DOCUMENT RESUME

ED 073 398 CG 007 938

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TITLE The Clinician as Teacher of Interpersonal Skills. Let's Give Away What We've Got.
INSTITUTION Massachusetts Univ., Amherst. Human Relations Center.
PUB DATE Jan 73
NOTE 16p.

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Audiovisual Aids; Counseling; *Counselor Role; Counselors; *Counselor Training; Helping Relationship; Interpersonal Competence; *Microcounseling; Models; Nonprofessional Personnel; *Training; *Video Tape Recordings; Volunteers

ABSTRACT

This article suggests that a major role for the practicing clinician is the teaching of his helping skills to those whom he would serve. Specifically, the paper describes microcounseling, a videobased system of teaching counseling or psychotherapeutic skills to counselors, clinical psychologists, and medical students. In addition, the method has proven equally effective in training paraprofessional counselors, parents as peer drug counselors, teachers, and the general lay public. Microcounseling is seen as a systematic program which enables the helping process to be taught directly and explicitly. It is a scaled-down sample of counseling in which the counselor, therapist, or lay trainee talk with volunteer clients during brief five-minute sessions which are video recorded. Microcounseling thus focuses on specific single skills and trainee learn quickly important aspects of the total helping process. Specific skills of microcounseling are outlined, illustrations of how methods may be used are presented, and implications of a teaching role for the professional psychotherapist are discussed. (Author/SES)

The Clinician as Teacher of Interpersonal Skills

LET'S GIVE AWAY WHAT WE'VE GOT

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January 1973

Abstract

Clinical work has too long been described as an "art," which "somehow" the therapist acquires. Systematic programs now exist which enable the helping process to be taught directly and explicitly. Microcounseling is a video based system of counselor/therapist training which has proven viable with a variety of paraprofessional and professional helpers. This same system has recently proven equally useful in teaching counseling and communication skills to clients. This article suggests that a major role for the practicing clinician is the teaching of his helping skills to those whom he would serve.

The successful counselor, therapist, or helper will change those "helpees" or clients with whom he works into helpers. No longer is it sufficient for therapists to "help" people; they also have the responsibility to teach others the skills they have mastered thus multiplying the helping process. The time has come to demystify therapy.

This paper describes microcounseling, one systematic approach to teaching counseling/psychotherapeutic skills proven effective with counselors (Ivey, Normington, Miller, Morrill, and Haase, 1968), clinical psychologists (Phillips, Moreland, Ivey, 1971), and medical students (Moreland, 1971). More interesting, however, is the fact that this same method has proven equally effective in training paraprofessional counselors (Haase and DiMattia, 1970), parents as peer drug counselors (Gluckstern, 1972), teachers (Rollin, 1970), and a wide variety of other populations (Ivey, 1971).

What is microcounseling? It is a scaled-down sample of counseling in which the counselor, therapist, or lay trainee talk with volunteer clients during brief 5-minute sessions which are video-recorded. Rather than teach helping "all-at-once" as is done in traditional training programs, microcounseling focuses on specific single skills. Thus, through a highly systematized form, trainees learn quickly important aspects of the total helping process.

The most vital dimension of microcounseling, however, is the recent discovery that the skills of helping need not be restricted to professional and paraprofessional helpers. The skills of the counselors and therapists can be taught systematically to the general lay public. Parents (Bizer, 1972), junior high school students (Aldrige, 1971), and elementary children (Goshko, in press) have all demonstrated their ability to learn and profit from the microcounseling framework and its adaptations. Extensions have

also been made into systematic work with psychiatric patients (Donk, 1972; Ivey, 1971; Ivey, in press[b]) which suggest that a teaching approach for behavior change is a viable therapeutic alternative.

This paper presents the basic microcounseling model and its possible training variations. Some of the specific skills of microcounseling are outlined with illustrations of how these skills are relevant not only for the professional therapist, but also for his client. Illustrations demonstrating how these methods may be used as a therapeutic alternative or supplement are presented. Finally, a summary section discusses the implications of a teaching role for the professional psychotherapist.

The Origins of Microcounseling

Microcounseling originated with a research team (Ivey, Normington, Miller, Morrill, and Haase, 1968) concerned with identifying specific behaviors of the helping process. The emphasis was on single discrete behaviors with the belief that if a trainee could learn one skill of helping and perform it well that this would be a more effective procedure than traditional classroom methods which teach the skills of therapy in a somewhat mystical fashion. The emphasis on single skills was and remains one of the most important aspects of the microcounseling format.

The standard paradigm for microcounseling training consists of the following steps:

1. Videotaping of a five minute segment of therapy, counseling, or, if a couple or a family, five minutes of interaction around a selected topic.
2. Training
   a. A written manual describing the single skill being taught is presented to the trainee(s).
   b. Video models of an "expert" therapist or "good" communication illustrating the skill are shown thus giving trainees a gauge

against which to examine the quality of their own behavior.

c. Trainees then view their own videotapes and compare their performance on the skill in question against the written manual and video model. Seeing oneself as other's see you is a particularly impactful part of the training procedure.

d. A trainer-supervision provides didactic instruction and emotional support for the trainees.

3. A second five to ten minute session is videotaped.

4. Examination of the last session and/or recycling of the entire procedure as in step 2 depending on the acquired skill levels of the trainees.

The time period for the training is approximately one hour while a recycling back to step 2 adds another 30-45 minutes. The procedures of microcounseling involve cue discrimination, modeling procedures, and operant reinforcement by the trainer of newly learned behavior (typically, the trainer ignores ineffective behavior and rewards positive behavior change).

Many variations of the basic microcounseling training model are feasible. Individuals, couples, or groups can participate in training in this form. Recent work reveals that the skills of group leadership can be taught within this format (Ivey, in press[a]). Audiotape may be substituted for videotape with verbally oriented skills (Goldberg, 1970; Warwykow, 1970). "Even sharper breaks in the basic microcounseling model are possible. Telling individuals about the skill and demonstrating it in a brief role-playing situation sometimes proves sufficient for the skill to be learned and generalized. Microcounseling skills can be and have been taught with the first five-minute session eliminated, omission of modeling tapes, with or without a supervisor, and with changes in order of presentation of materials," (Ivey, 1971).

Microcounseling is presented as a basic structure. While extensive research exists in the standard model, informal observation strongly suggests that these concepts will be used most effectively when the trainer adapts them to fit his own personal style and theoretical viewpoint.

Examples of Single Skill Units Within Microcounseling

Microcounseling builds on an "attentional" view of dyadic and group interaction. "Attention is central to the interaction between interviewer and client. Unless the interviewer listens or attends to the client, little in the way of understanding will occur" (Ivey, 1971). The basic skill of microcounseling is termed "attending behavior" which is defined behaviorally as eye contact, physical attention, and verbal following behavior.[3] The trainee manual stresses that people talk about what the helper attends or listens to both verbally and nonverbally. Thus stress on basic listening skills (behaviorally defined) represents the basic microcounseling skill. The beginning helper or trainee knows that he should listen, but often simply doesn't know what listening is.

Training in these three obvious, simple skills of listening continues to be of central focus in training programs with both professional and lay groups. With skilled individuals, work on this skill gives them an opportunity to become familiar with the video equipment and oriented to the skills concept of training. Those with less sophistication find the simple behavioral definition of listening skills an important eye-opener, which gives them the realization that perhaps they actually can be counselors and more effective listeners.

Training married couples and families in attending skills has proven helpful for effective listening is usually absent in disturbed families. In individual counseling, therapists frequently find it helpful to teach specific listening skills to their patients to help them observe and understand situations more completely. There are few individuals, almost regardless

of degree of mental health, who cannot profit from systematic training in listening skills.

Simple attending is, of course, only a beginning. Once trainees demonstrate effective listening, the question then arises as to what they should listen to. Rogerian reflection of feeling is usually the second skill emphasized. However, this skill is taught as selective attention to emotional aspects of the other. Instead of teaching undefinable empathy and respect, trainees are simply taught to reinforce emotional components of the other person's verbal and non-verbal behavior. For the clinical trainer, teaching beginning therapists to listen for feelings is a time-consuming and frustrating process. Most trainees within microcounseling reach beginning levels of proficiency within a two-hour time span.

The teaching of reflection or reinforcement of feelings has important implications for others than therapists and counselors, families, married couples, psychiatric patients and teachers can benefit from this type of training. In some cases, however, reflection of feeling proves to be too complicated for some trainees as they cannot recognize what an emotion is. The skills of "sharing behavior" and "expression of feelings" are then taught. With these skills, the emphasis is on teaching trainees how to express themselves more clearly and recognize what an emotion is. Later, they learn how to listen more carefully to others' emotions and ideas.

These skills provide only a sample of the systematic microcounseling skills. Counseling skills are organized into beginning skills of counseling (attending behavior, minimal encourages, and open questions), listening skills (reflection of feeling, paraphrasing, and summarization), self-expression skills (sharing behavior, expression of feelings, expression of ideas) and interpretative skills.

Perhaps the most important skill of all is direct authentic mutual communication. This skill, based on study of encounter group exercises and

existentially oriented therapy, focuses on here and now behavior between the helper and helpee or, more directly, between couples, families, or groups. Very similar in nature to level five of the facilitative conditions scales (Carkhuff, 1969), this communication skill aims at mutual exploration of experience. The behavioral orientation of this skill helps identify more clearly the nature of this dimension of helping.

The following summary from the final training session with a foreign student couple illustrates the viability of training in authentic communication. Previously this couple had been arguing rather vehemently about whether or not they should return to their home overseas.

> Wife: I feel insecure too. I don't know what will happen if we go back to our homeland. I really want to go back today to ----------, if we have things, but I am very scared. What will we do? We don't have anything back home.
>
> Husband: Yes, what is your feeling now at this moment? You can think about what we would have what we would not have. What do you feel about not having it?
>
> Wife: There is just a blank. I see nothing. The future makes me afraid. We have no definite opportunities in ---------- or here.
>
> Husband: It makes me feel right now that I'm not capable of doing it. How does my inability make you feel?
>
> Wife: I feel sorry. And I want you to do something about it. Keep trying and somehow we will manage it. If you can't, we both can do something.

(Higgins, Ivey, and Uhlemann, 1970, p. 24)

Factor analytic work analyzing this typescript and others suggests that the key dimensions in authentic communication are the use of personal names or pronouns, affective words, and keeping to here and now experiences (Crowley and Ivey, 1971).

Teaching Psychiatric Patients Skills of Living

Media therapy (Ivey, in press[b]) is a recent extension of the microcounseling training program for therapeutic situations. However, the emphasis in media therapy is not on remediation, but on the teaching skills of interpersonal interaction and communication. There is an important distinction between media therapy and microcounseling, however, despite the fact that both emphasize single skills. In media therapy, the patient is videotaped for five minutes in interaction with a therapist. However, the patients, through viewing the tape, determine what they want to change. Out of patient decisions, individually designed training programs are built, manuals written, and video modeling tapes developed. The patient determines his own direction of learning in consultation with the therapist-facilitator. At a later point, basic microcounseling skills may be introduced.

Depressed patients when viewing the original videotape most often comment on sad expressions, lack of movement, and lack of eye contact. The correspondence between these self-observations and attending behavior is readily apparent. When depressed patients talk, they generally have only one central topic....themselves and their problems. The patient is encouraged to select only one behavior at a time to change and the choice of behaviors has ranged from using more gestures to looking at people more to not talking about oneself. None of these single behaviors "cure" the depression, but the fact remains that it is harder to be depressed when moving, looking at others, and talking about something other than oneself. Further, the depressed patient who often says, "I can't do anything" finds himself mastering something provides and this an important beginning to more sophisticated skill training at later points.

Hyperactive, "schizoid" patients are often hard to calm down and talk with. However, it is impressive to see such a nervous patient who had previously been "jumping all over the place" sit still and watch closely as

the videotape is shown. In early sessions patients most often note their rapid physical movements and wish to slow them down. Many also comment on some variant of "topic jumps" and their inability to attend to a single stimulus. Individualized prescribed teaching/treatment programs are then devised to help them learn the specific behaviors they seek to change.

Early success with these basic verbal and non-verbal behaviors leads rapidly to an interest in learning more behaviors to help cope with their unique situation and it is here that many patients make a decision to start through aspects of the microcounseling skill format, some for their own personal growth and family relationships, others who seek to develop peer counseling expertise.

Each psychiatric patient who enters the media therapy program provided a new and unique problem for the facilitator/therapist. Although many patients elect to start with some verbal or non-verbal correlate within the attending behavior-microcounseling framework, others sometimes wish to work on broader constructs. These include role-played sessions on how to cope with specific family situations, practice in job interviewing, and simulated interpersonal conflict With the severely disturbed patient, it may be necessary to specify the skills very clearly and to provide immediate reinforcements. In one case with a schizophrenic patient who engaged in "word salad behavior" and constant interruptions, it was agreed that he would receive financial reinforcement for appropriate responses within a specific time period. For example, the patient was asked a question and if he responded inappropriately or interrupted he lost five cents. If he waited five seconds before answering and responded appropriately he received five cents. At later stages, the financial incentive was removed and social rewards substituted.

Some important side benefits developed out of this project. Patients now had identifiable interpersonal skills and in some cases started teaching

their new skills to their families. Some families expressed interest in the training program while others were threatened by the new skills of the patient and wanted no part of skills training. As such, it has become clear that while skills training may be sufficient therapy to help a patient move out of the hospital, the problem of returning a healthy patient to a "sick" environment remains. Thus recent thinking suggests that it is necessary to train psychiatric patients in "change agent" skills so that they can maintain themselves in the hostile environment of the outside world and set about producing systematic change in the systems which sent them to the hospital.

This sketchy summary only provides a prelude to the variants and possibilities inherent in utilizing a teaching approach to personal change. The procedures and possibilities are discussed in more detail by Ivey in a recent article (in press[b]). In the cases described, media therapy and micro-counseling training were the only formal treatment modalities thus suggesting that this approach is a viable alternative to traditional therapeutic modalities.

The Therapist as Teacher: The Need for Demystification

Teaching is direct process. For better or worse, teachers are "out-front" stating in relatively clear terms what they want their students to know. Counseling and therapy, however, are most often indirect. The counselor and therapist often have only the most vague idea of what they want to have happen to their clients. Small wonder that therapy is seen as a mystical process. Further the more guarded and decretive a group is about its particular skills, the more "professional" it is seen and the higher income that may be obtained.

Behavioral techniques, of course, follow the basic teaching model. Yet, it must be acknowledged that not all clients are "turned-on" by behavioral techniques and Lazarus (1971), best known for his significant work in behavioral psychology, has recently come to the position that the successful therapist needs a wide variety of techniques available to him to reach the broadest

possible client population. The danger of his position is that therapy once again returns to a mystical state. Microcounseling techniques serve one valuable route toward identifying more precisely what is going on in a variety of clinical situations.

There is a serious need to demystify and make clear what counseling and therapy really represent. The clinical interview could be considered, not as a continuous unit, but as a series of islands and hiatuses (Hackney, Ivey, and Oetting, 1970). The island consists of a topic (response class) or a series of closely related topics, clearly a unit. The hiatus occurs at the end of a conversational island and is the period where the counselor and client negotiate for a new topic. Observation in microcounseling situations suggests that counselors and clinicans behave very similarly during islands regardless of their theoretical viewpoint. During this time they basically attend. However, when the hiatus is reached, differences between interviewer styles becomes pronounced. For example, the non-directive counselor may say nothing, the "modern" client-centered clinician may express a personal feeling state, the analyst may interpret, and the vocational counselor may ask an open question about a previous job. In a similar fashion, the group leader determines what is to happen in his group (Ivey, in press[a]).

In short, all effective counselors, clinicians, and group leaders use basic attending skills. Most have the basic microcounseling skills in their repertoire to some degree, but differing skills appear at the hiatus or negotiation period. Thus the analytic or dynamically oriented psychologists differs from colleagues in that they systematically use different skills at hiatus points. Similarly, the non-directivist or even the charismatic guru have basic patterns of skill utilization. These skills are definable, teachable, and learnable.

Rather than keeping the clinical "art" to ourselves, it seems appropriate for the helping professions to give serious consideration to explaining

carefully and clearly to our clients what we are actually doing and the specific impact our behavior is likely to have on them (Ivey, 1969, 1972). Then having assumed an open contract, it is our responsibility to model these behaviors we claim to be ours and finally to teach others the skills we ourselves have found to be effective.

The Skills of Helping are too Important [illegible]pe to Clinicians and Professional Helpers.

When viewed from a traditional point of view, therapeutic skills are much too complex to be shared with the lay public. However, when the simpler more direct teaching model of microcounseling is considered, we have rather clear evidence that perhaps therapy is not as complex as we have been led to believe. It is now possible to teach our helping skills to our clients.... and teach them rather quickly and efficiently.

How can the clinician teach his skills to his clients? While a variety of methods are possible, three basic systems appear most feasible. The first is the establishment of small groups who study the helping process systematically under the guidance of the therapist. They can search out basic helping dimensions and then work on specific applications of these concepts in their own lives. In some cases, it may be anticipated that the therapist will also supervise lay helping efforts of his clients. As a second alternative, these methods could be used as a supplement to the regular therapeutic procedures. For example, a client could be referred to a skills laboratory for systematic training in communication skills. Finally, the therapist through modeling and "on-the-spot" instruction can teach communication skills to his clients as a portion of the regular therapy process.

Further, it is patently clear from our experience within the microcounseling model that the skills approach increases the flexibility of the helper. Most therapists see themselves restricted to rather narrow client populations. Those who work within microcounseling and skill approache

often find themselves working with individual psychiatric patients in the morning, giving a lecture to a group of teachers in the afternoon, working with a small group of elementary children on basic listening skills later in the day, and in the evening teaching parents these same skills. While some may question the ability of a psychologist to work with populations this diverse, the fact remains that viewing oneself as a person with competencies and basic skills provides the basis for a new and exciting view of the helping profession.

Footnotes

[1] Requests for reprints should be addressed to Allen E. Ivey, Human Relations Center, School of Education, University of Massachusetts, Amherst, Mass. 01002.

[2] The research on which this report is based was sponsored by the Charles F. Kettering Foundation and the U.S. Office of Education (Grant OEG -1 - 70 - 0019 - 509). Research on media therapy was completed at the Northampton V.A. Hospital, Saul Rotman, Chief of Psychology.

[3] For example, research by Aldrige (1971) found that microcounseling trainees reduced the number of eye contact breaks, number of irrelevant physical movements, and the number of "topic jumps" following training.

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