noxious emotions for patients. Giving a symptom complex a name and an explanation thus has a salutary effect: patients feel comforted that the physician knows what is wrong and can thus begin appropriate therapy. For instance, I had a patient who at first was relieved to learn that he had multiple sclerosis. For years he had felt that his doctors were implying that his evanescent neurologic symptoms were not real.

When psychosocial factors are a major part of illness, an effective form of explanation is to tell the patient's story back to him in a way that makes the development of illness almost a logical progression. This demonstrates to the patient that the physician has listened and has understood, and may help the patient to make sense out of confusing feelings and impressions. In sharing an understanding of the diagnosis, the physician can briefly teach the patient how mind and body work together in the promotion of illness and health. The physician uses his or her authority as an expert to legitimize psychosocial explanations when these are appropriate.

> A 35-year-old office manager complained of five years of severe headaches refractory to all medications and a recent septoplasty. Exploration of his psychosocial history revealed that he was the son of a fundamentalist minister. He had been involved in a "shotgun wedding" when he was 19. His wife had left him soon after the birth of their daughter, whom he allowed to be adopted by his wife's parents. He went to college, remarried, moved to another town, secured good employment, and became a leader in his community and church. No one in his town knew of his past. He and his wife had a son and then a daughter. His headaches began shortly after the birth of his second daughter, and upon learning that his first daughter was having emotional problems. Recently the first daughter had begun calling him "just to talk." As he spoke of his first child, he began to cry.
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> It was explained that headaches are often the body's response to the kind of emotional conflicts he was describing. He was an accomplished individual with a strong moral sense who felt torn between his embarrassment over his past and his need to acknowledge and help his first daughter. Headaches were not surprising in his situation. For his headaches to abate, he would need to face and resolve certain issues.

It is often difficult to discuss the etiologic role of psychosocial factors with patients whose longstanding symptoms are related to emotional conflicts, and whose "secondary gains" have perpetuated symptoms in their lives. Often called "problem patients," many will have DSM III psychiatric diagnoses.[31] While rejecting a psychiatric explanation, many are willing to accept that stress is playing some role in how they are feeling, and most would agree that their anxiety and depression about their symptoms are making them feel worse. These admissions may be the opening the physician can use to begin to help these patients change their psychosocial situations. Drossman suggests useful guidelines for working with these patients.[32]

Bringing the patient to a crossroads. In some patients, denial contributes to their illnesses. The business executive who denies that he has had a heart attack and the alcoholic are examples. Sometimes symptoms of illness serve a purpose in a patient's life. In certain dysfunctional families, illness may help to maintain family equilibrium.[33] Symptoms may serve to prevent the recognition of an intrapsychic conflict (which is fantasized to be more painful than the symptoms).[34] Patients will frequently hint at or relate interpersonal or intrapsychic conflicts to physicians without recognizing their relationships to symptoms. In these instances it is often effective for physicians to confront their patients.

For example, when symptoms seem to represent an intrapsychic conflict, sometimes an effective technique is to discuss conflicts with patients, relate the conflicts to symptoms, and then let patients know that they are at a crossroads: they can begin to work on resolving the conflicts or choose to continue to have symptoms. These confrontations can initiate new relationships between the conflicts, the patients, and the illnesses. In essence, illness has been "reframed" from a biological problem to a biopsychosocial one. Reframing means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame that fits the "facts" of the same concrete situation equally well or better, and thereby changes its entire meaning.[35] The previous case, and the following case, illustrate these points:

A 37-year-old woman developed disabling angina over two years, requiring increasing antianginal medication despite a negative cardiac work-up, which included catheterization. While reviewing the onset of her symptoms, she revealed that they had started after her husband's death. An older man, he had been an invalid in his last years after a massive heart attack. Although she had been very attentive to his needs, she had begun having an affair during his last month of life, and had been out with her lover when her husband died. Until the discussion about her husband, she had not connected his illness with her own. She volunteered that her angina was easier to take than her feelings of guilt and shame. Her physician explained how these feelings can sometimes cause physical pain, and were *at least a source* of stress making her pain worse: It would be important to her recovery for her to resolve her feelings about her husband. She agreed to see the physician monthly for counseling sessions. Over the next few months her pain markedly abated.

Suggestion. Suggestion is a powerful therapeutic tool that works in part by affecting patients' expectations of therapy. Suggestion via the placebo response can induce a wide variety of physiologic effects in patients, including release of endorphins.[36] Suggestion in hypnosis can induce patients to increase their pain tolerance, control skin temperature, and block skin response to a contact allergen. Some women can even increase their breast size.[37]

In the placebo response, the physician's communication of enthusiasm and positive expectations can have great effects on a patient's illness. Placebos have proven effective in treating many illnesses, including angina pectoris, rheumatoid and degenerative arthritis, hay fever, headache, peptic ulcer, and essential hypertension. The placebo response in clinical trials is known to be about 35%. However, on historical review of nonblind or single-blind trials of angina remedies later found to be useless, Benson and McCallie found that new treatments led to symptomatic improvement in as many as 90% of patients.[38]

Physicians can use suggestion to enhance the effectiveness of any therapy. If a physician honestly communicates optimism about a therapy, it will be more effective than if it is prescribed casually. Prescriptions given with hesitation or uncertainty may have diminished effectiveness. One hypnotic technique that may be useful is to make self-reinforcing positive suggestions. That is, patients may respond to positive suggestions such as, "As you recover from this heart attack and begin to be more active, you will feel less anxious and more optimistic." Suggestions such as this can set up a positive feedback loop: Patients may respond to positive suggestions with hope and well-being. As their physical conditions improve, these positive emotions not only confirm their senses of recovery but also tend to improve confidence in the physicians whose predictions have been accurate. Positive suggestions have limited value for patients with somatoform disorders. Although there may be initial benefits, the predictable recurrence of symptoms may then undermine patient confidence.

Patient education. Patient education has proven benefits in increasing patient satisfaction and compliance, and an overall positive effect on patients' coping.[39] Information can reduce patient anxiety, enhance feelings of personal control, improve a patient's attitude toward a painful procedure, and help patients cope with pain.[40] Preoperative educational interventions increase cooperation with treatment and speed of recovery, and decrease postoperative pain and post-hospital complications.[41] In general, physicians spend little time giving information to their patients, overestimate the time they have spent, and underestimate the amount of information the patient wants to receive.[42] Explanations about illness or about tests and procedures should be given in clear language without jargon, using concrete familiar examples, frequently testing for understanding. Careful attention to patient education is important since patients forget or misunderstand so much of what physicians tell them.[39]

Patient education includes correcting misconceptions and mistaken illness attributions.[26] A common example is the belief that hypertension is hyper-tension, that is, *feeling too nervous*, and that antihypertensive medications can be discontinued when the patient is not feeling stressed. Clinical reality may be viewed quite differently by patient and doctor: explanatory models of illness, which are often culturally derived, may give rise to misconceptions that can interfere with therapy. Physicians who elicit these explanatory models can then address points of misunderstanding or disagreement.[43]

Giving a prognosis. Prognoses should be realistic so that patients do not feel deceived if they become more ill than predicted, and optimistic to engender hope. For example, in conveying the diagnosis of a malignancy, many physicians will emphasize promising new therapies, and tell of other patients with the same disease who fared well. As in learning a diagnosis, knowledge about prognosis can help patients cope with illness by reducing the dysphoria of uncertainty. If the physician can correctly predict certain feelings or physical sensations, patients may avoid misinterpreting these sensations. For example, the patient who returns from

the hospital following a heart attack may experience marked tiredness. If the physician informs the patient that this is a natural and common occurrence, the patient will not misinterpret the tiredness as symptomatic of a failing heart.[44] Patients told what to expect can prepare and adapt. Egbert and associates randomly assigned 97 patients scheuled for elective intraabdominal surgery into experimental and control groups. The experimental subjects were told about the pain they would be likely to experience and about how they could reduce the pain through special breathing exercises; the controls were not told about postoperative pain. Patients in the experimental group requested 50% fewer narcotics for pain relief, and were discharged on average 2.7 days sooner than controls.[45]

Affective Therapeutic Strategies

Anger, depression, and anxiety are not only common reactions to illness, but can also amplify illness. Physicians can diminish these negative emotions and arouse positive emotional states through a variety of interventions. Bird, Cohen-Cole, and Mance emphasize empathy, legitimization, support, partnership, and respect.[46] An alternative classification of affective strategies is the following:

Empathy. Expression of empathy is one of the most potent therapeutic interventions.[18] Empathy is sharing in another's emotions or feelings as if they are one's own. All people have a need to be understood, a need made more pressing by illness. Empathy involves accurately identifying a patient's feelings and then communicating this to the patient: "I understand how difficult it is for you to be going through this illness"; "It sounds like your Mom's illness has been a real burden to you." Empathy also involves eliciting and responding to the meaning of illness for the patient. (E.g., "I can understand your worries about this angina, especially since your brother died of a heart attack.") In addition to strengthening the bond between doctor and patient, expression of empathy can aid the diagnostic process. After experiencing physicians' empathy, patients are often encouraged to reveal their most difficult problems. Communication of empathy is a skill that can be effectively learned.[47]

Encouraging emotional expression. Many physicians, especially physicians in training, feel uncomfortable when patients cry or grow angry in their offices. However, there are good reasons for encouraging emotional expression, without feeling the need to "resolve" negative feelings. "Ventilation" of strong emotions provides immediate relief for some patients. Conversely, being unable to express emotions makes patients feel alone and creates barriers between patients and physicians. Many forms of psychotherapies and healing disciplines arouse the patient's emotions, recognizing these as the motive power for attitudinal change.[48] Emotional "catharsis" is considered crucial in some psychotherapies and in many religious and magic healing rituals.[49] In some instances, when a patient realizes that a doctor is not threatened or appalled by his or her admissions, there may be a "corrective emotional experience." The physician can encourage emotional expression by making empathic comments, by inquiring about feelings, or by commenting on nonverbal expressions of affect, e.g., "You looked sad when you mentioned your son."

Encouragement. Encouragement is supportive of patients, conveys respect, and helps give them confidence and hope. Encouragement can induce patients to think more warmly of their physicians and to be more satisfied with their visits.[50] Encouragement generally consists of praising patients' personality strengths, attitudes, or actions (e.g., "You're a bright and conscientious man, and I think you will do fine in dealing with this complicated regimen"; "I think your sensitivity to your wife's feelings is laudable, and will help her a lot during these difficult times"). Praise as a reinforcer of desired behaviors is discussed below. When there is a dearth of personality strengths, the physician may need to resort to paradox, and redefine weakness into strength. For example, one can redefine a patient's masochism into ability to cope with suffering. The physician can then encourage and praise the patient's coping abilities.

Offering hope. Physicians also encourage by offering hope. Hope is a central coping mechanism: it defends against despair, diminishes anxiety, is energizing, and can stimulate patients to undertake health-promoting activities.[51] On the other hand, hopelessness, the most noxious of emotions both psychologically and physiologically, has been linked to disease onset and sudden death.[52] Patients' hopelessness can engender pessimism in their caregivers which impedes therapy. Mobilizing hope and instilling "expectant faith" that the physician will help the patient recover is a device used by all healing disciplines.[53] Offering hope is appropriate for patients with diverse illnesses, though the manner in which it is offered varies. Most dying patients maintain some hope until the end, feeling nourished by it in difficult times, and appreciate when hope is offered despite bad news. Physicians can maintain hope in their dying patients without deception by accepting their hopes and sharing with them the hope that they may have a remission, that they will live longer than expected.[54] For patients with longstanding psychosomatic illness in whom symptoms serve an adaptive function, it is best not to raise hopes for recovery, instead asserting that they deserve, and have a good chance for, some improve-

ment. In these patients it is helpful to emphasize coping as the goal rather than curing.

Touch. Placing a hand on a shoulder while talking to a hospitalized patient, or holding a hand during a moment of reassurance, is an important therapeutic intervention. Lewis Thomas calls touching "the oldest and most effective act of doctors."[55] From infancy on touch is associated with comfort and the relief of anxiety. "Laying on of hands" is common to most healing disciplines. It is significant that some patients begin to talk about emotional issues only while the physician is examining them (Robert Lawrence, personal communication). There is probably an optimal "dose" of touching, however. Too much touching or touching too early in the relationship may be associated with decreased satisfaction and patient understanding.[56]

Facilitation of self-forgiveness. Some symptoms are related to feelings of guilt, as in the example cited earlier of the young woman with chest pain. Guilt has been linked to the symptoms of conversion disorders, pathologic grief, depression, and psychogenic pain disorder. The associated somatic symptoms are conceptualized as forms of self-punishment to expiate guilty feelings.[34] Guilt may be related to the death of someone close toward whom the patient had harbored angry feelings. Much can be accomplished by exploring these feelings in the context of the past relationship, giving support to the patient about the appropriateness of past behavior and feelings. Often by exploring a patient's feelings of guilt, and occasionally by merely listening to a patient's confessions, the physician, taking on a clerical role, can help patients forgive themselves. Listening to a patient's confession is a part of many psychotherapies, religious practices, and diverse healing ceremonies in primitive cultures, where sickness is often viewed as punishment for sins.[57]

Reassurance. Most physicians have observed the beneficial effects of reassurance in allaying patient anxiety and diminishing the patient's sense of illness. However, reassurance is a complex phenomenon.[58] It is most ineffective when given prematurely, casually, or without conviction. Reassurance is most effective when it accurately addresses the patient's concerns and personal meanings of illness. It usually cannot be given effectively until the patient senses that the physician has listened and has understood his or her problems, and has performed the necessary evaluation. There are several categories of reassurance: Physicians can reassure patients that their illnesses are not as severe or threatening as they had imagined. Physicians can help remove the sense of isolation that illness imposes by reassuring patients that they have seen and successfully treated other patients with similar illnesses. Physicians can allay specific fears. It is also reassuring to patients to be told that the physician will continue to work with them whatever the course of the illness.

Behavioral Therapeutic Strategies

One of the major contributions of behavioral therapy research has been the demonstration that accomplishing behavioral changes through successful performance leads to lasting cognitive and affective changes.[59] The emphasis of most behavioral therapies is on changing current determinants of behavior. The therapist focuses on changing environmental cues, thoughts and feelings, and consequences of behavior that make the behavior more likely.[60] Physicians can use specific behavioral approaches in treating obesity, smoking, and noncompliance. Relaxation techniques can be useful in the management of anxiety. In addition, some behavior therapy principles are applicable in general medical practice.

Emphasis of the patient's active role. Many patients take a passive attitude toward their illnesses, often feeling that the illnesses are controlling them. This contributes to demoralization and depression. On the other hand, a sense of control or mastery has been linked to improved health status. Physicians accomplish much by emphasizing that patients have some control in overcoming illness, and by encouraging an "active patient orientation." In this approach, patients are viewed as collaborators in their care: they are given information that will help them discuss diagnostic and management decisions with their physicians; skill training and technical aids are made available to assist self-care activities (e.g., home blood pressure or glucose monitoring). This approach improves satisfaction, compliance, and functional abilities.[61]

Assigning self-monitoring of behavior also encourages an active role. Asking patients to keep diaries in which they record events relevant to their problems can provide physicians and patients with valuable information about the determinants of behavior, and a useful way to monitor progress. Other strategies that encourage a patient's active role include prescribing physical activity, giving assignments such as books to be read or courses to take, and working with patients to delineate conflicts that they must actively resolve.

Praising desired behaviors. In behavior modification techniques, praise is recognized as a reinforcer of desired behaviors. When patients successfully perform suggested behaviors, praise encourages them to continue their efforts. Praise can be used in this way in "shaping" a patient's behavior: even when patients have made only small improvements in their behavior, the physician praises these improvements, and praises successive ap-

proximations of the desired behavior until it is achieved.[62] Common examples are in treating hypertension and in promoting dietary compliance in treating diabetes or hypercholesterolemia, where physicians' praise of improving numbers reinforces a patient's progress.

Suggesting alternative behaviors. Patients may react to intolerable social situations with an exacerbation of their symptoms of illness. Sometimes illness may be in large part a reaction to, or a solution to, an intolerable social situation.[10] Because they are enmeshed in the situations, patients may be unable to perceive alternative strategies for coping. There are several classes of responses to intolerable situations: changing the situation, changing one's reaction to the situation, or leaving it. It is often helpful to explore these options with patients, and to suggest alternatives the patient was unable to see.

In suggesting alternative behaviors, physicians often engage in covert modeling.[60] They suggest behaviors they feel would be appropriate were they in similar situations. Overt modeling in the form of a mini-role play is often effective (e.g., "I'll be you for a minute and you be your angry son, and I'll demonstrate one technique that might just work"). Occasionally a patient hesitates to carry out a decision he or she has made which is a viable solution to an intolerable situation. The physician's agreement with and support of a difficult decision may enable the patient to begin to do what is adaptive. A key concept is that only by carrying out feared behaviors can patients compare their dire predictions with the actual events and correct their misapprehensions. The following example is illustrative:

> A 41-year-old woman developed chronic back pain after her 15-year-old daughter was raped. Feeling that she had failed to protect her daughter, she was now enmeshed in an overprotective relationship. She felt compelled to accede to her daughter's every demand in order to be a "good mother," even though this interfered greatly with her own needs. She most feared her daughter's anger and rejection. Her physician secured her agreement that the next time her daughter made an unreasonable demand she would say, "I'm sorry, but I won't be able to help you with that," and explain why not. While her daughter was at first angry with her mother's new behavior, she soon learned to accept the new limits. This was the beginning of a gradual improvement in their relationship.

Attending to compliance. Healing is promoted when patients follow an effective therapeutic plan and take their medications as prescribed. Unfortunately, noncompliance has been found to be 20–60%, depending on the type of regimen. Physicians typically overestimate rates of compliance among their patients, and are often inaccurate in identifying noncompliant individuals.[63] At a most basic level, simply checking with patients about their compliance will tend to increase it. When physicians ask about compliance, patients are more likely to express complaints or to admit having problems conforming to the regimen.[64] Many of the strategies described in this paper may increase physician understanding of the patient, and will enhance patient satisfaction, leading to increased compliance. Other strategies for improving patient compliance have been proven effective, such as improving patients' levels of information concerning the specifics of their regimens, reinforcing essential points with review, discussion, and written instruction, and emphasizing the importance of the therapeutic plan; simplifying and reducing the cost of the regimen; suggesting behavioral prompts (e.g., notes on the refrigerator); and creating physician–patient contracts that include a written outline of behavioral expectations and specified rewards/reinforcements.[65]

Social Therapeutic Strategies

Use of family and social supports. A noxious social environment with a lack of social and community ties has been associated with an overall increase in morbidity and mortality.[66] Conversely, positive family and social supports ameliorate illness, and improve compliance.[67] An essential ingredient of many healing rituals is the active participation of family and friends, which begins the reintegration of the ill person into family and community. This reintegration helps to dispel the social isolation frequently imposed by illness. Many rituals also stress mutual service, which counteracts the patient's morbid self-preoccupation and strengthens self-esteem by demonstrating that he or she can do something for others.[68]

Families should be assessed to see whether they are potential resources. Sometimes disengagement from a dysfunctional family is effective therapy. Often, though, families and friends will be helpful. In addition to providing support and encouragement of patients, they provide valuable perspectives that can help in designing therapy. Often family members will have specific informational needs that must be met for them to participate in therapy effectively.

Use of community agencies and other health care providers. Involvement in community agencies, self-help groups such as Alcoholics Anonymous, church, and other cultural and social groups

can play a major role in a patient's recovery. It is helpful for physicians to have first-hand knowledge of the make-up/workings of the important community agencies to which they plan to refer patients (particularly such programs as A.A., Al-Anon, Overeaters Anonymous, and Cardiac Rehab Programs). Involvement of other members of the health care team, including office staff and pharmacists, increases the patient's social interaction and helps the therapeutic process. Nurses often play essential roles in monitoring compliance, implementing and clarifying health education and attitude change strategies, enlisting family support, and helping with behavior modification strategies.

COMMENT

A re-emphasis on the therapeutic potential of the doctor–patient relationship could improve quality of care and reduce current public dissatisfaction with American medical care. Many psychosocial interventions have been shown to improve patient satisfaction, compliance, functional status, and the cost-effectiveness of care. There is clearly a need to restructure reimbursement schedules to reward physicians for their time and counsel. There is clearly a need to improve teaching and evaluation of interpersonal skills and psychosocial aspects of medicine at all levels of medical education. There should be wider application of the advances in educational theory and methodology in this area, such as the definition of discrete communication skills, and the use of microcounseling, didactic videotapes, trigger tapes, standardized patients, videotape review, and new evaluation technologies. New and current faculty must be trained to teach in this area. In this regard, the SGIM Task Force on the Medical Interview offers annual faculty development courses for teachers of medical interviewing and psychosocial medicine. These courses have been considered highly successful by course participants.[69]

Some of the potentially therapeutic aspects of the clinical encounter have been described here. Others discuss biopsychosocial care and the doctor–patient relationship more comprehensively.[2, 12, 15, 17, 68] A final thought: Though there is a need for more scientific study of the therapeutic process, it must be re-emphasized that medical therapy is also an art. Each physician uniquely synthesizes biopsychosocial knowledge, skills, and attitudes, and combines this synthesis with his or her own intuition, natural empathy, and caring for patients. With an organized approach to the therapeutic aspects of the doctor–patient relqtionship, the result is medical care that is both more scientific and more humanistic. This special melding of science and art is an ideal held by many early in medical training, and often lost along the way. It is an ideal that can be achieved with attention, care, and caring.

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A more extensive bibliography is available from the author.

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