

Interpersonal Helping Skills Instruction in the Undergraduate Internship in Psychology:

Instructor’s Guide (Part 3)

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# Instructor’s Guide: General Notes

**Overall Organization**

 This instructor’s guide provides background information, teaching ideas, and resource suggestions for each of 10 interpersonal helping skills. Handouts for students (one per skill) are provided in Part 2 of this resource. All skills are numbered, with handout numbers matching the section numbers presented here.

**Time Allotment**

This instructor’s guide assumes coverage of a maximum of one skill per week. In my own internship course, which meets 3.5 hours per week, I allocate time as follows: up to one hour for “group check-in,” during which students share and respond to one another about internship experiences; one hour for writing assignment and oral presentation instruction and workshop time (as a senior capstone in my department, students are required to complete several formal writing assignments); and the remaining time, approximately 1.5 hours weekly, in helping skills instruction and practice. After the midsemester point, I spend less time on check-ins, because students are generally well-acclimated to their internships, and focus relatively more time on helping skills.

**Supplemental Resources**

I highly recommend purchasing at least one of the many excellent counseling skills textbooks on the market. Because these texts are primarily aimed at graduate students, I find them more comprehensive and counseling-specific than seems appropriate for undergraduate psychology majors. Consequently, I do not assign readings from them to my students, but they do provide useful background information for instructors. My favorites include:

Egan, G. (2014). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Belmont, CA: Brooks/Cole.

Hill, C. E. (2014). *Helping skills: Facilitating exploration, insight, and action* (4th ed.). Washington, DC: American Psychological Association.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (8th ed.). Belmont, CA: Brooks/Cole.

Young, M. E. (2012). *Learning the art of helping: Building blocks and techniques* (5th ed.). Upper Saddle River, NJ: Pearson.

Wherever possible, I incorporate brief (5-10 min) video demonstrations of helping skills as a model for students. However, commercially available training films, such as the American Psychological Association’s (APA) psychotherapy video series, are more suitable for graduate student audiences (and expensive). In addition, a reliance on psychotherapy-focused clips will not show students the broader applicability of helping skills to other professional contexts.

I generally mix among varied sources, including videos I have found in my institution’s library holdings. I recommend the following sources:

* A number of video clips featuring Carl Rogers working with clients are available on YouTube. Although these are, again, focused narrowly on a psychotherapy context, there is no better model of helping skills than Rogers.
* Try an Internet video search for “active listening,” which will likely yield clips from different professional fields, including business and education (as well as clips from popular television shows). I try to incorporate career interests that reflect the interests of my students, so I vary clips from year to year.
* For health profession examples, some educational institutions and national organizations post short training videos or demonstrations online. For example, DocCom (<http://aachonline.org/dnn/DocCom/Demo-Modules>), a platform offered by the American Academy on Communication in Healthcare, provides open access to some video-based modules about general helping skills. The American Academy of Family Physicians has five training videos on cultural competency as part of their Quality Care for Diverse Populations program (<http://www.aafp.org/patient-care/social-determinants-of-health/cultural-proficiency.html>). Helpful search terms include “communication training” and “healthcare professionals.”
* The Internet is also a good source for video clips on motivational interviewing (MI). Although MI is the 10th and final skill in this resource, many aspects of MI overlap with the helping skills and can serve to demonstrate nonverbal and verbal listening behaviors as well as reflections of content and feelings. MI clips are available for a variety of settings (e.g., health care, substance abuse treatment, schools).
* Finally, if your search for a video clip does not yield an example you believe to be an especially good model, remember that you can always use a less effective clip as an opportunity for students to consider how an interaction could be improved. Viewing ineffective interactions also underscores that the helping skills are far more challenging to learn than most students assume at the outset of the course.

# Skill #1: Nonverbal Observation and Communication

**Activity: Initial Interviews**

Ask students to get into pairs and take turns interviewing one another for approximately 5-6 min in each direction (possible topics: internship placements, internship anxieties, career ideas, post-graduation plans). Emphasize that students will *not* be asked to present what they learned in the interviews, so they need not take notes. Ask permission to videotape. (The prospect of videotaping will alarm some students. I try to counter this by assuring students that I will watch videos before playing them in class, editing out anything potentially embarrassing; that I will not be videotaping pairs for more than 30 seconds at a time; and that I will destroy recordings after we view them in class.) I do *not* explain to students the full purpose of the video recording -- which will be to observe helper nonverbal behaviors -- because natural nonverbal behavior would likely change as a result.

 Following the interviews, I explain that the underlying purpose of the exercise was to introduce the importance of nonverbal behavior in communication. You may wish to engage students in a discussion about what they believe to be important elements of nonverbal behavior prior to calling their attention to the accompanying handout. Following this dialogue and review of the handout (see ideas below for discussion questions and other handout-related material), show the video in a subsequent class *with the sound turned off.* As noted, I watch the videotape prior to the class viewing, which means that teaching this skill requires one full class period plus a portion of the next. Although I have had to edit only rarely, this preview also allows me to make notes about exemplary nonverbal behaviors (e.g., eye contact, head nods, forward lean) that I can then point out in class.

Prior to the class viewing, I emphasize to students that I do not yet expect proficiency. Our purpose in watching is to create a baseline, gain comfort in self-assessment, and consider the impact of our own nonverbal behaviors on others. I also note that I will stop anyone who launches into a negative self-critique during our viewing (and I do!). While the video is playing, I point out effective helper nonverbal behaviors (e.g., “excellent eye contact,” “helpful head nod”), pausing the tape as needed. Following the viewing, I ask students to identify one aspect of their own nonverbal behaviors with which they are satisfied.

**Observing Clients’ Nonverbal Behavior: What Can We Learn? *(Student Handout Point 1)***

* Begin with data and discussion points about the impact of nonverbal behavior on impressions, emotional reactions, and attitudes (see Knapp, Hall, & Horgan, 2014; Matsumoto, Frank, & Hwang, 2013).
* Paul Ekman’s research on universal facial expressions is typically covered in introductory psychology coursework but is definitely worth a review. Ekman’s website (<http://www.paulekman.com/universal-facial-expressions/>) contains pictures of four facial expressions (anger, sadness, disgust, happiness) of a man from New Guinea never exposed to outside cultures; you can ask students to identify the emotions they believe are associated with each expression.
* Ask class members to brainstorm about the meaning of different aspects of nonverbal behavior, for example, “How might you perceive a lack of eye contact? Someone who is leaning forward/backward?” Be sure to emphasize cultural variation in nonverbal behaviors in the course of this discussion (see Matsumoto et al., 2013) as well as the importance of treating interpretations as mere hypotheses (i.e., not jumping to conclusions too quickly).

**Ideal Helper Nonverbal Behaviors: Communicating a Readiness to Help *(Student Handout Point 2)***

* Ask students what types of qualities they would like to convey to someone to whom they are listening, particularly to people with some type of concern or problem (e.g., compassion, warmth, openness, nonjudgment, caring, trustworthiness, acceptance). Discuss the importance of displaying these characteristics with nonverbal rather than verbal behavior (e.g., head nodding vs. “I’m listening”). For example, research suggests that nonverbal behaviors are vital in the communication of emotional and interpersonal messages (Henry, Fubrel-Forbis, Rogers, & Eggly, 2012). According to Knapp et al. (2014), the face is of particular importance in interpersonal interactions, facilitating the expression and decoding of emotions and serving as a basis for judgments about personality characteristics.
* Review ideal helper behaviors in each of the identified domains, such as body posture, eye contact, facial expressions, and so forth (see Knapp et al., 2014; Matsumoto et al., 2013). Note the relevance of each behavior to multiple disciplines (e.g., counseling, social work, health professions, business). For information about nonverbal behavior in health care professionals, see Collins, Schrimmer, Diamond, and Burke (2011) and Henry et al. (2012).

**Skill #1: References and Resources**

Collins, L. G., Schrimmer, A., Diamond, J., & Burke, J. (2011). Evaluating verbal and non-verbal communication skills, in an ethnogeriatric OSCE. *Patient Education and Counseling, 83,* 158-162. <http://dx.doi.org/10.1016/j.pec.2010.05.012>

The authors examined videotapes of interviews between patients and medical students or physicians. They provide evidence of the positive effect of maintaining adequate facial expressions, using affirmative gestures, and limiting “unpurposive movements” on ratings of interview quality and perceptions of cultural competence. The article contains an 8-item nonverbal communication checklist.

Ekman, P. (n.d.) Personal website: <http://www.paulekman.com/universal-facial-expressions/>

 This comprehensive website contains a biography of Ekman with links to popular summaries of his research areas; videos on human communication, the influence of emotions, and the power of emotions (among others); original journal articles; and even a parents’ guide to the popular movie, *Inside Out*.

Henry, S. G., Fuhrel-Forbis, A., Rogers, M. A. M., & Eggly, S. (2012). Association between nonverbal communication during clinical interactions and outcomes: A systematic review and meta-analysis. *Patient Education and Counseling, 86*, 297-315. [http://dx.doi.org:/10.1016/j.pec.2011.07.006](http://dx.doi.org/10.1016/j.pec.2011.07.006)

 This meta-analysis is based on 26 studies of client-health professional interactions in which direct observation of nonverbal communication was assessed. Ratings of clinician warmth were associated with greater patient satisfaction, and ratings of clinician negativity were associated with lower patient satisfaction. The article contains summaries of specific nonverbal qualities assessed in each study.

Knapp, M. L., Hall, J. A., & Horgan, T. G. (2014). *Nonverbal communication in human interaction* (8th ed.).Boston, MA: Wadsworth.

 Knapp et al.’s comprehensive textbook on nonverbal behavior incorporates a thorough review of multidisciplinary research. Especially relevant chapter topics include the impact of the face, eye behavior, and vocal cues; nonverbal behaviors in everyday communication; and the impact of the environment.

Matsumoto, D. R., Frank, M. G., & Hwang, H. S. (Eds.). (2013). *Nonverbal communication: Science and applications.* Los Angeles, CA: Sage. <http://dx.doi.org/10.4135/9781452244037>

 This textbook summarizes multidisciplinary studies on nonverbal behavior in different domains, including facial expressions, voice, and body language. Unique features of this resource include a chapter devoted to cultural influences and several chapters on topics relevant to the criminal justice system.

# Skill #2: Attentive Listening

**Discussion: Analysis of Quotations**

Listening is an important skill in any helping profession. In order to appeal to students with varied career interests, you may wish to include representative quotations from theorists or researchers in different fields. Among my students, psychotherapy practice is a consistent occupational goal, but other frequent interests include medicine or nursing, occupational therapy, speech and language pathology, and business or management.

 Discussion at the outset of class can highlight the need for strong listening skills in all helping professions. Additional points I try to convey through group reading and discussion of the quotations include

* the idea that although listening is valued among helping professionals, students are rarely explicitly instructed in listening skills (I ask students to consider how much of their education to date has focused on listening vs. speaking.)
* awareness that “simple listening” is both difficult and complex
* the belief shared by many people that listening is “not enough”

**Personal Reflection on Good and Bad Experiences in Listening**

Ask students to complete the chart on their handout regarding verbal or nonverbal responses that connote listening versus not listening. Then ask them to share ideas, listing these on the board. Poor listening examples might include lack of eye contact, attention directed elsewhere (to a cell phone or another conversation), quick advice, interruption or change of topic, one-upping (“You think you have it bad!”), invalidation, or a change of focus to one’s own (often related) problem.

 Alternatively, see Fedesco (2015) for an activity-based approach to this conversation. In either case, the goal is to demonstrate that good listening skills may be rarer and more difficult to sustain than we imagine.

**Challenges and Characteristics of Listening: Discussion Points *(Student Handout Points 1 & 2)***

* What is the impact of the digital age on listening? Consider Horowitz (2012): “Listening is a skill that we’re in danger of losing in a world of digital distraction and information overload” (para. 12). Are we too distracted on a day-to-day basis to focus intently on another person?
* Is it possible to deeply listen to someone while engaged in another activity? Many current psychological studies demonstrate the ineffectiveness of multitasking (e.g., Moisala et al., 2016). However, this isn’t a black-and-white issue, as we often listen while doing other things, e.g., in the car we can drive and listen, at a concert we can listen and watch/enjoy music.
* What makes listening an active process? Many students perceive listening as passive, and have not considered that listening requires conscious effort. Horowitz (2012) distinguishes between “hearing” and “listening,” which helps to clarify the difference. Aspects of listening that require activity include observing and processing both nonverbal and verbal communication, considering one’s own responses, and maintaining attention.

**Attending Behavior and Following *(Student Handout Points 3 & 4)***

* *Attending behavior* is a counseling term describing both nonverbal and verbal responses that demonstrate sincere efforts to listen to a speaker’s story, thereby encouraging a speaker to continue talking. Because students are often skeptical about the value of attending behavior, begin with a role play demonstration or video clip depicting effective attending responses. (If you use a video clip, it does not specifically have to model attending behavior; any two-person dialogue can usually suffice.)

* In addition to reviewing ideal nonverbal and verbal responses, I find it helpful to give students general guidance about the act of listening.
	+ Eliminating distractions. Some students are unaware of the impact of environmental distractions on their listening ability. Encourage assessment of these so that the immediate surroundings can be set up for maximal attention.
	+ I characterize listening as a flashlight that a listener is turning on a speaker. The listener’s goal is to keep the beam of light steadfastly fixed on the speaker. Self-disclosure, interruption, advice, or even some types of questions may inadvertently shift the flashlight beam back to the listener. This should be avoided in the early stages of a conversation.
	+ Attention gaps are to be expected. Much like the instructions given to novice meditators, listeners should simply recognize their mind-wandering activity and then quickly return focus to the speaker.

**Activity: Pairs Listening Practice**

Group students into pairs and ask them to take turns telling a story about something interesting that has happened so far during the semester. Each speaker should talk for 5 min. (I always time these intervals, flipping the light switch on and off when 30 seconds are left.) The job of listeners is to use *only* attending behaviors to keep the conversation going, that is, avoid questions, disclosures, or longer responses.

 Afterward, I ask students to share difficulties they experienced in the role of the listener. Students typically find this exercise quite challenging and will readily volunteer frustration with not being able to ask questions, discomfort with silences, or a temptation to disclose a similar experience. This is a good lead-in to discussion of roadblocks (see Student Handout Point 5), which I attempt to normalize. I explain that one goal of the exercise is to better understand one’s own listening struggles. In addition, I emphasize that I hope this exercise demonstrates the possibility of using very limited verbal communication to encourage another’s conversation.

**Video Clip**

The Gloria films (see Shostrom, 1965) are currently available on YouTube, and Carl Rogers’s session with Gloria is an excellent demonstrating of helpful attending behavior.

**Skill #2: References and Resources**

Boudreau, J. D., Cassell, E., & Fuks, A. (2009). Preparing medical students to become attentive listeners. *Medical Teacher, 31,* 22-29. <http://dx.doi.org/10.1080/01421590802350776>

The authors describe a novel curriculum on listening developed by medical educators at McGill University’s medical program. They present eight principles of attentive listening along with practical strategies for teaching them.

Fedesco, H. N. (2015). The impact of (in)effective listening on interpersonal interactions. *International Journal of Listening, 29,* 103-106. <http://dx.doi.org/10.1080/10904018.2014.965389>

This 20-min teaching activity is designed to demonstrate the negative impact of poor listening behavior.

Horowitz, S. S. (2012, Nov 9). The science and art of listening. *New York Times Sunday Review.* Retrieved from <http://www.nytimes.com/2012/11/11/opinion/sunday/why-listening-is-so-much-more-than-hearing.html?ref=opinion&_r=1>

 Horowitz is an auditory neuroscientist who contrasts “hearing” with “listening” at not only a practical level but also in terms of brain processing and structure.

King, G., Servais, M., Shepherd, T. A., Willoughby, C., Bolack, L., Moodie, S., …McNaughton, N. (2015). A listening skill educational intervention for pediatric rehabilitation clinicians: A mixed-methods pilot study. *Developmental Neurorehabilitation, 25,* 40-52. <http://www.tandfonline.com/doi/full/10.3109/17518423.2015.1063731>

 The researchers describe a pilot study in which they assessed the impact of teaching a new listening skills curriculum to rehabilitation therapists. This article is one (of many) that demonstrates the broad appeal of listening skills in professions outside of counseling.

Moisala, M., Salmela, V., Hietajärvi, L., Salo, E., Carlson, S., Salonen, O., ...Alho, K. (2016). Media multitasking is associated with distractibility and increased prefrontal activity in adolescents and young adults. *Neuroimage, 134,* 113-121. <http://dx.doi.org/10.1016/j.neuroimage.2016.04.011>

 This empirical study of multitasking among adolescents and young adults suggests that higher levels of media multitasking are associated with greater distractibility.

Shostrom, E. L. (Producer). (1965). *Three approaches to psychotherapy I* [video/DVD]. Corona Del Mar, CA: Psychological & Educational Films.

 Known popularly as the “Gloria Films,” three renowned therapists (Carl Rogers, Fritz Perls, and Albert Ellis) work individually with the same client, Gloria. In each film, the therapists talk about their theoretical models prior to interviewing Gloria and then follow the sessions with a short discussion of what they believe occurred. Rogers demonstrates many helping skills during his session, an excellent example of his warmth and empathy.

# Skill #3: Questions and Cultural Sensitivity

**Closed and Open-Ended Questions: Activities and Discussion Points *(Student Handout Points 1 & 2)***

After introducing the two types of questions, ask each student to think of a closed question to direct to a classmate (e.g., Where did you grow up? Do you have any pets?), emphasizing that the question should not request overly personal or potentially embarrassing information. Then proceed around the room, with students taking turns asking their question to the person on their right; the person being asked the questions should respond. (You should participate as well, leading off with the first question and providing the final answer.) Time how many minutes the questioning takes (typically 1-2 minutes for 12 questions), and then use this experience to engage the class in a discussion of advantages and disadvantages of closed questions (see Table 1).

 Next, repeat the exercise, requesting that this time students ask classmates open-ended questions. Again, timing the activity can be helpful in making the point that open questions require greater commitment and patience from the listener. As with closed questions, focus discussion around advantages and disadvantages.

Table 1

*Possible Ideas About Advantages and Disadvantages*

|  |  |
| --- | --- |
| Closed questions | Open questions |
| Advantages | Disadvantages | Advantages | Disadvantages |
| * Time-efficient
* Helpful for learning factual information
* Opportunities for quick clarification
 | * Directs rather than follows a speaker’s story
* Not as helpful for obtaining emotionally based information
* Can sound threatening or attacking
* Can be “leading,” i.e., masking advicea
 | * Encourages reflection and self-exploration
* Encourages greater disclosure
* Less opportunity for bias on part of questioner
* May lead to greater truthfulnessb
 | * Requires more time (so shouldn’t be used when listener is in a hurry)
* Can be motivated by listener’s uncertainty about what to say (e.g., “How did that make you feel?”)
* Too many “why” questions can be frustrating
 |

ae.g., “Do you think that if you get more sleep, you’d feel better?”

be.g., “Are you taking your vitamins every day?” vs. “How are you doing with your vitamins?”

 Professionals in many fields recommend open-ended questioning (e.g., AbuSabha, 2013; Robinson & Heritage, 2006). I conclude with the general advice to use open-ended questions unless a concrete reason justifies closed questioning. Open-ended questions may also minimize the likelihood of cultural insensitivity, a point you can make here or in the next section.

**Cultural Humility and Cultural Sensitivity *(Student Handout Point 3)***

Cultural humility and sensitivity in the helping process are essential topics that can be included anywhere – or *every*where – in a helping skills curriculum. I introduce cultural considerations here because (a) students have by this time had an opportunity to interact with their internship site clientele, potentially gaining real-world experience with diversity, (b) discussing cultural sensitivity in the context of questions (rather than with a later skill) may reduce the likelihood of a cultural misstep or microaggression, and (c) I can build on this brief overview in later helping skills instruction. However, other instructors may prefer to spend a full class session on cultural issues prior to beginning helping skills instruction, introduce the topic more fully while discussing nonverbal behaviors (Skill #1), or wait until a later time to begin this discussion.

Hook and colleagues (2013, 2015) describe cultural humility as an openness to learning about a client’s cultural identity, evidenced by therapist qualities such as respect, awareness of personal limitations in understanding, and genuine desire to learn about a client’s worldview. You might wish to describe this concept to students and ask them to generate ideas for its measurement, which could then be compared to the “Cultural Humility Scale” developed by Hook, Davis, Owen, Worthington, and Utsey (2013).

The overarching goal of a focus on cultural sensitivity is to assist students in developing cultural “awareness” (e.g., Gorski, n.d.), “competency” (e.g., Center for Cultural Competence, n.d.; National Association of Social Workers, 2015), or “respect” (e.g., National Institutes of Health, 2016). Although these terms are associated with different professions or theoretical positions, they share an underlying premise that greater understanding of cultural differences is necessary to provide thoughtful, ethical, and effective service to diverse others. In addition to these websites, Sue and Sue’s (2015) textbook, *Counseling the Culturally Diverse,* is a terrific, comprehensive resource on multicultural counseling.

An additional topic you may wish to include in your discussion is cultural identity. A longstanding tenet of diversity training is that understanding one’s own cultural identity is an essential first step in understanding individuals with different cultural identities. The identity “wheel” exercise is a concrete means of helping students explore their own backgrounds: Students list their varied identities and then graphically represent them via a pie chart (see American Association of University Women [AAUW], 2015).

Finally, if the topic of cultural privilege has not been addressed at a previous point in your department or university curriculum, it is important to incorporate activities or discussion points focused on it. Exercises designed to facilitate college students’ recognition of privileged identities can be found on many diversity education websites (e.g., AAUW, 2015; Society for the Teaching of Psychology, 2012).

**Cultural Considerations in Asking Questions *(Student Handout Point 4)***

**Microaggressions.** After explaining the concept of microaggressions (brief and usually unintended statements or behaviors that communicate derogatory beliefs about an individual’s cultural identities), I review the findings of Owen, Tao, Imel, Wampold, & Rodolfa (2014) regarding the experience of microaggressions among counseling center clients. I point out that open-ended questions can lessen the likelihood of a microaggression. Meredith and Robinson (2013) described an exercise in which students are asked to reword potential microaggression statements or questions to lessen the chance of offense; for example, the closed question, “How long have you lived in this country?” could be rephrased in an open-ended and neutral manner: “Could you tell me about your background?”

**Language issues.** Carteret (2014) noted the importance of attending to cultural background characteristics in health professional-patient interactions. In “low-context” cultures, such as the United States, communication tends to be direct and explicit, whereas in “high-context” cultures, such as most Asian and Middle Eastern countries, communication tends to be more dependent on situational cues and affected by societal expectations about interpersonal roles and hierarchy. A patient from a high-context culture may therefore respond to physicians deferentially, displaying nonverbal behaviors such as head nods that suggest, to the physician, patient comprehension, because the patient values politeness and respect at the expense of understanding. A U.S. health professional, accustomed to more unambiguous patient interactions, may not pick up on the communication gap. Carteret also called attention to the potential for “missing equivalents” in conversations with patients whose first language in not English: Some words, especially medical terms, are not easy to translate into another language or cultural mindset.

A focus on language challenges can segue to the importance of asking questions in a gentle, nonthreatening manner. Zalaquett, Chatters, and Ivey (2015) advised framing questions about “presenting problems” in terms of “challenges” or “concerns” to minimize risk of offense among diverse clients; “problems” may imply personal blame. Similarly, asking about strengths as well as challenges may help a client feel less vulnerable and more optimistic, while communicating a helper’s belief in a client’s resilience.

**Addressing cultural differences.** Most authorities in this area encourage helpers to directly address cultural differences with clients. I like to engage students in discussion of this idea, especially regarding their comfort or discomfort in talking openly to someone about differences: Most will admit to some unease about this. You may wish to model sample language for initiating a conversation about cultural difference.

* Basic (noted on student handout): “I’m wondering…what is your experience talking with me, a (insert your cultural identity, e.g., White female, straight male), about this issue?”
* More advanced (for students with previous education or experience talking about cultural issues): “I did want to bring up something. I’m a (insert cultural identity) and (I notice that/you’ve said that) you’re a \_\_\_\_. I’m wondering if you have any concerns about that you’d be open to sharing with me?”

**Skill #3: References and Resources**

AbuSabha, R. (2013). Interviewing clients and patients: Improving the skill of asking open-ended questions. *Journal of the Academy of Nutrition and Dietetics, 113*, 624-633. <http://dx.doi.org/10.1016/j.jand.2013.01.002>

 The author reviews theory and research on open-ended questions, providing specific examples in the context of nutritionist interviewing. This content is helpful in demonstrating consensus across varied helping professions on the value of open questions.

American Association of University Women. (2015). Social identity wheel. AAUW Diversity and Inclusion Tool Kit. Retrieved from <http://www.aauw.org/files/2015/11/Social-Identity-Wheel-activity-nsa.pdf>

 The AAUW tool kit was developed to help branch organizations become more inclusive. This chapter provides detailed instructions for introducing the identity wheel activity, including explanations and discussion questions.

Carteret, M. (2014). Reading between the head nods [Blog post]. *Dimensions of Culture: Cross-Cultural Communications for Health Professionals.* Retrieved from <http://www.dimensionsofculture.com/2015/10/reading-between-the-head-nods/>

This essay addresses linguistic barriers in cross-cultural interactions between doctors and their patients, for example, high- vs. low-context communication styles, “missing equivalents,” and diverse culturally-based beliefs.

Gorski, P. C. (n.d.). *Awareness activities.* Retrieved from <http://www.edchange.org/multicultural/activityarch.html>

 EdChange is an organization that provides professional development resources on diversity and equity in schools and communities. This portion of the website provides icebreaker ideas and exercises for teaching about cultural diversity.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60,* 353-366. <http://dx.doi.org/10.1037/a0032595>

Hook, J. N., & Watkins, C. E., Jr. (2015). Cultural humility: The cornerstone of positive contact with culturally different individuals and groups? *American Psychologist, 70,* 661-662. <http://dx.doi.org/10.1037/a0038965>

 Hook and colleagues introduced and pursued measurement of cultural humility through a 12-item scale, establishing its reliability and validity in their 2013 article. The complete scale is presented in Appendix B of the same article. Their 2015 essay argues that a lack of cultural humility is one reason many psychologists continue to struggle to effectively engage with culturally diverse clients.

Meredith, K. L., & Robinson, L. (2013). Module 10: Microaggression activity. In M. E. Kite, *Activities for teaching about prejudice and discrimination* (pp. 50-54). Office of Teaching Resources in Psychology. Retrieved from <http://www.apadiv2.org/Resources/Documents/otrp/resources/kite13.pdf>

 One of 12 classroom activities developed by undergraduate students enrolled in a seminar course, this brief (10-20 min) exercise introduces the concept of microaggression. The description includes background research, references, and discussion questions.

National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice.* Retrieved from <http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

 The NASW is the largest professional organization of social workers in the United States. This guide provides an explanation of and criteria for 10 cultural competence standards, including self-awareness, cross-cultural knowledge and skills, advocacy, and professional education.

National Center for Cultural Competence (n.d.). *What we do.* Retrieved from <http://nccc.georgetown.edu/about.html>

 Housed within Georgetown University Medical Center’s Department of Pediatrics, the center translates evidence on best practices in cultural competence into training programs for mental health and health care providers. The organization’s website contains numerous publications, research summaries, pamphlets, and training modules.

National Institutes of Health. (2016). *Cultural respect.* Retrieved from <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect>

 This NIH website provides an overview of cultural respect, including brief responses to frequently asked questions and links to additional resources.

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice, 45*, 283-290. <http://dx.doi.org/10.1037/a0037420>

 This research article describes a survey of university counseling center clients indicating that more than half experienced at least one microaggression in therapist-client interactions. Such statistics can be helpful in emphasizing the frequency of microaggressions and consequently the importance of cultural sensitivity.

Robinson, J. D., & Heritage, J. (2006). Physicians’ opening questions and patients’ satisfaction. *Patient Education and Counseling, 60,* 279–285. <http://dx.doi.org/10.1016/j.pec.2005.11.009>

 Researchers report a positive relationship between the use of open-ended questions by physicians and patient satisfaction.

Society for the Teaching of Psychology. (2012). *Presidential taskforce on diversity education*. Retrieved from <http://teachpsych.org/diversity/ptde/index.php/>

 The goal of this taskforce was to provide resources for instructors teaching about diversity. The comprehensive website provides a bibliography of books, articles, websites, and films related to multiple aspects of diversity, including aging, appearance, disability, gender, intersectionalities, privilege, race/ethnicity, and religion.

Sue, D. W., & Sue, D. (2015). *Counseling the culturally diverse: Theory and practice* (7th ed.). Hoboken, NJ: Wiley.

 This highly-respected textbook on multicultural counseling covers broad background issues such as the meaning of culture/identity and cultural competency, social justice implications of counseling, and systemic oppression. A chapter on microaggressions is aimed at psychotherapists but is applicable to any health professional. The text also contains stand-alone, practice-oriented chapters on counseling individuals from specific racial and ethnic minority groups (e.g., African Americans, American Indians, Latinos) as well as clients with other identity differences (e.g., class, disabilities, sexual orientation and gender identity).

Zalaquett, C. P., Chatters, S. J., & Ivey, A. E. (2013). Psychotherapy integration: Using a diversity-sensitive developmental model in the initial interview. *Journal of Contemporary Psychotherapy, 43,* 53-62. <http://dx.doi.org/10.1007/s10879-012-9224-6>

 Part of a special issue of this journal on conducting initial interviews with diverse populations, this article presents strategies for integrating a diversity-sensitive model of psychotherapy with traditional counseling microskills. For each therapy element, the authors provide practical, concrete tips to maximize cultural competence, such as asking about challenges or concerns rather than problems and requesting information about client strengths.

# Skill #4: Empathy and Reflecting Content

**Empathy and Helping *(Student Handout Point 1)***

**“What is empathy”/ reflection discussion.**  Most students already have some acquaintance with the term “empathy.” Rather than simply defining it for them, I find that encouraging a personal connection to the concept at an emotional level helps them appreciate its importance in relationship-building. I begin by asking students to think of a time when they were the recipients of empathy and to write about that experience for a few minutes. They might include what events had taken place prior to the experience, what the empathic other did or said, and what feelings resulted from the empathy. Emphasize that you will not ask students to share the experiences (as often these can be quite personal).

 Encourage students to share their thoughts about (a) what behaviors or statements indicated empathy, (b) how they might describe empathy, and (c) its impact. Make a list on the board that can be present throughout the skill discussion and practice.

**Mini-lecture: Carl Rogers.** Theorists and researchers across many different helping professions pay homage to Rogers’s ideas about empathy. Topics that might be addressed here include

* essential therapist characteristics (see Rogers, 1957),
* Rogers’s evolution in defining empathy (see Rogers, 1975), and
* Rogers’s influence on psychotherapy (e.g., Yalom, 2002).

**Evidence-basis of empathy.** Research has demonstrated that empathy is an important factor in psychotherapy effectiveness as well as in many health care professions. To underscore the point that a focus on empathy is empirically supported, I choose representative quotations from researchers in multiple helping fields (selecting professions in accordance with class makeup). Students are often intrigued about exactly how empathy can be studied. Time permitting, I explain the nature of a typical investigation in order to make the evidence-based concept more concrete, while correcting misperceptions (e.g., that therapists might be asked to be intentionally unempathic for purposes of research).

**Demonstrating Empathy Through Paraphrase *(Student Handout Points 2 & 3)***

* Explain the connection between reflection and empathy: that a paraphrase is an attempt to understand a speaker’s content and meaning, and consequently, can be a demonstration of empathy.
* Students respond well to specific, clear descriptions of skills, so I define paraphrases in terms of four qualities: brevity, use of different words, objectivity, and tentative phrasing/nonverbal cues. In addition to the example paraphrase on the handout, I typically offer two or more other verbal examples, showing students how the four qualities are represented in each.
* Video clip: Select a passage from a video resource during which the therapist exhibits multiple paraphrase statements. Ask students to jot down the statements they hear that they believe are examples of paraphrasing, and then review these with the class.
* Demonstration: If you feel brave, ask a student to tell you an innocuous story in front of the class, and demonstrate paraphrasing (and other skills, e.g.., nonverbal, attending behavior; open-ended questions) in your response.
* Other benefits of paraphrase: Briefly review with students some of the other functions of paraphrasing beyond demonstrating understanding. As appropriate in the dialogue, distinguish reflecting content from reflecting feeling, noting that the latter will be the basis of Skill #5.

**Practice**

Role play scenarios with the class in which you are a client or patient talking to a hypothetical helper. Ask students to write out a possible paraphrase following each scenario and then request at least two volunteers to read their paraphrases to the class, being sure to use the style and tone they believe appropriate. (Writing responses before saying them aloud allows students to carefully consider their wording and makes volunteering their responses to the class less intimidating.)

 Discussion of the sample paraphrases can be awkward, as some students will struggle. I generally ask students to self-critique, which many can do quite effectively (perhaps too conscientiously!), but occasionally you will need to suggest alternate or improved wordings. However, this discussion can be very helpful in illustrating that paraphrasing is not a simple skill (often students’ initial presumption), particularly when scenarios are challenging. You can also show that a variety of paraphrases can be equally appropriate with any given scenario.

 Sample scenarios might begin with anecdotes about basic life events (e.g., struggling to write a paper, getting a traffic ticket, applying to graduate programs), building to stories that involve conflicting thoughts or feelings (e.g., a college student who has just broken up with a romantic partner due to drug use, a young adult trying to balance career and personal life) or those that might invite some degree of judgment or advice (e.g., a teenager explaining poor performance on a test to a parent, a friend ready to move in with a very new romantic partner). During discussion, students can assess whether the paraphrases demonstrated the desired characteristics (brevity, especially, tends to be difficult for achievement-oriented students eager to show they absorbed every detail!) and served the intended functions. Students will often want to ask about different possibilities and consequently this practice and discussion can take 30 min or more.

**And More Practice**

A helpful strategy for reviewing this skill in future classes is to incorporate it into students’ discussion of their internship experiences. For example, if students “check-in” each week by sharing a story about their internship or responding to a specific prompt, each student can be asked to paraphrase the experiences described by the student sitting beside him or her. An added bonus of this activity is increasing students’ attentiveness to their peers.

**Skill #4: References and Resources**

Bodie, G. D., Cannava, K. E., & Vickery, A. J. (2016). Supportive communication and the adequate paraphrase. *Communication Research Reports, 33*, 166-172. <http://dx.doi.org/10.1080/08824096.2016.1154839>

 This investigation conducted by communication researchers compared the impact of four types of paraphrase statements on evaluations of helpfulness, sensitivity, and supportiveness. Statement types did not differ greatly (in contrast to the researchers’ expectations). The researchers speculated that the function of paraphrase messages may be to establish rapport and to demonstrate attentiveness and understanding rather than to facilitate coping.

Derksen, F., Bensing, J., & Lagro-Janssen, A. (2013). Effectiveness of empathy in general

practice: A systematic review. *British Journal of General Practice, 63,* e76-e84.

<http://dx.doi.org/10.3399/bjgp13X660814>

 Derksen et al. describe their review of studies of the impact of physician empathy on patient experience; only 7 of 964 potential articles met the inclusion criteria for high-quality investigations. Among these, empathic patient-physician communication was associated with greater patient satisfaction, lessened patient anxiety and distress, better clinical outcomes (including shorter duration of the common cold), and stronger patient enablement. The article’s introduction contains helpful definitions of empathy as well as applications to medical practice.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy,*

*48,* 43-49. <http://dx.doi.org/10.1037/a0022187>

 This article is part of a special issue of *Psychotherapy* focused on characteristics of evidence-based therapy relationships. The authors describe definitions and measures of empathy, summarize a meta-analysis on studies of the impact of empathy on therapy outcomes, and conclude that empathy is a medium-sized predictor of outcome.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors, 27,* 878–884. <http://dx.doi.org/10.1037/a0030274>

 Moyers and Miller consider research on empathy in addiction counselors and its impact on treatment effectiveness, concluding that empathy is a “moderately strong predictor” (p. 881) of outcomes in substance abuse treatment. They recommend that potential addiction counselors be screened for their empathic abilities.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103. <http://dx.doi.org/10.1037/h0045357>

 Rogers summarizes his beliefs about six conditions essential for personality change to occur, including three necessary therapist characteristics: genuineness, unconditional positive regard, and empathy.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist, 5,* 2-10. <http://dx.doi.org/10.1177/001100007500500202>

 In this classic essay, Rogers describes the evolution in his views and definitions of empathy during his career. He incorporates a brief review of research findings about empathy through 1974 as well as illustrative case examples.

Weger, H., Jr., Castle, G. R., & Emmett, M. C. (2010). Active listening in peer interviews: The influence of message paraphrasing on perceptions of listening skill. *International Journal of Listening, 24,* 34–49. <http://dx.doi.org/10.1080/10904010903466311>

 This investigation evaluated the effectiveness of paraphrase vs. “simple acknowledgement” in a one-time interview between strangers. Paraphrase was associated with greater social attraction, but perceived understanding and satisfaction did not differ between the two conditions. The researchers suggest that the small differences might be explained by the impersonal nature of the prescribed conversation, as well as the presence of encouraging nonverbal behaviors in both conditions. This content is useful in demonstrating that paraphrase can be studied empirically and that it can be applied in numerous settings, but that the nature of its helpfulness may depend in part on context.

Yalom, I. D. (2002). Empathy: Looking out the patient’s window (pp. 17-22). *The gift of therapy: An open letter to a new generation of therapists and their patients.* New York, NY: Harper Collins.

 In this short book aimed at beginning therapists, existential psychiatrist Irvin Yalom devotes a chapter to empathy, referencing Rogers’s ideas and offering interesting anecdotes helpful in illustrating practical aspects of empathy.

# Skill #5: Empathy and Reflecting Feelings

**Demonstrating Empathy in the Helping Process *(Student Handout Point 1)***

**Case example.** Following a recap of the previous week’s focus on the importance of empathy, a transcript can be helpful for demonstrating verbal forms of empathy more concretely. Asking students to read the parts aloud (while acting out appropriate nonverbal behaviors) can help students recognize the importance of not only the content of the helper’s words but also the subtleties of tone of voice, facial expression, and eye contact.

**Mini-lecture and discussion: Can empathy be taught?** Medical educators have conducted a great deal of research on facilitating empathy in students (see reviews by Batt-Rawden, Chisolm, Anton, & Flickinger, 2013; Bearman, Palermo, Allen, & Williams, 2015), in part due to the finding that empathy among medical students decreases over the course of their training. Students seem to find this an interesting outcome and will likely have good ideas about why this might be. Speculations offered by Batt-Rawden et al. (2013) included “psychological factors such as stress and fatigue, the ‘hidden curriculum,’ unstable learning environments, loss of idealism, and the perceived need for detachment” (p. 1175).

Students may enjoy hypothesizing about strategies for enhancing empathy, a literature that they may have encountered in social psychology coursework. Batt-Rawden et al.’s (2013) review categorizes empathy interventions that have been tried in medicine; Bearman et al.’s (2015) review focuses specifically on simulation-based strategies. Weekly reflection essays about internship experiences and role play exercises can both be tools for enhancing perspective-taking abilities. Because both are part of this class, I point out that students may be experiencing enhanced empathy over the course of the semester.

In addition, this is an appropriate time to note the challenge of being empathic to others when our own stress levels feel impossibly high. I make this point in future classes as well, particularly in discussing mindfulness as a means of stress reduction.

**Types of Empathy *(Student Handout Point 2)***

* The table of empathy types included in the student handout is derived from Elliott, Bohart, Watson, and Greenberg’s (2011) evidence-based literature review of empathy as well as the ideas described by Neukrug, Bayne, Dean-Nganga, and Pusateri (2013) in their article on creative approaches to expressing empathy. Each provides additional examples.
* In reviewing this list with students, I emphasize that I do not expect students to master all types of empathy. The point of the chart is to illustrate the variety of ways in which empathy can be expressed.

**Noting and Reflecting Feelings *(Student Handout Points 3-5)***

**Describe and model the skill.** After working through the example on the handout, I give other examples of feeling reflections, striving to phrase each one differently in the effort to keep the skill from taking on a formulaic quality. Introducing Carl Rogers’s (1986) ambivalence about the term, “reflection of feeling,” as well as his fear that the skill was taking on a “wooden quality,” is another way I try to head off the stereotypic reflection, “Sounds like you’re feeling sad.”

To be sure students understand the difference between reflecting content and reflecting feelings, you can read aloud from a prepared list of both and ask them to identify which is which. Try to create some examples that are ambiguous (e.g., “You have a huge workload in front of you tonight – more than you can handle.” Or, “You feel that your professor is unfair.”), which will allow you to show that they often overlap. You can then consider when and why one might be preferable to the other. (I view the phrase “feel *that*” as more of a cognitive belief than an emotion, and consequently I would label the second example a paraphrase.)

**Video clips.** As with teaching the paraphrasing skill, selecting a passage from a video during which a therapist or medical professional exhibits empathy is helpful to students. Ask students to jot down any nonverbal behavior or verbal statement they believe the client/patient would perceive as empathic. Then review their suggestions as a group.

**Reflection and pairs practice.** I ask students to write for up to 5 min about an experience of homesickness that they remember. I then ask them to share this experience, to the extent that they are comfortable doing so, with a partner whose job it is to respond with empathy on at least one occasion during a 2-3 min interaction. As with all exercises of this type, I carefully time the interaction period so that students all finish at the same time. The partners then switch roles so that both have the opportunity to role play homesickness as well as to be empathic. I don’t hover during the role playing because students’ evaluation anxiety tends to be very high at this stage of practice.

* In discussing the exercise afterward, I ask students why they think I asked them to write about the experience first. Most will recognize, based on our earlier conversation, that I was hoping to help them remember the pain of homesickness in the effort to facilitate their empathy with a partner. (I use the example of homesickness because it’s common and transient. While those qualities may make understanding easier, they can also lead to a “Oh, that’s not a big deal; it happens to everyone” response in students.)
* I then discuss challenges/roadblocks and ask students to consider which, if any, they might have experienced during the brief exercise. Talk time ratio, which is the relative amount of speech from a helper versus from the speaker, can be considered here. Although appropriate talk time will differ across settings (health professionals and therapists likely have varying perspectives on effective ratios), suggesting a ratio to aim for can provide structure that students appreciate (e.g., 70-90% talking by speaker, 10-30% talking by helper).

**Empathy and Cultural Issues**

* Discussion of the qualities required to be truly empathic with another individual’s point of view can be enlightening. This topic overlaps with cultural humility, mentioned previously, as empathy is also a component of cultural understanding (and vice versa). This can be a useful segue to continued focus on cultural issues.
* You may wish to introduce Paul Pedersen’s concept of “inclusive cultural empathy” (ICE; Pedersen, Crethar, & Carlson, 2008). Pedersen perceived the traditional view of empathy as individual in focus, a solely one-to-one connection in which one person senses the cognitive and affective experience of another. He argued that in non-Western cultures, empathy is a more inclusive concept because it focuses on not only an individual but also the individual’s significant others and cultural context.
* A concrete example of cross-cultural differences in empathy can be gleaned from a qualitative study of perspectives on empathy of Chinese immigrant clients living in Canada (Ng & James, 2013). The authors’ analysis of their interviews suggests that empathy is considered an important part of therapy in this population, though verbalized and conceptualized differently than in Western clients. The researchers provided specific ideas for how Western counselors might differentially demonstrate empathy with Chinese clients.

**Skill #5: References and Resources**

Batt-Rawden, S. A., Chisolm, M. S., Anton, B., & Flickinger, T. E. (2013). Teaching empathy to medical students: An updated, systematic review. *Academic Medicine, 88,* 1171-1177. [http://dx.doi.org/10.1097/ACM.0b013e318299f3e3](http://dx.doi.org/10.1097/ACM.0b013e318299f3e)

This review addresses the decline of empathy during medical school. The authors summarize prior reviews of measures of empathy and present a review of studies of empathy-enhancing educational strategies in medical education. Concluding that most interventions are effective, the article incorporates a helpful categorization of strategies (e.g., creative arts, writing, communication skills training, patient interviews, experiential learning).

Bearman, M., Palermo, C., Allen, L. M., & Williams, B. (2015). Learning empathy through simulation: A systematic literature review. *Simulation in Healthcare, 10,* 308-319. <http://dx.doi.org/10.1097/SIH.0000000000000113>

 This review focuses specifically on the use of simulation (e.g., role play exercises, games, or incorporation of simulated patients) in teaching empathy to pre-service health professionals. Overall, simulation appears to be a helpful strategy; in particular, activities in which learners are asked to assume the role of patients, especially through role play, seem to be most effective in developing empathy.

Boodman, S. G. (2015, March 15). How to teach doctors empathy. *The Atlantic.* Retrieved from <http://www.theatlantic.com/health/archive/2015/03/how-to-teach-doctors-empathy/387784/>

 Boodman describes a shift in medical education to incorporate greater focus on empathy training, defined as improved listening skills, better ability to decode nonverbal cues, and reduced defensiveness. The article includes interviews with medical education professionals and refers to specific programs (e.g., Duke’s “Oncotalk,” Massachusetts General’s “Empathetics,” and Columbia’s University narrative medicine program).

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48,* 43-49. [http://dx.doi:.org/10.1037/a0022187](http://dx.doi.org/10.1037/a0022187)

 Cited on the Skill #4 handout in the context of evidence-based therapy relationships, this article also provides a helpful clinical example and practice-based recommendations. The authors categorize, describe, and give examples of four types of empathic statements: understanding responses, affirmations, evocations, and conjectures.

Kelley, K. J., & Kelley, M. F. (2013). Teaching empathy and other compassion-based communication skills to nurses. *Journal for Nurses in Professional Development, 29,* 321-324. <http://dx.doi.org/10.1097/01.NND.0000436794.24434.90>

 The authors argue that empathy plays an essential role in nursing, and they review active listening skills and “comfort skills” (e.g., compassion, consolation, commiseration) that can be incorporated in nursing education.

Neukrug, E., Bayne, H., Dean-Nganga, L., & Pusateri, C. (2013). Creative and novel approaches to empathy: A neo-Rogerian perspective. *Journal of Mental Health Counseling, 35,* 29-42. <http://dx.doi.org/10.17744/mehc.35.1.5q375220327000t2>

 This article offers a historical review of the concept of empathy, calling attention to Rogers’s contributions to its acceptance as a key value of most schools of psychotherapy. The authors suggest six modern techniques for demonstrating empathy: reflecting deeper feelings, pointing out discrepancies, visual imagery, analogies, metaphors, and targeted self-disclosure.

Ng, C. T. C., & James, S. (2013). Counselor empathy or “Having a heart to help”? An ethnographic investigation of Chinese clients' experience of counseling. *The Humanistic Psychologist, 41,* 333-349. <http://dx.doi.org/10.1080/08873267.2013.779276>

 This article is a qualitative examination of the concept of empathy from the perspective of first-generation Chinese immigrants living in Canada. The study suggests that empathy is important to Chinese clients though viewed somewhat differently, linguistically and conceptually, than it is among Western clients. The authors include ideas for communicating empathy, e.g., by directly informing clients that they are understood, disclosing similar personal experiences, and paraphrasing statements with metaphors.

Pedersen, P. B., Crethar, H. C., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. Washington, DC: American Psychological Association.

I especially recommend Chapter 1 (Traditional and nontraditional perspectives on empathy, help-seeking, and healthy outcomes, pp. 7-21), Chapter 3 (Defining cultural empathy, pp. 41-59), and Chapter 9 (Integral skills: Microskills for inclusive cultural empathy, pp. 181-198). Inclusive cultural empathy (ICE) is construed as a revision of the traditional concept of empathy; whereas traditional empathy emphasizes similarities of experience in a relationship, ICE acknowledges both similarities and differences. Helpers are encouraged to learn about their own cultural assumptions and to increase understanding of specific similarities and differences between themselves and clients.

Rogers, C. R. (1986). Reflection of feelings and transference. *Person-Centered Review, 1,* 375-377.

 Rogers discusses his concern that the reflection of feelings has become “a very wooden technique,” suggesting that such responses would better be labeled “testing understandings” or “checking perceptions.”

# Skill #6: Self-Appraisal and Mindfulness

**Overview**

I divide content on self-appraisal across two classes. In the first class, I begin by discussing the importance of self-understanding in helpers, and then I introduce the topic of mindfulness. I focus on mindfulness because it is effective in stress reduction and consequently, it is a useful skill for future helping professionals. More immediately, it can be a useful strategy for preparing oneself to listen attentively to a partner in the pairs exercise (described below). In the subsequent class, I introduce the concepts of transference and countertransference, emphasizing how self-awareness can facilitate recognition of these processes.

**Self-Appraisal and Coping Strategies *(Student Handout Points 1 & 2)***

**Discussion: Why is self-appraisal an important skill for helpers?** I ask students why they believe self-awareness and stress management are so essential. Important points to cover include

* the potential for other people’s problems, physical or emotional, to trigger one’s own (potentially unresolved) issues – which can interfere with helpers’ ability to be nonjudgmental, accepting, and fair-minded;
* the obligation of helpers to focus on other people’s needs rather than their own – which means that ideally motivation to help others is based in healthy altruism rather than a need for self-worth or a means of self-healing;
* that overly stressed helpers may be too distracted by their own issues to effectively focus on or attend to others, be empathic, or engage in helpful problem-solving (see Irving, Dobkin, & Park, 2009, for a summary of the effects of work stress on patient care); and
* that maturity and personal adjustment are essential to withstanding the inevitable challenges of helping. Examples include coping with client/patient pain and suffering, handling one’s own feelings in the midst of client/patient negativity, withholding one’s own opinion and maintaining neutrality, and limit-setting.

**Mini-lecture: Helper support and coping.** Some instructors may wish to delve into issues of burnout or compassion fatigue at this juncture. (I shy away from the topic at this stage because I am fearful of overwhelming students with negativity about helping careers, though I recognize it is an important topic.)

I primarily focus on coping strategies here, always a topic from which highly stressed college students can benefit. In addition to those noted on the handout, you may also want to include practices derived from the positive psychology literature, such as savoring techniques, gratitude, acts of kindness, and flow states. (See <http://sonjalyubomirsky.com/> or <https://www.positivityratio.com/> for ideas.)

**Mindfulness *(Student Handout Point 3)***

**Mindfulness overview.** You may wish to introduce the concept of mindfulness by assigning students a popular article in advance of class or showing a video clip during class (see “resources for students”). Some ideas to introduce or reinforce include

* a definition and description of mindfulness (for overview, see the chapter on mindfulness in Barbezat & Bush, 2014; in addition, all of the research articles listed in the “references and resources” section provide concrete definitions);
* sample mindfulness activities, including, but not limited to, meditation (see Barbezat & Bush, 2014, or any of the readings in the “resources for students” section);
* research on the efficacy of mindfulness activities in reducing anxiety, depression, and perceived stress (see Khoury, Sharma, Rush, & Fournier, 2015).

**Mindfulness for helping professionals: Background information.** Mindfulness-based stress reduction (MBSR) is an 8-week training program with an established track record in improving mental health functioning (e.g., Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016). Two reviews demonstrated its success in relieving stress specifically in mental health and health care professionals (Irving et al., 2009; Khoury et al., 2015), occupations in which emotional exhaustion and burnout are common.

 MBSR classes are typically held once per week for 2.5 hours and incorporate instruction in a variety of mindfulness techniques, group sharing of their experiences, and regular homework assignments (see Center for Mindfulness, <http://www.umassmed.edu/cfm/>). Describing elements of the program for students can add to the credibility of the mindfulness concept.

Related to mindfulness practices in our class, I review data on high rates of mental and behavioral health problems in college students (Douce & Keeling, 2014) and discuss perceptions of greater distractibility and attentional challenges in millennials (e.g., Parry, 2013). I explain that we will practice different mindfulness strategies in class (e.g., guided meditations, imagery instructions, deep breathing) so that students can consider which, if any, successfully improve their focus during our pairs helping exercise.

**Pairs Helping Exercises *(Student Handout Point 4)***

 **Description.** The pairs exercises are an important component of the course, as they occur in four class sessions and require 40-45 min of each class period. In brief, students work with an assigned partner, alternatively serving as a helper and an individual with a problem, in the effort to practice helping skills. I initially describe the pairs helping exercises during the preceding class so that I have an opportunity to invite students to (a) share any concerns they might have about participation and (b) reflect upon a problem or concern they are willing to discuss with someone else in the class.

 I have been facilitating some form of these exercises in this course for over a decade, and I have never had a student object to participation. Given that students enrolled in the course most likely hope to pursue a career in a helping profession, their openness to the exercise is not surprising. However, I am careful to emphasize that students are welcome to role play when in the client role if they feel uncomfortable sharing personal information with another student. I also stress the critical importance of confidentiality about the specific content of weekly discussions. (Note that because each student will serve as both helper and client in the same student pair, their reciprocity in interactions likely encourages both self-disclosure and confidentiality.) Finally, I repeatedly mention that this exercise should not be perceived as counseling or psychotherapy, and I use this opportunity to make connections to the American Psychological Association’s (2016) ethical standards regarding competence, human relations, and education and training.

 **Assignment of pairs.** After describing the exercise during the previous week’s class, I ask students to identify classmates they know well so that I do *not* assign them to work together in the pairs exercise. (I have found students to be very honest about this.) I also avoid teaming classmates who typically sit next to each other, as they have most likely already worked together on several role-play exercises. Once I account for these issues, I assign pairings in semi-random fashion (“semi-random” because the small size of my class allows me to be reasonably well-acquainted with students by this point in the semester, which doubtlessly has some bearing on my assignments).

 I always cap the maximum enrollment in this class at an even number in order to have solely two-person pairs. In the rare semesters in which a student has had to drop the course, leaving an uneven number of students, I have constructed a three-person group. This solution, far from ideal, requires that student A serves as the helper for student B, student B serves as the helper for student C, and student C serves as the helper for student A; the timing of sessions is therefore different than with other pairs in the class, and the reciprocity advantage of a student being both a helper and client with the same person is lost.

**Prior research.**  Clara Hill, author of one of the seminal counseling skills textbooks, demonstrated the positive impact of helping skills instruction in undergraduates following their completion of a semester-long training course (see Hill et al., 2016). Hill’s model, more complex than the interpersonal skills approach described here, originally targeted graduate students in counseling and consisted of three stages (exploration, insight, and action). However, her impressive research program, described in several recent articles, established that undergraduates can progress substantially in learning helping skills. I hope similar progress results from the present curriculum.

 At this point in the course I note that research studies in many disciplines demonstrate a positive impact of interpersonal communication skills. For example, active listening education has been associated with greater conversational satisfaction and perceived social attractiveness among college students talking to helpers (Bodie, Vickery, Cannava, & Jones, 2015; Weger, Bell, Minei, & Robinson, 2014; Weger, Castle, & Emmett, 2010) and improved communication ability in speech and language pathologists (Thistle & McNaughton, 2015) and special education teachers (Vostal, McNaughton, Benedek-Wood, & Hoffman, 2015). Such studies, in combination with evidence of the critical importance of several elements of the therapist-client relationship (e.g., individual therapy alliance, empathy, goal consensus, collaboration, and positive regard; see Norcross, 2011), provide a rich evidence basis for helping skills.

**Pairs Helping Exercise, Session 1** ***(Student Handout Point 4)***

**Timing for Session 1.** For the first pairs helping exercise session, I allow 75 minutes. This provides ample time to carefully introduce the overall exercise and its goals, review helping skills covered to date, establish ground rules, and provide instructions for Session 1. After I announce the pairings, partners move chairs close together, spreading out across the room with as much space between pairs as is physically possible. I then give students 3 min for individual mindfulness practice, followed by at least 15 min for Partner A to serve as the helper and Partner B to serve as the client. This is followed by an additional 3 min of mindfulness practice and another 15-min session, in which Partner B serves as the helper and Partner A serves as the client.

I oversee Session 1 from the front of the room so that students can establish rapport with their partners without worrying about my presence. I flip the lights on and off with 30 seconds remaining in the time period so that students (as helpers) have an opportunity to frame a final summary paraphrase.

**Instructions for Session 1.** As noted on the student handout, goals for this session include establishing rapport, encouraging trust, demonstrating basic listening skills, striving to understand the partner’s problem, and communicating caring. Each of these goals has been covered in prior class meetings and can be quickly reviewed.

One topic that hasn’t been addressed previously is resisting the temptation to give advice. Many students will want to “solve” their partners’ problems by offering their advice or opinions. I try to head this off by engaging students in a discussion of the potential disadvantages of advice-giving early in a helping relationship. These include the strong probability that helpers don’t know enough about clients or their situations to be giving advice at this juncture; the likelihood that clients have already heard the advice, will respond with “yes, but…”, or simply not follow it; the importance of clients figuring out their own solutions to problems; the potential that advice will be wrong or inappropriate, or could backfire. I also model for students a simple, empathic response to someone’s request for advice, e.g., “I would really love to be able to give you advice, and if I thought I really knew what would be best, I’d tell you. But I know I can’t possibly know enough about you or your situation yet to be able to do that.”

**Mindfulness exercises.** I experiment with a variety of mindfulness exercises for the 3-min period (and some instructors may wish to incorporate a longer period). For mindfulness options, search the internet using the terms, “guided meditation,” “breathing meditation,” or “guided imagery.” As students become more comfortable with the process, you might try silence or music instead of a narrated exercise.

**Post-session reflection.** I ask students to write a reflection about their helping experience. I use a “data – impressions – plan and self-assessment (DIPS)” structure, but many formats are possible. (I have used the term “assessment” in place of “impressions” in the past, but I have found that students often interpret assessment as evaluation or even diagnosis, which is a mindset I try to discourage.) Because I read students’ reflections, I ask that they describe the theme of the conversation in general terms only, being careful to omit details that partners may not want me to know. I insist students do not take notes during sessions, but I give them a few minutes after their sessions to jot down ideas.

**Skill #6: References and Resources**

American Psychological Association. (2016). *Ethical principles of psychologists and code of conduct including 2010 and 2016 amendments.* Retrieved from <http://www.apa.org/ethics/code/index.aspx>

 The APA’s code of ethics, reproduced in full at this website, is intended to guide psychologists’ behavior in all aspects of their professional work. Sections of the code with relevance to helping work or internships include competence, human relations, privacy and confidentiality, and education and training.

Barbezat, D. P., & Bush, M. (2014). *Contemplative practices in higher education.* San Francisco, CA: Jossey-Bass.

 This comprehensive reference surveys contemplative methods that encourage deep reflection, internal focus, and present orientation, e.g., mindfulness, deep listening and beholding, contemplative movement, journaling. In this excellent resource for faculty considering broader adoption of contemplative pedagogy, the authors summarize research on contemplative practice, provide examples for inclusion of practices in college classrooms, and offer concrete suggestions for implementation.

Bodie, G. D., Vickery, A. J., Cannava, K., & Jones, S. M. (2015). The role of “active listening” in informal helping conversations: Impact on perceptions of listener helpfulness, sensitivity, and supportiveness and discloser emotional improvement. *Western Journal of Communication, 79,* 151-173. <http://dx.doi.org/10.1080/10570314.2014.943429>

 Based on a controlled research design in which students were assigned either a trained or untrained active listener, Bodie et al. found that active listening behaviors were associated with higher ratings of emotional awareness and improvement.

Center for Contemplative Mind in Society. <http://www.contemplativemind.org/>

 The Center for Contemplative Mind in Society is currently focused on promoting the integration of contemplative practices into higher education teaching and learning. The organization’s website provides readings, contemplative practice ideas, a blog and newsletter, and information about campus initiatives.

Center for Mindfulness in Medicine, Health Care, and Society. <http://www.umassmed.edu/cfm/>

 The Center for Mindfulness, based at the University of Massachusetts Medical School, is where MBSR was developed. The organization has a continued focus on mindfulness-based education and training, research, and clinical care, and their website offers extensive resources and research information.

Douce, L. A., & Keeling, R. P. (2014). *A strategic primer on college student mental health.* Washington, DC: American Council on Education. Retrieved from <http://www.apa.org/pubs/newsletters/access/2014/10-14/college-mental-health.pdf>

 This report, jointly published by the APA, national organization of student affairs professionals, and the American Council on Education, focuses on the connection between student mental health and learning. After summarizing data on the prevalence of mental and behavioral health issues, the report urges colleges to respond to the crisis with greater provision of outreach education, consultation, and prevention services.

Hill, C. E., Anderson, T., Kline, K., McClintock, A., Cranston, S., McCarrick, S., ... Gregor, M. (2016). Helping skills training for undergraduate students: Who should we select and train? *The Counseling Psychologist, 44,* 50-77. <http://dx.doi.org/10.1177/0011000015613142>

Hill, C. E., Spangler, P. T., Jackson, J. L., & Chui, H. (2014). Training undergraduate students to use insight skills: Integrating the results of three studies. *The Counseling Psychologist, 42,* 800-820. doi:10.1177/0011000014542602

Hill and colleagues have conducted extensive research demonstrating the effectiveness of instructing undergraduates in Hill’s helping skills training model. Their 2014 study is a compilation of three investigations showing a positive impact of teaching insight skills, with lecture and practice being particularly effective pedagogical strategies. The 2016 study investigates the impact of a semester-long course in helping skills; students improved in their abilities, as indicated by reduced talking and greater use of exploration skills, better-quality sessions, and greater self-efficacy for using helping skills.

Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary Therapies in Clinical Practice, 15,* 61–66. [http://dx.doi:.org/10.1016/j.ctcp.2009.01.002](http://dx.doi.org/10.1016/j.ctcp.2009.01.002)

 Irving et al. review 10 studies of the impact of MBSR on health care professionals, including physicians, nurses, premedical and medical students, hospital administrators, and mental health professionals. The article provides a summary of the impact of stress and burnout and a description of mindfulness and MBSR. The authors conclude that MBSR is helpful in reducing negative emotional states and perceived stress.

Khoury, B., Sharma, M., Rush, S. E., & Fournier, C. (2015). Mindfulness-based stress reduction for healthy individuals: A meta-analysis. *Journal of Psychosomatic Research, 78,* 519-528. [http://dx.doi:.org/10.1016/j.jpsychores.2015.03.009](http://dx.doi.org/10.1016/j.jpsychores.2015.03.009)

 This meta-analysis includes the findings of 29 studies focusing on MBSR interventions in nonclinical populations (e.g., college students, hospital employees, teachers, community members). The findings demonstrate moderate reductions in levels of depression, anxiety, and distress and larger improvements in stress and quality of life assessments. In addition, traditional-length MBSR was found to be more effective than shortened versions.

Lamothe, M., Rondeau, E., Malboeuf-Hurtubise, C., Duval, M., & Sultan, S. (2016). Outcomes of MBSR or MBSR-based interventions in health care providers: A systematic review with a focus on empathy and emotional competencies. *Complementary Therapies in Medicine, 24,* 19-28. [http://dx.doi:.org/10.1016/j.ctim.2015.11.001](http://dx.doi.org/10.1016/j.ctim.2015.11.001)

 This review of 39 studies demonstrates that MBSR is effective in improving mental health outcomes (depression, anxiety, burnout, and perceived stress) and increasing levels of mindfulness. Of seven studies assessing empathy, five reported empathy improvements.

Norcross, J. C. (Ed.). (2011). Evidence-based psychotherapy relationships. *Psychotherapy, 48*(1).

 This special issue focuses on qualities of evidence-based therapy relationships. Each article summarizes research on one relational element, provides a case example, and offers practice recommendations. “Demonstrably effective” elements of individual therapy include the alliance, empathy, and collecting client feedback; “probably effective” elements include goal consensus, collaboration, and positive regard.

Parry, M. (2013, March 24). You’re distracted. This professor can help. *The Chronicle of Higher Education.* Retrieved from <http://www.chronicle.com/article/Youre-Distracted-This/138079/?cid=wc>

 Focused on technology overload among college students, this article profiles University of Washington professor David Levy’s novel “Information and Contemplation” course. The author also describes research on meditation and provides reading suggestions on contemplative practices, attention and multitasking research, and technology impacts.

Thistle, J. J., & McNaughton, D. (2015). Teaching active listening skills to pre-service speech-language pathologists: A first step in supporting collaboration with parents of young children who require AAC. *Language, Speech, and Hearing Services in Schools, 46,* 44-55. <http://dx.doi.org/10.1044/2014_LSHSS-14-0001>

 Graduate students in a speech-language pathology program were trained in active listening skills. Pretest-posttest comparisons demonstrated that the instruction improved active listening abilities. Following training, participants’ communication was viewed more positively by others.

Vostal, B. R., McNaughton, D., Benedek-Wood, E., & Hoffman, K. (2015). Preparing teachers for collaborative communication: Evaluation of instruction in an active listening strategy. *National Education Teachers Journal, 8,* 5-14.

 Students trained in active listening communication behaviors were found to improve in their use of them, as evidenced by pretest and posttest comparison and observations of posttraining videos.

Weger, H., Jr., Bell, G. R., Minei, E. M., & Robinson, M. C. (2014). The relative effectiveness of active listening in initial interactions. *International Journal of Listening, 28,* 13-31. [http://dx.doi:.org/10.1080/10904018.2013.813234](http://dx.doi.org/10.1080/10904018.2013.813234)

Weger, H., Jr., Castle, G. R., & Emmett, M. C. (2010). Active listening in peer interviews: The influence of message paraphrasing on perceptions of listening skill. *International Journal of Listening, 24,* 34-49. <http://dx.doi.org/10.1080/10904010903466311>

 Weger and colleagues demonstrate the effectiveness of active listening in controlled studies with undergraduates. In their 2010 study, participants receiving paraphrasing from trained students viewed them as more socially attractive than did participants receiving simple acknowledgements. In their 2014 investigation, participants who received active listening responses felt more understood and more satisfied than participants who received simple acknowledgements.

**Resources for Students**

Kabat-Zinn, J. (2012). *Mindfulness for beginners: Reclaiming the present moment - and your life.* Boulder, CO: Sounds True.

 Kabat-Zinn, the founder of the Stress Reduction Clinic and the Center for Mindfulness in Medicine at the University of Massachusetts Medical Center, introduces mindfulness to novices. The book contains brief (1-2 page) chapters that can be stand-alone readings and an accompanying CD containing guided meditations.

Parry, M. (2013, March 24). You’re distracted. This professor can help. *The Chronicle of Higher Education.* Retrieved from <http://www.chronicle.com/article/Youre-Distracted-This/138079/?cid=wc>

 (See above for annotation.)

Williams, M., & Penman, D. (2011). *Mindfulness: An eight-week plan for finding peace in a frantic world.* New York, NY: Rodale.

 This clearly written “how-to” book outlines a week-by-week mindfulness program. It combines elements of mindfulness-based stress reduction and mindfulness-based cognitive therapy.

# Skill #7: Self-Appraisal and Understanding Transference/Countertransference

**Transference *(Student Handout Points 1 & 2)***

**Mini-lecture.** After describing transference, I focus discussion around two main points:

* Transference can occur in many types of relationships. If students remember the concept of transference from earlier psychology classes, they frequently view it as a Freudian construct with little relevance to modern-day therapy, much less other types of relationships. I try to combat this view with examples from popular media (interest in celebrities, the frequency of stalking) and everyday life (“love at first sight,” meeting people who remind you of parents/siblings/childhood friends).
* Being the object of transference can be highly uncomfortable. I have had interns struggle in the past as a result of transference issues, most often involving youth clients. Examples include a young child who clings to the intern; being called “Mommy” or “Daddy”; an older teenager asking for an intern’s phone number or contacting an intern on social media; being at the receiving end of a youth’s tantrum or violent outburst. I explain to students that transference can feel puzzling, awkward, and unfair and that learning to recognize transference reactions is an important aspect of self-appraisal.

**Applications to internships.** I then ask students to try to provide examples from their internship sites of possible experiences of transference. If none come to mind, I ask them to consider experiences in which transference *could* potentially play a role in the future. Most can do this quite easily. (Depending on time constraints, you may wish to introduce transference and countertransference together; in this case, asking students to volunteer an example of either experience from their internships works well.)

**Dealing with transference.** I emphasize that should students experience reactions from clients at their internships that they believe to be transference, they should talk with supervisors (or me) about these as soon as possible. I repeat many of the same suggestions I made in the previous class regarding the importance of self-exploration, noting that transference reactions can add to a helper’s perception of stress and need for self-care. Although I sometimes model responses to transference so that students understand that it is possible to be simultaneously caring and set limits, I am clear that I do not want interns to attempt to manage transference on their own.

**Countertransference *(Student Handout Points 3 & 4)***

**Mini-lecture.** Theory and research on countertransference is quite prevalent, both within psychology as well as within other helping professions. I try to “normalize” countertransference by providing examples from a variety of career perspectives. For example,

* Professors: A qualitative study of 14 college professors indicated that all could recount experiences of countertransference, such as student criticism, arrogance, or lack of appreciation triggering extremely negative feelings described as “out of character” (Slater, Veach, & Li, 2013).
* Speech-language pathologists: One example is an individual’s underlying fears of inadequacy being aroused following a lack of success following three sessions with a 2-year old client (Geller & Foley, 2009).
* Physicians: Despite their brevity, patient-doctor visits can spark intense emotional reactions in physicians, such as a patient who refuses to follow the treatment plan arousing frustration or anger, or a patient whose story produces deep empathy. Introducing the concept in medical training could improve health care by helping physicians identify and then manage their feelings (Moukaddam, Tucci, Galwankar, & Shah, 2016).

Examples from different careers or types of helping relationships can also help students understand the difference between rational and irrational reactions to clients. Cartwright (2011) provided excellent background on this issue, distinguishing between “objective” (rational) and “subjective” (irrational) therapist reactions, and introducing a case example. Because the goal of Cartwright’s article is to demonstrate the applicability of countertransference to cognitive therapy, a perspective that has historically underemphasized attention to the therapeutic relationship, this article is also helpful in establishing the widespread relevance of countertransference.

**Dealing with countertransference.** As with transference, the main point of discussing this skill is that self-awareness is a key element of effective helping relationships. The work of Hayes and colleagues (e.g., Fatter & Hayes, 2013; Hayes, Gelso, & Hummel, 2011) suggests that therapists’ skillful management of countertransference is associated with more positive therapy outcomes. Exploration of Hayes’s research with students can add credibility to the concept of countertransference while reinforcing the importance of self-appraisal and personal insight.

**Self-Disclosure *(Student Handout Point 5)***

**Background information.** In the context of client-therapist relationships, Zur (2016) defined self-disclosure (SD) as the therapist’s sharing of personal information, distinguishing between “boundary crossing” SD (appropriate disclosure offered for the therapeutic benefit of a client) and “boundary violation” SD (disclosure motivated by the therapist’s needs, potentially burdening a client). Zur’s review also provided historical context for the topic as well as summaries of views of SD from different theoretical frameworks. Baca (2011) extended attitudes toward self-disclosure to the nursing profession.

 Jaffe and Diamond (2011) discussed the advantages and disadvantages of SD in therapeutic work with clients struggling with infertility or pregnancy loss. Because such clients are typically seeking supportive counseling rather than help for chronic mental illnesses or personality problems, SD may have some unique benefits and drawbacks. For example, a therapist who experienced difficulty in conceiving may help a client dealing with infertility feel understood. However, a therapist whose reproductive difficulties did not result in a biological child may cause a client to feel hopeless. Concrete examples can help students more thoughtfully explore the pros and cons of self-disclosure.

**Class discussion of SD’s benefits and drawbacks.** Because Millennial Generation students are accustomed to – and often comfortable with – what professors might view as oversharing and “TMI” (too much information), I think the topic of self-disclosure is essential. I ask students to share what they imagine to be both benefits and risks, prodding them with specific examples, such as experience with depression or substance abuse. Table 2 displays additional ideas.

Table 2.

*Potential Benefits and Drawbacks of Self-Disclosure*

|  |  |
| --- | --- |
| Potential Benefits | Potential Drawbacks |
| * Nondisclosing therapist may be seen as cold or distant
* Client may feel less isolated or alone if the SD indicates a shared experience
* Client may feel better understood or that an experience/feeling is validated
* Therapist is demonstrating genuineness
* Therapist SD may encourage greater client SD
* Therapist may instill hope/serve as a model (e.g., with clients in recovery)
* Therapist may have greater credibility (e.g., a therapist who shares a diversity with a client)
* SD may foster a more egalitarian relationship (e.g., a goal of feminist therapy)
 | * Therapist SD removes focus of session from client
* Client may be distracted from own needs by SD
* Client may feel burdened or overwhelmed by a highly personal SD
* Client may feel a responsibility to listen to/help therapist
* Therapist SD may detract from client’s sense of uniqueness
* SD may blur the boundaries of the relationship/make the relationship more like a social relationship
* SD interferes with transference (an issue primarily for psychodynamically oriented therapists)
* SD may indicate a therapist’s unresolved issues
 |

*Note.* SD = Self-Disclosure

**Guidelines.** I conclude the discussion with a middle-road position: Limited SD may have benefits, but it is only appropriate if it meets certain guidelines:

* Use with caution: Consider that there are at least as many disadvantages as advantages on the list. A “do no harm” philosophy suggests that *not* disclosing is going to be the safer course than disclosing.

* Make sure there is a goal: A helper should only self-disclose if doing so has a clear benefit.
* Consider the timing: SD must be timed carefully, e.g., not during a client’s crisis.
* Consider the “match”: SD must be relevant to the client’s experience. Helpers must check to be sure the SD is not simply an excuse to tell a story.
* Have a plan to “get in and get out”: Helpers should plan in advance how they could self-disclose and then quickly move the focus back to the client.

**Pairs Exercise, Session 2**

I allow 50-60 min for this second pairs helping exercise experience. As with Session 1, I introduce the goals of the session, addressing any concerns that arose in my reading of students’ DAS reflection from the initial session. I then give students 3 min for another guided meditation, imagery, or breathing exercise, followed by at least 15 min for the session. As with Session 1, I repeat this timing (3-min meditation, 15+ min session) with partners reversing roles.

 Goals of the session for helpers include increasing comfort and rapport with partners, practicing reflections of content and feelings, and learning to allow partners to choose the topics and decide how to use the time. (Per the student handout, specific instructions for the session may vary according to what issues seem to be most difficult for students. For example, asking helpers to work on their comfort with silence stems from my sense that many helpers – anxious with any pause in dialogue – jump in with questions; often such questions are somewhat off-topic.)

 I do walk around the room to observe pairs during Session 2. However, I do not interrupt sessions or linger long, as it is clear that for most pairs, my presence is highly anxiety-producing. Yet, my silent observation seems to keep partners on track and motivated to follow through on the goals of the assignment.

**Skill #7: References and Resources**

Baca, M. (2011). Professional boundaries and dual relationships in clinical practice. *Journal for Nurse Practitioners, 7,* 195-200. <http://dx.doi.org/10.1016/j.nurpra.2010.10.003>

 Baca addresses the topics of self-disclosure, transference, and countertransference from the perspective of maintaining professional boundaries that support trusting and caring relationships between nurses and patients. She construes self-disclosure as a boundary crossing or violation, suggesting that there are few circumstances in which it is appropriate.

Cartwright, C. (2011). Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist, 15,* 112-120. [http://dx.doi:.org/10.1111/j.1742-9552.2011.00030.x](http://dx.doi.org/10.1111/j.1742-9552.2011.00030.x)

 Cartwright undertakes a theoretical literature review of the concepts of transference and countertransference. She describes transference from a traditional psychodynamic perspective as well as from modern social cognitive, attachment, cognitive-analytic, and schema-focused models and considers “subjective” countertransference (therapists’ responses to a client that result from therapists’ personal issues) vs. “objective” countertransference (therapists’ responses that are realistic reactions to a client’s personality characteristics or behaviors). The article includes a case illustration and suggests that cognitive therapists could benefit from increased attention to these processes.

Fatter, D. M., & Hayes, J. A. (2013). What facilitates countertransference management? The roles of therapist meditation, mindfulness, and self-differentiation. *Psychotherapy Research, 23,* 502-513. <http://dx.doi.org/10.1080/10503307.2013.797124>

 This article describes the findings of a survey study of 78 therapist trainees and their supervisors. Lengthier meditation experience in trainees was correlated with supervisors’ higher ratings of trainees’ ability to manage countertransference. The authors suggest that meditation training may facilitate development of qualities such as self-awareness and empathy, which in turn aid therapists in successfully navigating countertransference.

Geller, E., & Foley, G. M. (2009). Expanding the "ports of entry" for speech-language pathologists: A relational and reflective model for clinical practice. *American Journal of Speech-Language Pathology, 18,* 4-21. [http://dx.doi.org/10.1044/1058-0360(2008/07-0054)](http://dx.doi.org/10.1044/1058-0360%282008/07-0054%29)

 Geller and Foley apply multiple psychological concepts, including transference and countertransference, to speech-language (SL) pathology practice. They construe transference as an “everyday phenomenon” (p. 10) and discuss the importance of SL pathologists understanding the emotions that are likely to be a part of their work with children and their parents. They emphasize that the goal of such insight is not to share an interpretation with clients but to be able to better manage one’s own affective responses.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy, 48,* 88-97. <http://dx.doi.org/10.1037/a0022182>

One of a series of articles in a special issue of *Psychotherapy* focused on characteristics of evidence-based therapy relationships, this article provides a history and definitions of countertransference, contrasting four perspectives: classical (therapist unconscious reactions to client transference), totalistic (all therapist reactions), complementary (therapist reactions resulting from client interpersonal style), and relational (therapist reactions mutually constructed by therapist and client). The authors recommend an integrated view, provide a clinical example and practice recommendations, and conclude that effectively managing countertransference is a quality of therapists judged excellent by peers, most likely enhancing therapy outcomes.

Jaffe, J., & Diamond, M. O. (2011). Self-disclosure, transference, and countertransference. In *Reproductive trauma: Psychotherapy with infertility and pregnancy loss clients* (pp. 159-177). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/12347-008>

Jaffe and Diamond consider relational issues from the lens of therapists working with clients struggling with reproductive issues. They review theoretical perspectives on self-disclosure and provide guidelines for appropriate self-disclosure regarding therapists’ experiences with infertility or miscarriage (e.g., for client’s benefit, if alliance is strong) along with case examples.

Moukaddam, N., Tucci, V., Galwankar, S., & Shah, A. (2016). In the blink of an eye: Instant countertransference and its application in modern healthcare. *Journal of Emergencies, Trauma, and Shock, 9,* 95-96. [http://dx.doi.org/10.4103/0974-2700.185279](https://dx.doi.org/10.4103/0974-2700.185279)

 This essay suggests that physicians’ emotions toward patients must be acknowledged and that models for understanding countertransference in nonpsychological contexts are lacking. The authors describe the phenomenon of “instant countertransference,” the idea that emotional responses to patients’ behaviors and personality characteristics can develop quickly. The authors believe that with training and supervision, physicians can learn to recognize and manage such feelings.

Slater, R., Veach, P. M., & Li, Z. (2013). Recognizing and managing countertransference in the college classroom: An exploration of expert teachers’ inner experiences. *Innovative Higher Education, 38,* 3-17. [http://dx.doi.org/:10.1007/s10755-012-9221-4](http://dx.doi.org/10.1007/s10755-012-9221-4)

 This qualitative research study of 14 college professors defines countertransference as “reactions to others that stem from our own areas of personal conflict” (p. 7). Each study participant reported experiences that he or she perceived as fitting the definition. Interviews focused on countertransference triggers, reactions, and management strategies.

Zur, O. (2016). Self-disclosure & transparency in psychotherapy and counseling: To disclose or not to disclose, this is the question. Retrieved from <http://www.zurinstitute.com/selfdisclosure1.html>

 Zur conducted a literature review of self-disclosure definitions and types, historic and current theoretical perspectives, and rationales for disclosure with different types of client populations.

# Skill #8: Building a Working Alliance and Cross-Cultural Relationships

**Working Alliance *(Student Handout Points 1 & 2)***

**Introductory mini-lecture.**  A brief overview of the concept of the working alliance can help students grasp its importance. Horvath, Del Re, Flückiger, and Symonds (2011) provided an excellent historical context and reviewed different definitions of the therapeutic alliance. Although the alliance overlaps with the topic of empathy (Skill #5) both theoretically and empirically (Nienhuis et al., 2016), I emphasize their differences in this introduction. For example, the alliance forms gradually across time, and once a strong alliance is in place, it is likely to be consistent. A belief that one’s therapist is empathic no doubt contributes to a client’s perceptions of the alliance, but views of empathy may be more variable over time. In addition, most contemporary theorists describe a collaborative relationship, in which therapist and client share consensus on therapy goals or procedures, as one aspect of the alliance. This element is not especially relevant to empathy.

Horvath et al. (2011) described the findings of their meta-analysis of the relationship between the alliance and treatment outcomes. Regardless of how or when the alliance was measured, or the type of therapy evaluated, the results suggested a strong relationship between the alliance and individual therapy success.

Although the literature on the alliance is rooted in psychotherapy theory, the concept is mentioned in other helping professions. For example, a recent article on diabetes management encouraged healthcare providers to take the time to form alliances with patients to facilitate greater commitment to behavior change (Jones, Vallis, Cooke, & Pouwer, 2016). In a sample of neurology patients, Fuertes, Boylan, and Fontanella (2009) found that the working alliance was associated with empathy and multicultural competence and that the alliance was associated with patient satisfaction, perception of treatment utility, and self-efficacy regarding treatment adherence.

**Exercise.**  To make the concept of the alliance more concrete, and to apply it to the helping pairs activity, ask students to complete an adapted version of one of the common measures of the alliance. For example, the Helping Alliance Questionnaire (HAq-II; available at <http://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf>) is a 19-item instrument assessing the therapeutic alliance; it consists of separate versions for the therapist and the client. You may wish to shorten and adapt the measures, replacing the term “therapist” with “helper,” and the term “patient” with “client.” Students could complete the patient/client version based on their experiences as clients in the helping pairs practice. You might also experiment with asking them to complete the therapist/helper version, based on their helper experiences in the pairs practice. In Helping Pairs Session 3, helpers may then wish to ask clients about their responses.

A shorter instrument option is described in Shaw and Murray (2014), who reviewed research indicating that collecting and making use of client feedback is associated with therapy success. The Session Rating Scale (available at <http://www.magellanofaz.com/media/250346/myoutcomes%20tools%20-%20ors_srs_cors_csrs.pdf>) is a 4-item survey typically presented to clients at the close of a session, assessing qualities and events present in just that session. The four items measure the degree to which a client felt heard and understood by the therapist, was satisfied with the topics discussed, perceived the therapist’s approach to be a good fit, and felt content with the session overall.

**Implications.** Per the handout, I provide students with a rationale about why attentiveness to the alliance is important. Horvath et al. (2011) is also a helpful source for this information.

**Video analysis.** Pick a helper-client video and show the first 7-8 min. It can be one in which a strong alliance either is or is not forming. Ask students to evaluate characteristics of the alliance from the client’s point of view.

**Multicultural/Cross-Cultural Helper-Client Relationships *(Student Handout Point 3)***

**Discussion: Preference for culturally matching therapists.**  Chu, Leino, Pflum, and Sue (2016) provided a summary of previous research on preference for racial/ethnic matching between therapist and client. Students can readily generate reasons for this preference as well as reasons why culturally matching relationships may result in more effective therapy. For example, matching therapists are perceived as more understanding/empathic, trustworthy, competent, and sensitive to experiences of bias.

However, Chu et al. (2016) also reviewed studies indicating that when asked to rank preferences regarding different qualities in prospective therapists, participants do not rank racial/ethnic match as their highest priority; similarities in beliefs, values, and personality are all considered more important. As students quickly grasp, it is therefore at least theoretically possible for nonmatching therapists and clients to develop strong relationships.

**Mini-lecture: Cultural competence.** Depending on the extent to which you have introduced this concept previously (e.g., with Skill #2 or Skill #5), you may wish to segue here to an explanation of cultural competence. Chu et al. (2016) reviewed definitions of cultural competency that emphasize therapist characteristics (cultural awareness and beliefs, knowledge, and skills), process models (interactions among client, therapist, and therapy), and interventions (specialized skills involving adaptations of evidence-based treatments). They also offered a theoretical model attempting to explain why cultural competency results in better treatment outcomes.

**Video clip.**  Showing 7-8 min of a multicultural therapy relationship can be helpful, ideally serving as a contrast in styles with the earlier clip. Ask students to evaluate how the therapist may be demonstrating different characteristics or behaviors in an attempt to make a cross-cultural connection. I recommend Patricia Arredondo’s APA video (<http://www.apa.org/pubs/videos/4310723.aspx>) on multicultural counseling, Series V, which is focused on counseling Latina/Latino clients.

**Discussion: Effective multicultural relationships.** Because the working alliance skill focuses on the quality of the helper-client relationship, I direct the conversation about cultural competence to a focus on qualities of effective multicultural relationships. If I have assigned reading on the topic in advance of class, I ask students to generate ideas about how they might establish a strong alliance with someone who is culturally different. Some ideas from Chu et al. (2016), Comas-Díaz (2012), and Fuertes, Brady-Amoon, Thind, and Chang (2015) include the following:

* Being aware of one’s own cultural identities, biases, and possible privilege;
* Being open to hearing about/validating a client’s experiences of prejudice or oppression;
* Having patience: a trusting alliance may take more time to develop with culturally different clients;
* Inquiring about how cultural differences might affect the therapeutic relationship;
* Matching behaviors and approaches where possible;
* Gaining knowledge about the histories and issues of different cultural groups;
* Recognizing “ethnocultural” transference, such as client avoidance of issues related to culture or ethnicity, client mistrust about a helper’s ability to understand;
* Recognizing “ethnocultural” countertransference, such as excessive curiosity about cultural differences that interferes with a focus on client needs, guilt about societal oppression.

**Pairs Exercise, Session 3 *(Student Handout Point 4)***

I again allow 50 min for the full exercise, although if necessary I have reduced the time for each helper’s turn from 15 to 12 min. As with previous sessions, I introduce goals of the session, address any concerns revealed in students’ most recent DAS reflection, and allow 3 min prior to each session for a mindfulness preparation period.

* Goals of the session for helpers include continued practice of the helping skills and engaging in a conversation about the alliance. In introducing the latter objective, I encourage students to take 1-2 min to jot down some ideas about how they will introduce this conversation and what specific questions they might ask. Alternatively, they might wish to use an item from the Session Rating Scale, described above. (Most students find this directive quite awkward, but I think the value of initiating a conversation about relational issues outweighs potential discomfort.)

* By Session 3, I will typically sit down and quietly observe pairs for up to 30 seconds. Sometimes – if helpers seem unusually quiet in their listening – I tell students that to get rid of me, the helper must make a comment (e.g., paraphrase, reflection of feeling), which I will reinforce by moving on to the next pair.

**Skill #8: References and Resources**

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice, 47*, 18-29. <http://dx.doi.org/10.1037/pro0000055>

 Chu et al. address cultural competency at the person level (the type of person the helper is), at the process level (interactions between helper and client), and in terms of the helper’s skills. They provide a thorough review of literature on principles of cultural competency as well as a case example and conceptualization.

Comas-Díaz, L. (2012). Multicultural therapeutic relationship: Seeing yourself in the other. In *Multicultural care: A clinician's guide to cultural competence* (pp. 121-148). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/13491-005>

 Comas-Díaz devotes this chapter of her book on cultural competence to multicultural relationships. She addresses white privilege, microaggressions, and power differentials; considers cultural variation in views of the helper role; discusses management of multicultural therapist-client relationships, including cultural empathy; and concludes with a focus on cultural aspects of transference/countertransference.

Fuertes, J. N., Boylan, L. S., Fontanella, J. A. (2009). Behavioral indices in medical care outcome: The working alliance, adherence, and related factors, *Journal of General Internal Medicine, 24,* 80-85. <http://dx.doi.org/10.1007/s11606-008-0841-4>

 This empirical study examined the impact of the doctor-patient alliance on patient perceptions of treatment utility and adherence to treatment. Among a diverse sample of patients at a neurology clinic, patient ratings of the alliance were positively associated with patient satisfaction, though not adherence.

Fuertes, J. N., Brady-Amoon, P., Thind, N., & Chang, T. (2015). The therapy relationship in multicultural psychotherapy. *Psychotherapy Bulletin, 50,* 41-45. Retrieved from <http://societyforpsychotherapy.org/the-therapy-relationship-in-multicultural-psychotherapy/>

 In this essay, the authors respond to issues raised at a round-table discussion on multicultural therapy relationships. Their suggestions for building trust with culturally different clients include being open to hearing about and validating clients’ experiences with oppression and racism; sometimes engaging clients in discussion about cultural differences and their relevance to treatment; learning about the history and issues common to different cultural groups (though being careful not to overgeneralize); and being sensitive to the potential for microaggressions.

Helping Alliance Questionnaire (HAq-II). Retrieved from <http://www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf>

 This 19-item survey, which has separate therapist and client versions, was originally developed and revised by Lester Luborsky. The instrument, scoring information, and an empirical article about its development are available from the University of Pennsylvania Center for Psychotherapy Research (see <http://www.med.upenn.edu/cpr/instruments.html>).

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9-16. [http://dx.doi:.org/10.1037/a0022186](http://dx.doi.org/10.1037/a0022186)

In an article from the special issue of *Psychotherapy* focused on characteristics of evidence-based therapy relationships, Horvath et al. provide differing perspectives on the meaning of the “alliance.” They summarize the findings from a meta-analysis on studies of the impact of the alliance on therapy outcomes, offer a case study and practice implications, and conclude that the relationship between the alliance and outcome is robust, consistently present regardless of how the alliance or outcome is measured or the type of therapy that is assessed.

Jones, A., Vallis, M., Cooke, D., & Pouwer, F. (2016). Working together to promote diabetes control: A practical guide for diabetes health care providers in establishing a working alliance to achieve self-management support. *Journal of Diabetes Research, 2016,* 1-6. <http://dx.doi.org/10.1155/2016/2830910>

 The authors review prior research suggesting that patient relationships with their healthcare providers affect treatment outcomes in diabetes. They conclude that healthcare providers could learn from the psychological literature on the alliance, and they encourage taking the time to build supportive relationships with patients in the effort to support greater self-management of diabetes.

Nienhuis, J. B., Owen, J., Valentine, J. C., Black, S. W., Halford, T. C., …Hilsenroth, M. (2016).

Therapeutic alliance, empathy, and genuineness in individual adult psychotherapy: A meta-analytic review. *Psychotherapy Research, 7,* 1-13. doi:10.1080/10503307.2016.1204023

 This meta-analysis of studies examining relationships among alliance, empathy, and genuineness demonstrates that the concepts are, at least in part, overlapping.

Shaw, S., & Murray, K. (2014). Monitoring alliance and outcome with client feedback measures. *Journal of Mental Health Counseling, 36,* 43-57. <http://dx.doi.org/10.17744/mehc.36.1.n5g64t3014231862>

 The authors review research indicating that therapists’ views of the therapeutic relationship and progress are not consistent with clients’ views; yet, clients’ views are the more predictive of therapy effectiveness. They suggest two brief instruments that therapists can use to monitor both variables, and they summarize studies establishing that collecting feedback is associated with lower dropout rates and improved outcomes.

# Skill #9: Goal-Setting and Brainstorming

**Overview**

I join these two somewhat unrelated skills because they are both concrete and action-oriented strategies. Because they can be broken down into specific steps, they are a welcome relief for students who have been struggling with what they perceive to be a “passive” approach to helping (and want to “do something”). Though logically goal-setting, in particular, could be introduced earlier in the helping process, I have found that students struggle more in developing listening and reflecting skills than in learning directive techniques. Consequently, I prefer to focus on the former initially so that they can be well-practiced by this point in the curriculum. When I have introduced goal-setting earlier, I have found some students less able to grasp the subsequent importance of relationship-building.

**Goal-Setting *(Student Handout Point 1)***

**Background information.** Collaborative goal setting appears to be a cornerstone of the helping process across a wide variety of professions. For example, evidence-based findings include

* individualized goal setting with families of children in physical therapy was associated with greater engagement and better outcomes (Brewer, Pollock & Wright, 2014),
* students with behavioral problems who were involved in focused goal-setting strategies were more likely to attain their goals (Bruhn, McDaniel, Fernando, & Troughton, 2016),
* a brief (15-min) goal-setting intervention helped patients with diabetes set and achieve specific behavioral health goals (DeWalt et al., 2009), and
* managers have effectively used goal-setting interventions in improving employee performance for decades (see Miller & Weiss, 2015).

**Exercise.** Though students readily accept the premise of goal-setting, formulating *specific* goals can be challenging. You can give students practice with establishing “SMART” goals, a goal-setting strategy attributed to a management consultant George Doran in 1981 (Haughey, 2014), by first describing a goal and then articulating it in SMART language:

S = Specific. Language in which the goal is written must be precise; the goal can be broken into small steps.

M = Measurable. The goal must be able to be evaluated in terms of some metric, such as quantity, quality, or effectiveness. Progress toward the goal can be tracked.

A = Attainable. The goal should be achievable – not too simple or too challenging; it should also be within the individual’s capability, motivation, and resources.

R = Relevant. The stated goal must be related to a larger, overall goal.

T = Time-bound. The goal must be accomplished within a set timeframe.

I suggest using an example from a helping profession outside of counseling (e.g., changing exercise patterns, reducing procrastination behavior, increasing writing output, decreasing substance use). Then ask students to take 5-10 min to reflect on a personal goal using the SMART framework.

Revello and Fields (2015) demonstrated that nurses increased their use of SMART goals with patients following a 30-min educational intervention. The training consisted of basic information about the effectiveness research on SMART goals and practice in rewriting vague goals to meet the SMART criteria. For example, “decreased back pain” might become “As measured on a 10-point scale, patient’s level of pain will move from a rating of 8 to no more than a rating of 6 within the next 24 hours.”

**Brainstorming *(Student Handout Point 2)***

**Background information.** Brainstorming is a technique for generating creative ideas, originally developed in the 1950s by advertising executive Alex Osborn. Osborn outlined four rules: generate as many ideas as possible, do not criticize ideas as they are being produced, say anything that comes to mind, and build on the ideas of others. Empirical work suggests that Osborn’s focus on quantity – or generating as many ideas as possible – continues to be an effective means of producing not only a large number of ideas, but also a large number of high-quality ideas (Paulus, Kohn, & Aarditti, 2011).

 Given the potential impact of such processes as evaluation anxiety, conformity pressure, and groupthink, the effectiveness of brainstorming in groups is sometimes debated. However, brainstorming individually or in the presence of a supportive listener is likely to be helpful in encouraging creative thinking. Research has demonstrated the disruptive impact of stress on cognitive performance (Boals & Banks, 2012), suggesting that help-seeking individuals may struggle with thinking about their problems in new or innovative ways. A helper may be able to stimulate reflection about different approaches to problem-solving.

**Exercise.**  Brainstorming can be demonstrated in a group context by enlisting the class in a brainstorming activity. Depending on class size, you may wish to divide into smaller groups, perhaps varying the instructions in order to demonstrate the importance of the three-step process as described. Brainstorming about a real or hypothetical teaching issue can be enlightening for students, such as, how can I assign grades for internship hours? What should a teacher do about students who are chronically late for class? What sort of helping skills have we not covered yet that you would like to cover?

**Pairs Exercise, Session 4 *(Student Handout Point 3)***

I allow 45-50 min for Session 4. I find that students, in the role of helpers, are eager to provide a “tangible” service to their partners by facilitating a brainstorming session. If done well, even the full 15 min is not likely to be enough time. As previously, I introduce goals of the session, allow time for questions, and provide 3 min prior to each partner’s turn as helper for a mindfulness preparation period.

As the last of the four pairs exercise, I incorporate brainstorming but not goal-setting in my instructions. I prioritize brainstorming because my students rarely have difficulty coming up with an issue appropriate for this exercise. (As graduating seniors, they are frequently in the midst of serious decision-making about their future plans and appreciate the opportunity to discuss options with a neutral listener.) However, if you were to separate these skills, it would be possible to ask students to set a goal or goals as a wrap-up exercise: Students could consider goals, suggested by their pairs session conversations, that they would like to pursue in the future.

 As in Session 3, I sit down and quietly observe pairs for a brief period. The brainstorming exercise is one that sometimes invites questions from the helper, and occasionally I will try to assist in reframing the issue in terms of brainstorming opportunities.

**Skill #9: References and Resources[[1]](#footnote-1)**

Boals, A., & Banks, J. B. (2012). Effects of traumatic stress and perceived stress on everyday cognitive functioning. *Cognition and Emotion, 26,* 1335-1343. <http://dx.doi.org/10.1080/02699931.2011.651100>

 This article consists of a review of prior research indicating the negative impact of stress on cognition, followed by an empirical study of the relationship between stress and cognitive failures (everyday errors in attention or memory) in undergraduates. Participants with higher levels of perceived stress reported a greater incidence of cognitive failures.

Brewer, K., Pollock, N., & Wright, F. V. (2014). Addressing the challenges of collaborative goal setting with children and their families. *Physical and Occupational Therapy in Pediatrics, 34,* 138-152. <http://dx.doi.org/10.3109/01942638.2013.794187>

Bruhn, A. L, McDaniel, S. C., Fernando, J., & Troughton, L. (2016). Goal-setting interventions for students with behavior problems: A systematic review*. Behavioral Disorders, 41,* 107-121. <http://dx.doi.org/10.17988/0198-7429-41.2.107>

DeWalt, D. A., Davis, T. C., Wallace, A. S., Seligman, H. K., Bryant-Shilliday, B., Arnold, C. L., ... Schillinger, D. (2009). Goal setting in diabetes self-management: Taking the baby steps to success. *Patient Education and Counseling, 77,* 218-223. <http://dx.doi.org/10.1016/j.pec.2009.03.012>

Haughey, D. (2014). *A brief history of SMART goals*. Retrieved from <https://www.projectsmart.co.uk/brief-history-of-smart-goals.php>

Miller, L. E., & Weiss, R. M. (2015). Setting goals in different roles: Applying key results from the goal-setting literature. *Organization Management Journal, 12,* 14-22. <http://dx.doi.org/10.1080/15416518.2014.969367>

Paulus P. B., Kohn, N. W., & Arditti L. E. (2011). Effects of quantity and quality instructions on brainstorming. *Journal of Creative Behavior, 45,* 38-46. <http://dx.doi.org/10.1002/j.2162-6057.2011.tb01083.x>

 This empirical study compared the impact of brainstorming on idea generation when different instructions were employed. Traditional brainstorming instructions to generate “as many ideas as possible” was most effective in producing a greater number of ideas and higher-quality ideas.

Revello, K., & Fields, W. (2015). An educational intervention to increase nurse adherence in eliciting patient daily goals. *Rehabilitation Nursing, 40,* 320-326. http://dx.doi.o rg/10.1002/rnj.201

 Applying SMART goals to nursing practice, researchers demonstrated that a 30-min educational program for nurses using the SMART approach improved ability and willingness to write SMART goals. Patients also reported improvement in feeling informed by health care staff as a result of the intervention.

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. *Psychotherapy, 48,* 50-57. <http://dx.doi.org/10.1037/a0022061>

This article, from the special issue of *Psychotherapy* that focused on characteristics of evidence-based therapy relationships, summarizes the findings of a meta-analysis on the relationship between goal consensus/collaboration and psychotherapy outcomes, suggesting strong associations between the two. Practice recommendations include initiating work on client problems only after explicit agreement on therapy goals, explaining to clients the importance of collaboration, encouraging the completion of homework, and checking in with clients regularly to ensure mutual understanding.

# Skill #10: Motivational Interviewing

**Overview**

Motivational interviewing (MI) is a skill that can be addressed briefly (1 session) or in greater depth (2-4 sessions). I opt for the brief approach because of time limitations in my course, but a longer-term focus would certainly facilitate greater proficiency with the skill. For example, in one study, undergraduate psychology students receiving either a semester-long or a 40-hour intensive training experience in MI significantly outperformed students receiving a basic 1-hour lecture on the topic (Madson, Schumacher, Noble, & Bonnell, 2013). However, students can make progress with considerably less exposure. Nursing students improved their ability to implement MI strategies after approximately eight contact hours of instruction (Nesbitt, Murray, & Mensink, 2014), and physical and occupational therapy students rated their progress after just three training sessions as surpassing a beginner level of proficiency (Schoo, Lawn, Rudnik, & Litt, 2015).

**Mini-Lecture**

The literature on MI is extensive, including several excellent books on MI applications in different professional fields (nutrition and fitness, schools/classroom management, social work practice, health care). Research on MI is likewise considerable; searches using the PsycINFO and PubMed databases yielded more than 1000 empirical resources each during the past 10 years. Consequently, an instructor’s first challenge is to avoid being overwhelmed by the available information on MI.

MI developer William Miller’s fundamental book, *Motivational Interviewing: Helping People Change* (Miller & Rollnick, 2012), offers a wealth of practical information and ample guidance for any instructor new to MI. If you do not have a copy of this resource, the following articles and internet resources will suffice to make four key points.

* Miller developed the MI method following his experience working with problem drinking. He saw a need for intervention that would allow a therapist to respond to clients empathically rather than confrontively and would encourage change to come from clients rather than therapists (see Miller & Rose, 2009).
* MI is both similar to and different from client-centered therapy, as well as the helping skills covered earlier in the course. In contrast to some perceptions, MI skills are complex and take time and practice to master (see Miller & Rollnick, 2009).
* The relationship between helper and client is important in MI, and MI is made up of both a relational and a technical factor (see Moyers, 2014).
* MI is evidence based and is in widespread use across many professions and disciplines (see Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012; Ekong & Kavookjian, 2016; Hettema & Hendricks, 2010; Morton et al., 2015; VanBuskirk & Wetherell, 2014).

**Relational Skills: OARS *(Student Handout Point 1)***

O = Open-ended questions

A = Affirmations

R = Reflective listening

S = Summaries

Because of the overlap between the OARS techniques and the helping skills already taught in the course, I do not focus much on specific OARS strategies. However, ideas for teaching OARS principles, as well as all other elements of MI, can be found in either of two training resources: one extremely comprehensive manual geared to educators (Motivational Interviewing Network of Trainers [MINT], 2014) and one less detailed overview aimed at health care professionals (Professional Patient Advocate Institute, 2010).

**Technical Skills *(Student Handout Point 2)***

I spend the bulk of my time teaching students about recognizing, eliciting, and strengthening “change talk,” which are statements suggesting that an individual has at least some interest in initiating a behavior change.

**Recognizing change talk.** DARN (preparatory) CAT (implementing):

D = Desire

A = Ability

R = Reason

N = Need

C = Commitment

A = Activation

T = Taking steps

After reviewing the “DARN CAT” concepts and discussing the example statements for smoking cessation on the student handout, pick a different behavioral issue and ask students to provide new change talk examples. Possible target behaviors that have relevance to a student population include increasing sleep, decreasing alcohol intake, reducing social media use, making a dietary modification, or initiating a mindfulness practice.

**Recognizing change talk exercise.**  To give students practice in recognizing change talk, give them the example target behavior of initiating an exercise program. Ask them to indicate which of the following statements (listed on the student handout) are indicative of change talk. (The type of change talk is identified following each correct example.)

1. I really can’t see adding anything to my schedule right now.
2. I wouldn’t mind feeling less stressed-out all the time. – C (desire)
3. I learned in my health class last semester that people who exercise regularly get sick less often. – C (reason)
4. It’s not like I know anyone else who exercises.
5. I always hated gym class when I was a kid.
6. I have to admit I admire other students who somehow manage to squeeze in exercise on top of everything else they do. – C (desire)
7. I’ve heard that some people get a sort of endorphin “high” after exercise. – C (desire)
8. Who has time for taking care of themselves?
9. I’m so tired of just sitting around studying all the time. – C (desire?)
10. I don’t mind walking on a pretty day. – C (ability)
11. When I was in high school, I actually played three sports.
12. I decided that after Thanksgiving I am going to start doing something. – C (commitment)
13. Isn’t there a drug for this?
14. I know if I keep sitting on my butt all the time, I will just wind up burned out and unhealthy. – C (need)

(based on the “Drumming for Change Talk” exercise in MINT, 2014)

Some of these examples are intentionally ambiguous, depending on context, and so may spark interesting discussion.

**Evoking change talk.** When change talk is not forthcoming, a helper uses MI strategies to elicit it. As a directive skill, this is an important point of difference between MI and client-centered therapy.

**Evoking change talk exercise.** To give students practice in generating questions that will elicit change talk, you could role play a client/patient/student who has just remarked, “Maybe I should cut down on my drinking/try mindfulness/stop procrastinating” (or any other behavior change of your choosing). Each student then selects one card from a pile of index cards, each of which lists a strategy for stimulating change talk:

1. open-ended question about desire
2. open-ended question about ability
3. open-ended question about reasons
4. open-ended question about importance
5. looking back (“Tell me about a time before [this issue] began…were things better?”)
6. looking forward (“How would life be different if you [made this change]?”)
7. extremes, worst (“What’s the worst thing that could happen if you don’t make this change?”)
8. extremes, best (“What the best thing that could happen if you make this change?”)
9. change ruler (“On a scale of 0 to 10, where are you now? Where would you like to be?”)
10. values (“What values are important to you in life? How does [this behavior] fit with those?”)

Students take turns asking you a question based on the prompt they selected; you should respond to their questions in character. You can then ask other students to try to guess which strategy was just demonstrated (ideas based on MINT, 2014, “Ten strategies for evoking change talk” and “Out of a talk”).

**Responding to change talk.** A role play demonstration or video example is helpful for providing specific strategies for responding to change talk. Although students are generally facile in devising follow-up responses, I find that they sometimes are tempted to do more than is desirable. For example, they launch into indirect advice (“Have you considered trying…?”) or even argue with someone’s nonchange talk (“Oh, but really it’s not that hard…”). Consequently, it is important to give students practice not only in a one-time response to change talk but in a longer conversation.

**Responding to change talk exercise.** This activity consists of students working with a partner on a behavior change they are genuinely considering. Ask students to first take some time to individually reflect upon a possible behavior change and then to write down honest thoughts and feelings about doing so; these ideas should be categorized for themselves as either change or nonchange talk.

 In pairs, ask students to converse for 3-5 min (in each direction) about their potential behavior changes. Helpers should respond to change talk statements in one of the ways indicated on the handout, such as, asking for elaboration or examples, reflecting or affirming, or pointing out discrepancies. Walk around and help students who get stuck. If any students are particularly adept at the skill, ask them to demonstrate for the class.

**Skill #10: References and Resources[[2]](#footnote-2)**

Barnett, E., Sussman, S., Smith, C., Rohrbach, L. A., & Spruijt-Metz, D. (2012). Motivational interviewing for adolescent substance use: A review of the literature. *Addictive Behaviors, 37,* 1325-1334. <http://dx.doi.org/10.1016/j.addbeh.2012.07.001>

Ekong, G., & Kavookjian, J. (2016). Motivational interviewing and outcomes in adults with type 2 diabetes: A systematic review. *Patient Education and Counseling, 99*, 944-952. <http://dx.doi.org/10.1016/j.pec.2015.11.022>

Hettema, J. E., & Hendricks, P. S. (2010). Motivational interviewing for smoking cessation: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78,* 868-884. <http://dx.doi.org/10.1037/a0021498>

Madson, M. B., Schumacher, J. A., Noble, J. J., & Bonnell, M. A. (2013). Teaching motivational interviewing to undergraduates: Evaluation of three approaches. *Teaching of Psychology, 40,* 242-245. <http://dx.doi.org/10.1177/0098628313487450>

 This empirical study compared the effectiveness of teaching MI to undergraduates across three formats: a 1-hour lecture, a 16-week MI course, and a 40-hour intensive MI course. Students enrolled in both MI course formats gained greater skills and knowledge than students in the 1-hour lecture, and their posttraining expertise was on a par with “beginning proficiency” levels of standardized assessments.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

 This is a key resource, written by the psychologist who developed MI. Miller and Rollnick describe the four processes of MI and incorporate practical examples to illustrate implementation in varied clinical settings. Guilford Press also provides a free companion website with additional case studies, a bibliography, and reflection questions: <http://www.guilford.com/companion-site/Motivational-Interviewing-Third-Edition/9781609182274>

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64,* 527-537. <http://dx.doi.org/10.1037/a0016830>

 Miller and Rose provide an overview of the origins of MI, efficacy studies, and attempts to understand why MI is effective. For example, use of MI and therapist empathy predict client change talk and lessened resistance, which lead to a commitment to change and subsequent behavior change. The researchers also consider remaining issues such as understanding the causal link between change talk and change, and the role of dishonest or insincere change talk.

Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy, 37,* 129-140. [http://dx.doi/org/10.1017/S1352465809005128](http://dx.doi/org/10.1017/S1352465809005128%20)

 This helpful clarification of the parameters of MI considers 10 issues, including what it is (e.g., a complex skill, a tool for addressing the specific problem of reluctance about needed behavioral change) and what it is not (e.g., the transtheoretical model of change, a technique, either cognitive-behavioral or client-centered therapy).

Morton, K., Beauchamp, M., Prothero, A., Joyce, L., Saunders, L., Spencer-Bowdage, S., ... Pedlar, C. (2015). The effectiveness of motivational interviewing for health behaviour change in primary care settings: A systematic review. *Health Psychology Review, 9,* 205-223. <http://dx.doi.org/10.1080/17437199.2014.882006>

Motivational Interviewing Network of Trainers. (2014). *Motivational interviewing training new trainers manual.* Retrieved from <http://www.motivationalinterviewing.org/sites/default/files/tnt_manual_2014_d10_20150205.pdf>

 This terrific, free 213-page toolbox for MI trainers provides explanations, exercises, and activities for teaching MI. The ideas were compiled from MI trainers who developed them in the effort to improve their MI instruction practices. Sections are organized by content areas, such as, training process, icebreakers, MI spirit, OARS, change talk, planning, coaching, and demonstrations.

Moyers, T. B. (2014). The relationship in motivational interviewing. *Psychotherapy, 51,* 358-363. <http://dx.doi.org/10.1037/a0036910>

 Moyers focuses on the critical role of the relationship in MI effectiveness. Characterized as the “spirit” of MI, relationship core elements include collaboration, support of client autonomy, evoking, empathy, acceptance, and compassion. Moyers suggests that successful MI practitioners must be trained in interpersonal skills.

Nesbitt, B. J., Murray, D. A., & Mensink, A. R. (2014). Teaching motivational interviewing to nurse practitioner students: A pilot study. *Journal of the American Association of Nurse Practitioners, 26,* 131-135. <http://dx.doi.org/10.1002/2327-6924.12041>

This study of graduate nursing students examined the impact of a 4-week MI educational intervention involving readings, lecture, discussion, practice, and application. Pretest-posttest comparisons showed that students increased their use of several MI strategies, including open questions, affirmations, and reflections, while decreasing advice-giving and closed questions.

Professional Patient Advocate Institute. (2010). *Motivational interviewing: An emerging trend in medical management.* Retrieved from <http://www.patientadvocatetraining.com/wp-content/themes/patientadvocate/static/pdf/ppai_specialreport_mi.pdf>

 This MI training manual is geared toward health professionals, providing an MI overview and applications in treating chronic illnesses, case studies, training tools, and a research bibliography.

Reich, C. M., Sharp, K. M. H., & Berman, J. S. (2015). A motivational interviewing intervention for the classroom. *Teaching of Psychology, 42,* 339-344. <http://dx.doi.org/10.1177/0098628315603250>

 In an empirical investigation, the researchers evaluated the impact of an adapted MI approach on college student motivation for studying. Students receiving the brief (15-20 min) intervention improved test performance while participating in a relevant learning experience.

Schoo, A. M., Lawn, S., Rudnik, E., & Litt, J. C. (2015). Teaching health science students foundation motivational interviewing skills: Use of motivational interviewing treatment integrity and self-reflection to approach transformative learning. *BMC Medical Education, 15,* Article 228, 1-10. <http://dx.doi.org/10.1186/s12909-015-0512-1>

 Schoo et al. conducted a qualitative study of students in Australian occupational and physical therapy graduate programs exposed to basic training in MI, including one lecture and two practice-oriented sessions. Students self-assessed their progress in simulated interviews as surpassing the beginner proficiency level (possibly an overvaluing of their skill levels) but viewed MI as complex and challenging.

VanBuskirk, K. A., & Wetherell, J. L. (2014). Motivational interviewing with primary care populations: A systematic review and meta-analysis. *Journal of Behavioral Medicine, 37,* 768-780. <http://dx.doi.org/10.1007/s10865-013-9527-4>

1. Annotations are provided only for those resources deemed most beneficial for instructors. Articles that are not annotated were included because their findings were incorporated into the research reviewed here. [↑](#footnote-ref-1)
2. Annotations are provided only for those resources deemed most beneficial for instructors. Articles that are not annotated were included because their findings were incorporated into the research reviewed here. [↑](#footnote-ref-2)