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WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Listening Well

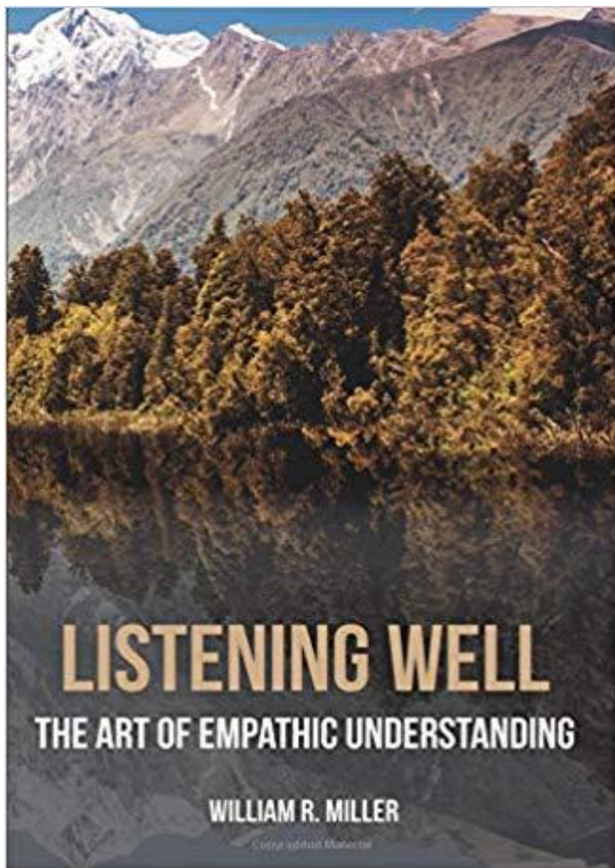
Wisconsin Public Psychiatry Network Teleconference
September 3, 2020

Presentation outline

1. Listening well defined
2. Research base
3. Skillful practice
4. Demonstration, observation, debrief
5. Closing

Listening well defined

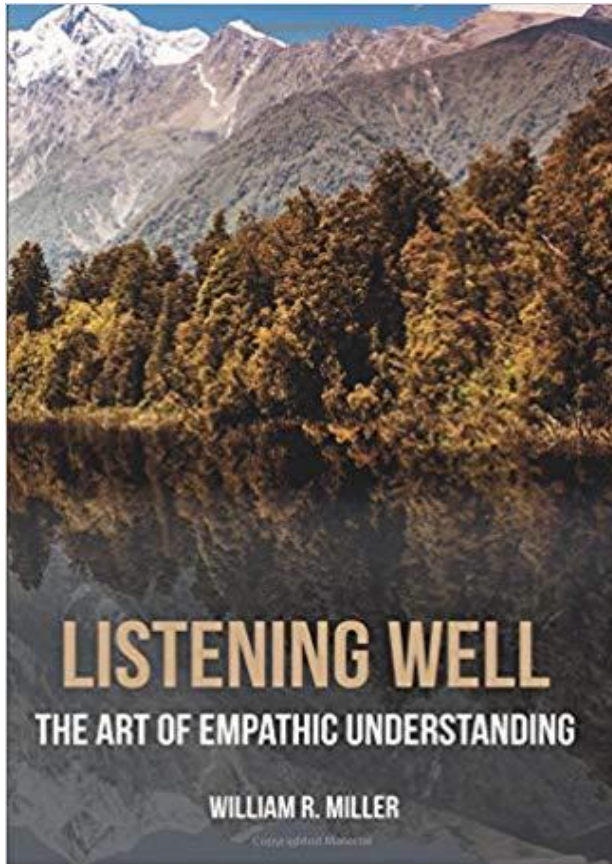
Listening well comprises a way of being and doing.



(Miller, 2018)

- **Accurate empathy** is a way of being with people that involves careful listening with genuine interest and curiosity to understand another's experiences and perspectives.
- **Reflective listening** is what a listener does as an expression of accurate empathy.

Listening well defined



(Miller, 2018)

- Listening well is the most important skill in human service work.
- Listening well can be taught, learned, measured, observed, assessed, and improved.
- Self-assessed listening skill does not correlate with actual practice.

What listening well is not

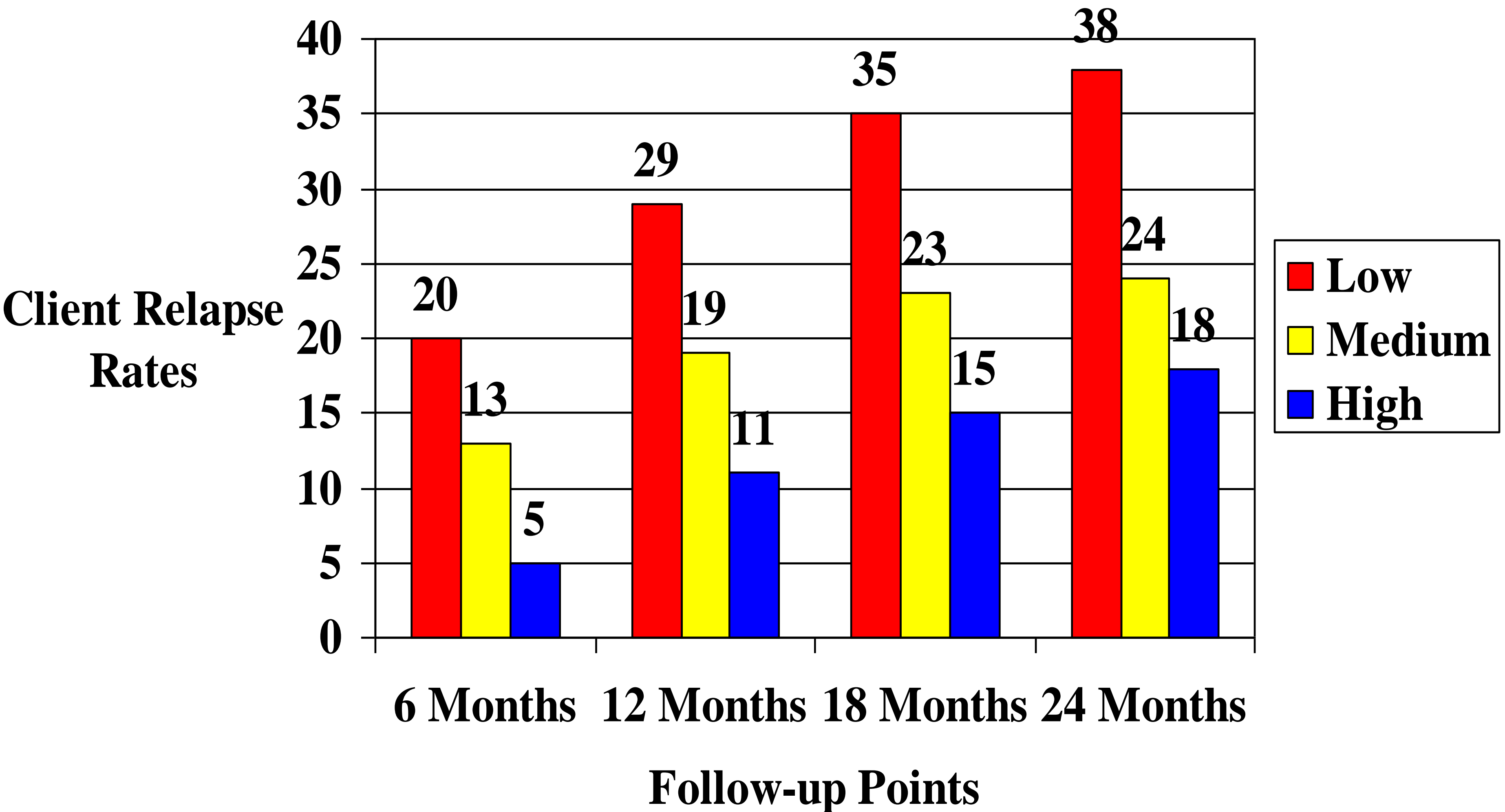
- Giving advice, making suggestions
- Persuading with logic
- Questioning, probing, gathering info
- Agreeing, approving, praising
- Reassuring, sympathizing, consoling

Thomas Gordon's listening roadblocks
(cited in Miller & Rollnick, 2013, p. 49)

The research base of listening well

2 studies, 2 meta-analyses,
and a bottom line

Valle (1981): Reflective listening skill level and drinking outcomes



Moyers et al. (2016): Therapist empathy and outcomes

Therapist Empathy, Combined Behavioral Intervention, and Alcohol Outcomes in the COMBINE Research Project

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Samara L. Rice
University of New Mexico and State University of New York at Buffalo

Richard Longabaugh
Brown University

William R. Miller
University of New Mexico

Objective: Common factors such as therapist empathy play an important role in treatment for addictive behaviors. The present study was a secondary analysis designed to evaluate the relation between therapist empathy and alcohol treatment outcomes in data from a large, multisite, randomized controlled trial. ***Method:*** Audio-recorded psychotherapy sessions for 38 therapists and 700 clients had been randomly selected for fidelity coding from the combined behavioral intervention condition of Project COMBINE. Sessions were evaluated by objective raters for both specific content (coping with craving, building social skills, and managing negative mood) and relational components (empathy level of the therapist). Multilevel modeling with clients nested within therapists evaluated drinks per week at the end of treatment. ***Results:*** Approximately 11% of the variance in drinking was accounted for by therapists. A within-therapist effect of empathy was detected ($B = -0.381$, $SE = 0.103$, $p < .001$); more empathy than usual was associated with subsequent decreased drinking. The Social and Recreational Counseling module ($B = -0.412$, $SE = 0.124$, $p < .001$), Coping with Cravings and Urges module ($B = -0.362$, $SE = 0.134$, $p < .01$), and the Mood Management module ($B = -0.403$, $SE = 0.138$, $p < .01$) were also associated with decreased drinking. No between-therapist effect was detected, and the Empathy $\times$ Module Content interactions were not significant. ***Conclusions:*** The results of the study appear consistent with the hypothesis that skills building and therapist empathy are independent contributions to the overall benefit derived from the combined behavioral intervention.

What is the public health significance of this article?
This study suggests that the interpersonal skills of the therapist influence the effectiveness of a behavioral treatment for problem drinking.

Keywords: combine, empathy, therapist effects, skills-building, alcohol

Two decades of randomized controlled trials (RCTs) have yielded conclusive evidence that psychosocial treatments are a worthwhile addition to the array of interventions now available for problem drinking. Despite the clear advantage of these treatments for a person seeking to change problematic drinking, there is still little evidence to help us understand how they convey the advantage they do. Efforts to explore specific elements and theory-driven procedures as causal mechanisms in empirically supported treatments (ESTs) for addiction have often failed to support the theories generating them (Bergmark, 2008; Morgenstern & McKay, 2007; Magill & Longabaugh, 2013). An alternative perspective is that the value of these treatments derives from factors common to them, such as engaging the client's hope and providing an acceptable rationale for change (Anderson, Lunnen, & Ogles, 2010; Bohart & Wade, 2013). Characteristics of therapists who deliver these treatments are sometimes cited as a possible ingre-

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"Therapist empathy was inversely associated with client drinking at the end of treatment. That is, when therapists expressed more empathy than they usually did, the client drank less at the end of treatment, and, conversely, when therapists expressed less empathy than they usually did, the client drank more at the end of treatment." (p. 225)

Moyers & Miller (2013): Is low therapist empathy toxic? meta-analysis

BRIEF REPORT

Is Low Therapist Empathy Toxic?

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One of the largest determinants of client outcomes is the counselor who provides treatment. Therapists often vary widely in effectiveness, even when delivering standardized manual-guided treatment. In particular, the therapeutic skill of accurate empathy originally described by Carl Rogers has been found to account for a meaningful proportion of variance in therapeutic alliance and in addiction treatment outcomes. High-empathy counselors appear to have higher success rates regardless of theoretical orientation. Low-empathy and confrontational counseling, in contrast, has been associated with higher drop-out and relapse rates, weaker therapeutic alliance, and less client change. The authors propose emphasis on empathic listening skills as an evidence-based practice in the hiring and training of counselors to improve outcomes and prevent harm in addiction treatment.

Keywords: empathy, therapist effects, listening skills, training

In discussions regarding the merits of evidence-based addiction treatment, prominent attention has focused on the effect of therapist variables on behavior change (Imel, Wampold, & Miller, 2008; Morgenstern & McKay, 2007). Indeed, it appears that one of the strongest determinants of clients' outcomes in addiction treatment in particular is the counselor to whom they happen to be assigned (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; McLellan, Woody, Luborsky, & Goehl, 1988; Miller, Taylor, & West, 1980; Valle, 1981). Research consistently shows that differences among therapists account for between 5% and 12% of the variance in a variety of client outcomes, including substance use (Elliot, Bohart, Watson, & Greenberg, 2011) and that a better relationship between the client and therapist is associated with higher levels of treatment engagement and retention in substance abuse programs (Meier, Barrowclough, & Donmall, 2005). Empirically based substance abuse interventions such as cognitive–behavioral treatment, 12-step facilitation, and motivational interviewing rely at least in part on the interpersonal skills of the provider for their impact, yet little research exists concerning which skills or attributes contribute to variation in the quality of the therapeutic interaction.

Psychotherapy research generally has suggested that therapist differences may be attributable in part to outlier counselors with unusually adverse or particularly good client outcomes (Okiishi, Lambert, Nielsen, & Ogles, 2003; Shapiro, Firth-Cozens, & Stiles, 1989; Wampold & Bolt, 2006). In the area of substance abuse treatment more particularly, at least four studies have reported therapists with unusually poor client outcomes. In a multisite clinical trial (Project MATCH Research Group, 1998), therapist differences were no longer significant after removing one or two outliers in each treatment condition whose clients showed particularly poor drinking outcomes. In a naturalistic experiment following the resignation of two drug counselors, McLellan and colleagues (1988) randomly reassigned their 62 cases to four other counselors. This allowed them to observe differences in outcomes for these reassigned clients as a function of the new counselor to whom they had been assigned. Relative to their functioning at the time of reassignment, the clients of three of these counselors showed varying degrees of improvement on all measures, but a fourth counselor's caseload showed *increased* rates of drug-positive urines, methadone dosage, and unemployment, and no reduction in arrests. In another clinical trial reported by this same group, one of three therapists providing supportive-expressive therapy had clients whose drug use on average *increased* during treatment, in contrast to significant improvement of cases assigned to two other therapists delivering the same manual-guided treatment (Luborsky et al., 1985). Finally, among clients randomly assigned to nine counselors providing manual-guided behavioral self-control training, the rates of within-caseload adverse outcomes ranged from zero to 75% (Miller et al., 1980).

What may account for such differences in efficacy among therapists treating substance use disorders? Reference is often made to common or nonspecific factors that influence outcome regardless of the particular theoretical orientation of a therapist (Hubble, Duncan, & Miller, 1999; Wampold, 2001). Evidence points in particular to therapists' interpersonal skills as a predictor of outcome (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Valle, 1981). Just how common such skills are among

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"We know of no therapeutic approach where low empathy has been linked to better outcomes in any area of healthcare… Of 'evidence-based practices' currently being promoted, [empathy] seems to us to be one of the most promising to improve outcomes and prevent harm in addiction treatment." (p. 882)

Elliott et al. (2018): Empathy meta-analysis

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Meta-Analysis > Psychotherapy (Chic). 2018 Dec;55(4):399-410. doi: 10.1037/pst0000175.

Therapist empathy and client outcome: An updated meta-analysis

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Affiliations + expand

PMID: 30335453 DOI: 10.1037/pst0000175

Free article

Abstract

Put simply, empathy refers to understanding what another person is experiencing or trying to express. Therapist empathy has a long history as a hypothesized key change process in psychotherapy. We begin by discussing definitional issues and presenting an integrative definition. We then review measures of therapist empathy, including the conceptual problem of separating empathy from other relationship variables. We follow this with clinical examples illustrating different forms of therapist empathy and empathic response modes. The core of our review is a meta-analysis of research on the relation between therapist empathy and client outcome. Results indicated that empathy is a moderately strong predictor of therapy outcome: mean weighted $r = .28$ ($p < .001$; 95% confidence interval [.23, .33]; equivalent of $d = .58$) for 82 independent samples and 6,138 clients. In general, the empathy-outcome relation held for different theoretical orientations and client presenting problems; however, there was considerable heterogeneity in the effects. Client, observer, and therapist perception measures predicted client outcome better than empathic accuracy measures. We then consider the limitations of the current data. We conclude with diversity considerations and practice recommendations, including endorsing the different forms that empathy may take in therapy. (PsycINFO Database Record (c) 2018 APA, all rights reserved).

- 80 studies
- 6,000+ participants
- Therapist empathy was a moderately strong predictor of clinical outcomes

The research base of listening well: Bottom line

- Decades of hard science consistently shows that listening well is not a soft skill, but is a robust predictor of positive outcomes.
- Not listening well runs the risk of client disengagement, drop out, and suboptimal outcomes.

4 steps to listening well

1. Hear what the person is saying.
2. Make an educated guess about the person’s underlying meaning.
3. Choose your reflection direction.
4. Share your guess as a concise reflective listening **statement** (not a question).

Listening well
Step 1

Hear what the person is saying.

- Avoid your listening roadblocks.
  (giving advice, making suggestions, persuading, questioning, probing, gathering information, agreeing, approving, praising, reassuring, sympathizing, consoling)
- Make the decision to listen.
- Use strategies to be in the present moment.

Listening well
Step 2

Make an educated guess about the person's underlying meaning.

- It is not possible for a person to put into words a lifetime of experiences, therefore, listening well requires listening for underlying meaning.
- An educated guess is not an assumption because of Step 1.

Listening well
Step 3

Choose your reflection direction.

Type of Reflection	Direction
Simple Reflection	Repeat or rephrase what was said for clarification or emphasis
Feeling	Reflect implied emotion by naming the feeling
Double-Sided	Reflect both sides of ambivalence (cons/pros of change)
Coming Alongside	Reflect in the direction of no change, side with the negative
Continuing the Paragraph	Reflect in the direction of change to encourage “change talk”

Listening well
Step 4

Share your guess as a concise reflective listening **statement** (not a question). Infect your voice down at the end:

- You've got a lot on your mind? (up for question)
- You've got a lot on your mind. (down for statement)

- You're feeling anxious?
- You're feeling anxious.

Listening well
Step 4

Share your guess as a concise reflective listening statement. Starters:

- Sounds like…
- You mean...
- It seems to you that…
- For you it's a matter of…
- From your point of view…
- You're feeling…

Listening well practice summary

- ✓ Make the decision to listen.
- ✓ Avoid your listening roadblocks.
- ✓ Take risks to offer educated guesses about underlying meaning.
- ✓ Be mindful of direction.
- ✓ Offer reflections as concise statements.
- ✓ Get the “I” out of it.

Demonstration

- **Practitioner** - make the decision to listen
- **Speaker** - real play (not role play)
- **Observers** - create observer sheet to count and categorize practitioner behavior

Observer sheet

	Type of Reflection	Count (hash mark)	Practitioner Example
Listening Statements	Simple reflection		
	Feeling		
	Doubled-Sided		
	Coming Alongside		
	Continuing the Paragraph		
	Question		
	Listening Roadblocks		

Debrief

Listening well is readily observed, measured, and assessed.

Benchmarks of listening well:

- Absence of listening roadblocks
- Simple reflections are no more than 50% of all reflective listening statements
- At least 1:1 ratio of reflections to questions

Closing

- What are 1-2 things you learned or relearned about listening well?
- If you made 1-2 adjustments to your everyday listening, what might you try?

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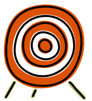
Reflective Listening Cheat Sheet

- **Simple Reflection.** Repeat or rephrase what the person said. Useful for clarifying or emphasizing what was said.
- **Paraphrase.** Restatement which brings in an educated guess about a person's underlying meaning or inference to add meaning to what the person said.
- **Feeling**. Reflection of implied underlying feeling; name it.
    - Client: If I keep smoking marijuana my Probation Officer is going to lock me up.
    - Practitioner: You're *worried* about the consequences.
- **Double-Sided**. Both sides of ambivalence (pros/cons) are contained in a single reflection; end with the positive or change side.
    - On one hand, the medication side effects are uncomfortable, and on the other hand, you've benefited from taking it.
- **Metaphor**. This is "picture language" or statements that evoke an image.
    - It's like a dam finally broke this week and everything is flooding out.
    - It's like climbing a ladder: you're reaching for the next goal.
    - You hit a wall trying to figure this out.
- **Coming Alongside**. Take up and reflect the side of no change; side with the negative; empathy in action.
    - Client: I can't give up drinking – it's how I socialize. Practitioner: Drinking is very important to you.
    - Client: This program isn't helpful. Practitioner: You're having a bad experience here.
- **Continuing the Paragraph**. Anticipate the next statement that has yet to be said. Starts with conjunction (and… because…) to make a guess in the direction of change or future action toward change.
    - Client: I have to get my kids back. Practitioner: …and you're ready to take a step toward change.



Reflect back more than the person said, but not more than the person meant to say.

Reflection starters:

- It sounds like you…
- It seems to you that…
- From your point of view…
- For you, it's a matter of…
- You mean that…
- You're wondering if…
- You're feeling…
- You must be…
- So you…

Best practices:

- Make the decision to listen.
- Offer reflections as statements.
- Be mindful of direction.
- Keep it concise.
- Get the "I" out of it.

Listening Well Practice Profile [1]

This practice profile operationalizes practitioner competencies (knowledge, attitudes, skills) for listening well with defined fidelity standards as expected use in practice. [2] Assessment is based on direct observation of practice, such as a 15-20 minute audio recorded sample of practice. [3]

Core Component	Contribution to Outcome	Expected Use in Practice (Fidelity)	Developing Use in Practice	Unacceptable Use in Practice
Knowledge of listening well includes being able to identify 4 steps of listening, types of reflections, and general findings from research.	Knowledge of listening well underscores skillful listening practice.	Score of 90% or higher on written test of knowledge.	Score of at least 70% on written test of knowledge.	Score lower than 60% on written test of knowledge.
Attitudes toward listening to people in the delivery of routine services.	Attitudes toward listening well underscores skillful listening practice.	Practitioner views listening well as central to professional development. Approaches people with openness and curiosity. Self-aware of biases, judgments, and listening roadblocks.	Practitioner views listening well as somewhat central to professional development. Approaches people with openness and curiosity. Somewhat self-aware of biases, judgments, and listening roadblocks.	Practitioner does not view listening well as central to professional development. Discounts peoples' perspectives. Not aware of how biases, judgments, and listening roadblocks impact service delivery.
Accurate empathy as a way of being.	Accurate empathy and skillful reflective listening are robust predictors of client engagement and of positive client outcomes. [4, 5, 6, 7]	Global measure of empathy [8] is at least 4 on 1-5 scale.	Global measure of empathy [8] is at least 3 on 1-5 scale.	Global measure of empathy [8] is 2 or lower on 1-5 scale.
Depth of reflective listening.		Percentage of complex reflection is at least 50% of total reflection.	Percentage of complex reflection is 30-40% of total reflection.	Percentage of complex reflection is less than 20% of total reflection.
Frequency of reflective listening (relative to questions).		Ratio of reflection to question is at least 2:1.	Ratio of reflection to question is at least 1:1.	Ratio of reflection to question is less than 0.5:1.
Absence of listening roadblocks such as confronting, directing, warning, and judging.	These behaviors tend to be associated with poor client engagement and negative outcomes of services. [9]	Absence of listening roadblocks during a client encounter.	One occurrence of a listening roadblock during a client encounter.	Several occurrences of listening roadblocks during a client encounter.

Notes:

1. Listening well inspired by W. R. Miller's (2018) book of the same title. Practice profile created by Scott Caldwell at the Wisconsin Department of Health Services, July 2019.
2. Listening fidelity standards taken from Miller, W. R., & Rollnick, S. (2013, p. 400). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press; and Moyers, T. B., Manuel, J. K., & Ernst, D. (2014). *Motivational Interviewing Treatment Integrity coding manual 4.1*. Unpublished manual, University of New Mexico, Center on Alcoholism, Substance Abuse, and Addiction. Retrieved from http://casaa.unm.edu/download/MITI4_1.pdf
3. Direct observation of practice is critical for reliable assessment of listening skills because research consistently shows that practitioner self-report does not correlate with actual practice, for example, see Carroll, K. M., Martino, S. & Rounsaville, B. J. (2010). No train, no gain? *Clinical Psychology: Science and Practice, 17*, 36-40.
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7. Elliott R., Bohart, A. C., Watson J. C. et al. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy, 55*(4), 399-410.
8. Global measure of empathy, reproduced with permission from Moyers, Manuel, and Ernst (2014):

1 (low)	**2**	**3**	**4**	**5** (high)
Practitioner gives little or no attention to the client's perspective.	Practitioner makes sporadic efforts to explore the client's perspective. Practitioner's understanding may be inaccurate or may detract from the client's true meaning.	Practitioner is actively trying to understand the client's perspective with modest success.	Practitioner makes active and repeated efforts to understand the client's point of view. Shows evidence of accurate understanding of the client's worldview, although mostly limited to explicit content.	Practitioner shows evidence of deep understanding of client's point of view not just for what has been explicitly stated but what the client means but has not yet said.

9. White, W., & Miller, W. R. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30.