Using Microcounseling to Teach RN Nursing Students Skills of Therapeutic Communication

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ABSTRACT

This study assessed the degree to which nursing students acquired and retained six generic skills of communication.

Fifty-three second-year female RN students were randomly assigned to either an experimental group (E-group) which received microtraining, or a nonattention control group (C-group). All subjects completed both the Carkhuff Indices of Communication and Discrimination as pretests. The E-group then had approximately 25 hours of microtraining in six basic communication skills. Following training, each subject completed the Carkhuff Indices again, the Empathy Construct Rating Scale, and a 10- to 15-minute audiotaped interview in which she assumed the role of a helping nurse.

Multivariate analysis of covariance indicated a significant main effect suggesting that the E-group performed better than the C-group when all the measures were combined together. As well, the experimental trainees performed significantly better than the control trainees on empathy, reflection of feeling, and summarizing. The E-group made fewer communication errors, asked fewer closed questions, made more Good responses, and showed a significant increase in empathy over training.

At the nine-month follow-up, while there were no statistically significant differences between the groups on any dependent measure, the E-group outperformed the C-group on all dependent measures.

Introduction

The importance of communication skills to nursing has been well-documented (Clark, 1981; LaMonica, 1979; Murphy, 1982). While nursing, by definition, is a helping profession and accepts the importance of good communication, compelling evidence suggests that the need for good communication is of more than just theoretical interest to nurses as health professionals. Several studies indicated that when health professionals have good interpersonal and communication skills, a variety of positive patient responses are observed. Such responses include:

- relief from anxiety and pain and improved cardiovascular and respiratory performance (Gerrard, 1978; Wood, 1982),
- reduction in the number of self-deprecating comments in elderly patients (Williams, 1979),
- increased patient satisfaction and compliance (Francis & Morris, 1969; Wood, 1982), and

Conversely, lack of effective communication by the nurse has been linked to adverse effects such as increased self-deprecating comments in elderly patients (Williams, 1979). The 1977 report of the Ombudsman to the National Health Service in England indicated that over 50% of the cases of patient complaints had communication as the major consideration (Bridge & Speight, 1981).

This, in part, has motivated a recent emphasis on communication skills in the nursing literature. For one, Nursing Times felt the issue to be important enough to name 1981 as "Communications Year." A second factor was the consistent trend in the early literature suggesting that nurses tend not to be good therapeutic communicators. Early studies such as Matthews (1962) found that less than 7% of nurses encouraged their patients to communicate. A recent review of the literature from the 1960s and 1970s suggested that nurses tend to lack essential communication skills such as empathy (Daniels, 1985).

In spite of the recognized value of and the need for communication skills in nursing, historically, little has been done to include known effective methods of teaching communication skills in nursing curricula. Clark (1981) suggested that little time is actually spent in nursing education explicitly teaching skills of therapeutic com-
munication. She states “... in practice, little attention has been paid to the fact that communication involves skills which, like others, can and should be taught” (p.12). Hills and Knowles (1983) suggested that while available programs exist for developing interpersonal and communication skills, these typically have not been used in nursing education. Furthermore, they indicated that most nursing programs deal with communication skills at a conceptual level, allowing little or no time for practice or assessment. Clark (1981) stated, “I have been struck by an apparent contradiction surrounding the fact that although ‘communication’ is central to the whole of nursing, it is an aspect which is almost never explicitly taught” (p.18). And finally, LaMonica, Carew, Winder, Haase, and Blanchard (1976) called for a formal integration of theory and experience in teaching helping skills in nursing programs.

Within the general field of counseling psychology, considerable progress has been made in the development of methodologies for teaching skills of therapeutic communication and helping. One of the most widely reported of such methods is microcounseling (Ivey, 1971; Ivey & Authier, 1978).

Microcounseling: A Theoretical Framework

Microcounseling/microtraining (the terms are essentially interchangeable) is a highly systematic and structured methodology for teaching communication and interviewing skills (Ivey, 1971). Microcounseling applies several diverse perspectives on learning. The first is social learning theory. Miller and Dollard (1941) suggested that observers learn to model as a result of vicarious reinforcement. Bandura (1969) reported that modelling leads to the acquisition of new behaviors and the modification of existing behaviors. Second, operant learning theory holds that feedback in the form of reinforcement facilitates the acquisition of new behavior (Buchheimer, 1966; Kagan, Krathwohl, & Miller, 1963). Third, focusing on a single skill tends to increase confidence in the learner, whereas the teaching of multiple skills at once tends to be confusing (Bear, 1968; Lovaas, 1968). And fourth, self-observation and self-confrontation lead to behavior change (Allen, 1967; Walz & Johnson, 1963).

Microcounseling/microtraining emphasizes a psycho-educational approach to teaching the fundamental skill-units (microskills) of therapeutic communication. It is a short-term intensive period of training, experiential in nature, in which only one skill is taught in a given training sequence. While microcounseling is an open system (many variations are possible), the training paradigm/sequence usually includes the following ordered components and steps:

- In any one training session only one skill is taught. Typically, such a session ranges from two to four hours.
- Trainees usually complete an audio/videotaped baseline interview.
- Trainees read and discuss a written manual which describes the skill in detail.*
- Trainees observe video-models demonstrating the effect on communication of the use and misuse of the skill in question.*
- If the trainees have completed a baseline interview, this is now reviewed. The supervisor emphasizes positive aspects of the trainee's behavior.
- Trainees practice the skill. They are given feedback on their performance by their peers and the supervisor. The supervisor maintains a warm supportive relationship.
- Finally, the skill is reviewed.

*Training tapes and manuals for teaching nurses are commercially available.

At the simplest level, the microskills include: attending behavior (eye contact, comfortable posture, and verbal tracking), minimal encouragers (e.g., “mm-hm”, “yes . . .”), or non-verbal gestures such as head nods), open questions, paraphrasing, reflection of feeling, and summarizing. This is referred to as the Basic Listening Sequence (Ivey, 1983).

Recent studies have shown that when trainees are taught the basic microskills, there is a concomitant and significant increase in their level of functioning in core therapeutic conditions such as empathy (Geary, 1979; Simek-Downing, 1981; Bailey, 1981; Crabb, Moraco & Bender, 1983). Microcounseling also appears to be useful for teaching higher level therapeutic skills such as interpretation, influencing, self-disclosure, and therapeutic confrontation (Ivey, 1983).

An extensive review of over 250 microcounseling studies has suggested that this paradigm is effective for teaching a variety of both professional and lay populations including: psychologists, physiotherapists, and medical students/doctors (Kasdorf & Gustafson, 1978). However, only a few studies have assessed the efficacy of microcounseling within the field of nursing, and the results have been encouraging but mixed.

The main purpose of this study was to investigate the applicability of microcounseling in teaching RN diploma-program nursing students six skills (the Basic Listening sequence) of therapeutic communication. The following four research questions were addressed:

- Will the experimental trainees exhibit a significantly higher “overall” level of therapeutic functioning at posttraining than the nonparticipating control trainees?
- At posttraining, will the experimental trainees have a significantly better facility than the control trainees to: use the microskills, discriminate facilitative responses, communicate empathy, and make less communication errors?
- Will the experimental trainees, in contrast to the control trainees, demonstrate a significant increase from pretest to posttest, in their ability to communicate empathy and discriminate facilitative/helpful responses?
- What will be the subjects' level of communication
TABLE 1
THE EXPERIMENTAL DESIGN

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Treatment</th>
<th>Audiotape</th>
<th>Posttest</th>
<th>Follow-up (9 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-group</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>C-group</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**MEASURES**
- Carkhuff Index of Discrimination
- Carkhuff Index of Communication (empathy)

**SKILLS TAUGHT**
- 24 hours of MICROCOU.
- Attending Behavior
- Questioning
- Paraphrasing
- Minimal Encouragers
- Reflection of Feeling
- Summarization (skill integration)

**MEASURES**
- Carkhuff Index of Discrimination
- Carkhuff Index of Communication
- Empathy Construct Rating Scale
- Ivey Taxonomy
- 6 Microskills
- Focus dimension (helper, self, other, dyad)
- Therapist Error Checklist
- Good
- Fair
- Poor
- 28 Errors of Communication
  - focus
  - role definition
  - facilitation of communication
  - (Total errors)

skills functioning at the nine-month follow-up assessment?

**Methodology**

This study employed an experimental design with covariates (see Table 1 for diagrammatic representation).

The sample consists of all full-time second year female students (n = 60) in a two-year, eight-month registered nurse (RN) diploma program. In all, there are 56 females and four males. The age range for this group is 18 to 36 years, with a mean age of 21.2 years. Within this population, 54 of the students are single, four are married, and two are separated from their spouses. Thirty-three of the students have high school matriculation, one has a university degree, and 26 have postsecondary education of up to two years. The males were dropped from the analysis and there was a further attrition of three subjects leaving a sample of 53 for the analysis.

**Instrumentation**

All but one of the instruments used in this study are commonly used in communication research. At the time of this study, The Empathy Construct Rating Scale (LaMonica, 1981) was an experimental device primarily used in nursing research. Detailed validity and reliability data on all the instruments used in this study may be found in the literature. Generally speaking, validity and reliability coefficients are in the order of .80.

**Procedure**

Prior to assigning subjects to their respective groups, all subjects completed the Carkhuff Indices of Communication and Discrimination (Carkhuff, 1969). Subjects were randomly assigned to either an experimental group or a nonattention control group. The subjects in the experimental group then received approximately 25 hours of microcounseling training (using the microtraining paradigm described in the previous section). The training was divided into six segments, each three to five hours in length. Only one microskill was taught per training segment. The skills were taught in the following order: attending behavior, questioning, minimal encouragers, paraphrasing, reflection of feeling, and summarizing.

During the period of microcounseling training of the experimental subjects, the control subjects were nonattended. Essentially, the control subjects spent this period of
time entirely on their own and received no supervision or structured training experience of any kind.

Following training of the experimental trainees, all subjects of both groups again completed the Carkhuff Indices as well as The Empathy Construct Rating Scale. As well, each subject conducted a 10- to 15-minute audiotaped nursing interview. These interviews were conducted with a variety of adults at the subject's choosing, provided that informed consent was given by the interviewee and that the interview was otherwise conducted in an ethical manner. These audiotaped interviews were rated for the presence of the microskills on the Ivey Taxonomy (Ivey & Authier, 1978) and for the presence of communication errors on the Therapist Error Checklist (Matarazzo, Weins & Saslow, 1966) (All tape-ratings and written empathy ratings were done by independently trained raters who had demonstrated interrater reliability in excess of .88; all other instruments have objective scoring.)

Nine months following the microtraining, at the completion of the RN program, a follow-up assessment was conducted. At that time, the subjects completed all assessment devices again and conducted a 10- to 15-minute audiotaped nursing interview.

### Results

The pretests (see Table 2) suggest that all (or most) of these students were functioning at low levels of both empathy and discrimination. The Carkhuff Empathy Scale (Carkhuff, 1969) is a five-point rating scale with Level 1 representing complete absence of empathy and Level 5 representing extremely precise accurate empathy. Level 3 is considered the minimally facilitative level of empathic functioning. In this case, both the E- and C- groups, at pretest, were functioning at a level of empathic and discriminative functioning comparable to that of the general public (Carkhuff, 1969).

Multivariate analysis of covariance of the posttest data yielded an $F(1, 46) = 3.50, p < .001$. This suggests that the E-group performed significantly better than the C-group on all the measures of therapeutic functioning when these measures were combined together.

Univariate F-ratios can be seen in Table 3. The E-group performed significantly better than the C-group on the two measured dimensions of empathy. First, the experimental trainees were better able to communicate empathy as measured by the Carkhuff Empathy Scale. And second, the experimental trainees performed better on the Empathy Construct Rating Scale. This implies that they had a better knowledge of empathy and viewed themselves as more frequent empathizers.

The experimental trainees made significantly more error-free communications than did the control trainees. As well, the E-group asked significantly fewer closed questions than did the C-group. Closed questions are felt to thwart therapeutic communication (Ivey, 1983). And, finally, the E-group made significantly more summarizing statements than did the C-group.

With the exception of open questions, the E-group performed better on all the other therapeutic dimensions than did the C-group. However, none of these differences was statistically significant, $p < .05$.

Table 4 shows pre-post functioning on empathy and discrimination. It can be seen that, in contrast to the C-group, the E-group significantly increased its ability to communicate empathy from pretest to posttest. While the E-group showed an increase in its ability to discriminate and the C-group a decrease, neither change was statistically significant, $p < .05$.

At the nine-month follow-up period, the E-group performed better on all the dependent measures than the C-group. However, these differences failed to reach statistical significance, $p < .05$. MANOCOVA for the follow-up data yielded $F(1, 17) = .47$, $p < .05$.

### Conclusions and Discussion

The results of this study offer support for the efficacy of microcounseling within the context of nursing education. While a nonattention control group was used, one might query whether the attention alone paid to the experimental group accounted for the results (the Hawthorne Effect). Two particular lines of evidence suggest that this is not the case and that the experimental effect may be attributed specifically to the microcounseling treatment.

The first line of evidence is found in comparative studies in the microcounseling literature. In two extensive reviews of the microcounseling literature, Kasdorf and Gustafson (1978) and Daniels (1983) indicate microcounseling to be superior to no instruction. Furthermore, several studies indicate microcounseling to be superior to attention-placebo (Dunn, 1975; Hearn, 1975), didactic instruction (Moreland, Ivey & Phillips, 1973; Sawyer & Sawyer, 1981), and traditional counselor training methods involving mostly instruction (Moreland, Ivey & Phillips, 1973). Where therapeutic skill acquisition is concerned, Ford (1979) indicated that instruction alone is less effective than modeling, feedback, or either of the major systematic training programs available to counselor education including microcounseling.

The second line of evidence concerns the behavior of
TABLE 3
DEPENDENT VARIABLES AT POSTTEST—MEANS, STANDARD DEVIATIONS, AND ANOVA

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>F</th>
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<tr>
<td>Carkhuff</td>
<td>E</td>
<td>24</td>
<td>2.04</td>
<td>.22</td>
<td>10.15††</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>29</td>
<td>1.87</td>
<td>.34</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>E</td>
<td>24</td>
<td>1.02</td>
<td>.25</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>28</td>
<td>1.87</td>
<td>.27</td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td>E</td>
<td>24</td>
<td>188.80</td>
<td>42.10</td>
<td>7.60†</td>
</tr>
<tr>
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<td>C</td>
<td>29</td>
<td>151.94</td>
<td>40.90</td>
<td></td>
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<tr>
<td>Construct</td>
<td>E</td>
<td>23</td>
<td>11.4</td>
<td>6.9</td>
<td>5.37*</td>
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<tr>
<td></td>
<td>C</td>
<td>29</td>
<td>7.3</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Error-Free</td>
<td>E</td>
<td>23</td>
<td>47.2</td>
<td>26.4</td>
<td>.95</td>
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<tr>
<td>Responses</td>
<td>C</td>
<td>28</td>
<td>40.6</td>
<td>23.1</td>
<td></td>
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<tr>
<td>Attending</td>
<td>E</td>
<td>23</td>
<td>5.1</td>
<td>3.3</td>
<td>.02</td>
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<tr>
<td>Behavior</td>
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<td>28</td>
<td>5.1</td>
<td>3.8</td>
<td></td>
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<tr>
<td>Open</td>
<td>E</td>
<td>23</td>
<td>6.0</td>
<td>3.7</td>
<td>7.70††</td>
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<tr>
<td>Questions</td>
<td>C</td>
<td>28</td>
<td>10.4</td>
<td>6.7</td>
<td></td>
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<tr>
<td>Closed</td>
<td>E</td>
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<td>26.3</td>
<td>19.6</td>
<td>2.88</td>
</tr>
<tr>
<td>Questions</td>
<td>C</td>
<td>28</td>
<td>17.3</td>
<td>16.0</td>
<td></td>
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<tr>
<td>Minimal</td>
<td>E</td>
<td>23</td>
<td>6.7</td>
<td>6.5</td>
<td>2.73</td>
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<tr>
<td>Encouragers</td>
<td>C</td>
<td>28</td>
<td>4.5</td>
<td>2.3</td>
<td></td>
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<tr>
<td>Paraphrases</td>
<td>E</td>
<td>23</td>
<td>3.7</td>
<td>2.8</td>
<td>8.73††</td>
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<tr>
<td>Reflection of</td>
<td>E</td>
<td>23</td>
<td>1.7</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Feelings</td>
<td>C</td>
<td>28</td>
<td>.8</td>
<td>.9</td>
<td>15.67††</td>
</tr>
</tbody>
</table>

* p < .05
†< .01
†† < .001

TABLE 4
ANOVA ON THE GAIN SCORES FROM PRETEST TO POSTTEST ON CARKHUFF EMPATHY AND DISCRIMINATION

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Dependent Measure</th>
<th>F</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Group vs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-Group</td>
<td>Empathy</td>
<td>4.59*</td>
<td>1.40</td>
<td>129.19</td>
<td>11.64</td>
</tr>
<tr>
<td></td>
<td>Discrimination</td>
<td>1.68</td>
<td>1.40</td>
<td>1.05</td>
<td>.62</td>
</tr>
</tbody>
</table>

* p < .05

Skilled vs nonskilled subjects. Subjects' levels of empathy and discrimination prior to the study were about on par with what one might find in the general public and quite below facilitative levels (Carkhuff, 1969). In other words, these students could be considered to lack the skills being taught. The Hawthorne Effect appears to be more relevant where skills are already present and "the attention" increases the frequency of skill application (Maccoby, Newcomb & Hartley, 1958).

With this in mind then, after a relatively short period (25 hours) of microtraining in six generic skills of communication, the E-group trainees were able to demonstrate a significantly higher level of functioning on a number of important psychotherapeutic dimensions. In particular, the E-group trainees were operating at a higher cognitive and functional level of empathy than the C-group members. The importance of this therapeutic dimension is consistently emphasized in the nursing literature (Bridge & Speight, 1981; Clark, 1981; Gagan, 1983; Lamonica, et al., 1976; Norris, 1986). Data from this study are consistent with that of previous studies that suggest that where the basic microskills are taught, there is a concomitant and significant increase in the trainees' empathic functioning (Geary, 1979; Simek-Downing, 1981; Crabb et al., 1983).

In addition to the gain in empathic functioning, the E-group trainees, in contrast to those of the C-group, showed a posttraining use of other important communication skills including reflection of feeling and summarizing. Both of these skills are useful in structuring interviews and facilitating clarification (Ivey & Authier, 1978).

The E-group asked fewer closed-questions than the C-
group. Many agree that closed-questions tend to block communication (Ivey, 1971; Ivey & Authier, 1978). Such a result, together with the significantly fewer error-free responses made by the E-group, implies that these trainees were functioning as better communicators in the nursing interview than were the C-group trainees.

The nine-month follow-up data were less conclusive however. Statistically, significant differences between the groups were not evident on any of the dependent measures. On the one hand, this is difficult to interpret, as only 24 of the original 53 subjects participated in the follow-up assessment (E-group = 8, C-group = 16). However, this finding is entirely consistent with other microcounseling studies where follow-up data were gathered. It appears that when there is no follow-up training and little or no opportunity to practice the skills learned, the skills tend to deteriorate over time (Kasdorf & Gustafson, 1978).

Students spent the six months following the experiment in clinical placement. While students were encouraged to actively communicate with their patients, no formal opportunities to do therapeutic communication was provided for these students during this placement. Furthermore, these students' communications with their patients were not systematically supervised, and no follow-up training was given during the six-month clinical placement. In spite of this, the E-group trainees outperformed the C-group trainees at follow-up, although this difference was not statistically significant. It must therefore be concluded that further follow-up training and structured opportunity to practice the skills learned are required if the trainees' skill level is to be maintained.

Anecdotally, the E-group trainees responded most positively to the microtraining. They reported that they were quite pleased with the procedure and found it compatible with other learning experiences in their nursing program. Subsequent to the microtraining, a significant number of the E-group trainees reported that they felt more confident in themselves during communication with patients and others. For some, this confidence remained after they had graduated. One student stated, "Before, I understood about empathy. Now I feel that I can actually do it."

Of the variety of training methodologies available for teaching therapeutic communication, microcounseling appears to be ideally suited to nursing. Whereas other approaches often tend to focus on teaching the larger therapeutic dimensions such as empathy, subjects trained in the basic microskills tend not only to improve on empathy but learn a variety of other useful skills in the process (e.g., styles of questioning, paraphrasing, and summarizing).

While there is no doubt of the importance of empathy to the nursing process, the literature suggests that other communication skills are vital to good nursing as well. These skills include: offering emotional support, clarification, communication of treatment programs to patients and ensuring patients' understanding of their treatment, and taking admission history (Bowen-Jones, 1979; Clark, 1981; Murphy, 1982). Ivey (1983) suggests that a doctor or nurse, when diagnosing a problem, essentially works through the Basic Listening Sequence (the basic microskills of attending, questioning, encouraging, paraphrasing, reflecting feeling, and summarizing).

Several considerations for further research are indicated as a result of the findings in this study. As this study focused on second year students, microtraining with first year students and nursing students would offer information on the ability to generalize this training paradigm within the population of nursing students. Furthermore, were training to be integrated into the diploma-program curriculum, the degree of "skill internalization" could be investigated over time.

Investigation of the effects of microskills learned on an index of patient improvement or general nursing performance would be useful. The application of this paradigm to teach nursing skills other than communication should be studied. Finally, a most promising area for future microcounseling/nursing research would be the development of microcounseling materials focusing on teaching nurses how to handle specific problematic situations in the work place. Such training might include how to handle the sexually aggressive patient, the verbally hostile patient, and the noncommunicative patient.

References


Halifax, Nova Scotia.

Dunn, R.(1975). Comparative effects of three counselor training techniques or reflection of feeling. Paper presented at the

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