THERAPEUTIC LISTENING IN CARING RELATIONSHIPS

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Abstract

Therapeutic listening is a proven and highly valuable tool used in professional, semi-formal, and formal caregiving relationships. The following work is a pilot project intended for use as a continuing education tool in the training of formal, yet unpaid, caregivers in a spiritual ministry serving in long-term, one-to-one relationships with a single care receiver. Methods used were derived from adult learning theory, small group communication theory, humanistic psychology, behavioral learning theory, social learning theory, symbolic interactionism, and interpersonal communication theory to name a few. Active listening and active learning strategies designed for adults are explored and utilized. The final project builds on existing knowledge of the use of therapeutic listening in various social and psychological relationships, but addresses the underrepresented application in formal and unpaid caregiving relationships. Professionals and other formal caregivers benefit from the findings and application of this project. The project may also be helpful in providing a basis for more in-depth training or application in a longitudinal study on the use of therapeutic listening in these types of caregiving relationships.

Keywords: care giving, interpersonal communication, therapeutic listening, adult learning
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Chapter 1. INTRODUCTION: THE GOAL AND DEFINITION OF TERMS

THE GOAL

Importance of the Project

The goal of the following written, visual, and aural work is to provide training participants, care giving individuals, trainers, and teachers with a holistic perspective of the background and application of therapeutic listening as a tool of caregiving relationships. The positive results of therapeutic listening have been widely studied and explored. Therapeutic listening is used to promote health and wellbeing of individuals and systems in many caring settings from professional to informal. Some areas of improvement, such as emotional and psychological healing, self-awareness, and problem solving, are noted with the use of therapeutic listening as an intentional component to interpersonal communication between care receivers and care givers. Therapeutic listening training may promote improved individual and systems health and wellbeing for care receivers and care givers serving in caring relationships. The results of this project provide direction for continuing education in the field of therapeutic listening in caring relationships. Identification of techniques and barriers provides opportunities to individuals and groups for improved interpersonal communication in caring relationships. Exploration of literature providing a holistic look at the use of therapeutic listening and examples demonstrating its use in caring settings serves as a sort of “how to” guide on techniques of and barriers to the use of effective therapeutic listening in care giving relationships. Finally, a look at aspects related to teaching adults and teaching within the context of a small group setting provides support for both lay-educators and professionals alike.

DEFINITION OF TERMS USED
Before proceeding it is important to define terms contained within the project. First, all forms of listening requiring action and empathetic or emotionally responsive components and with a specific intention of use as a tool in a caring relationship is referred to herein as therapeutic listening. A caring relationship is defined here as one that is comprised of a single caregiver and a single care receiver and is conducted through a formal relationship with formal guides and boundaries. The term caregiver refers to a trained individual who provides care to another in the forms of emotional, psychological, spiritual, and/or at times physical help and within the confines of a professional, formal, or semi-formal relationship. Finally, care receiver refers to the recipient of this stated care and within the confines of these relationships.

**ORGANIZATION OF REMAINING CHAPTERS**

Chapter two, the literature review, provides an exploration on applicable theoretical contributions along with examples of therapeutic listening as it is applied. Additionally, contributing thought to the design and production of the training module will be presented. The literature review is succeeded by chapter three, a chapter defining the scope, methods, and limitations of the training session presented. Chapter four presents the final product with a brief description of the individual components and their specific purpose and use within the project. Finally, a brief conclusion is presented as a reflection on the production of the written work and working production of the training session.
Chapter 2. REVIEW OF THE LITERATURE

Therapeutic Listening and Caring Relationships

The following literature review was conducted as a means to support and facilitate a continuing education adult learning session on the use of therapeutic listening as a tool in Christian care giving ministry. First, it is important to note that within the context of this literature review, responsive, reflective, active, and empathetic listening will most often be referred to under the umbrella of therapeutic listening due to the interchangeable components employed by practitioners and discussed by writers (Browning & Waite, 2012; Cooley, 1998; Covey, 2004; Davis, Foley, Crigger, & Brannigan, 2008; Knowles, 1980; Morland, 2003; Stephen Ministry, 2000; Welch 2003). This review will focus on a holistic approach to training adults on the topic of therapeutic listening as a tool in one-to-one relationships.

The following review will cover several areas pertinent to the production of the above stated training session. First, a brief discussion on why therapeutic listening is an important interpersonal communication tool in therapeutic relationships will be presented. Next, a glimpse into the background of contributing thought used in therapeutic listening and as a component of interpersonal supportive relationships will be offered. After background is examined, an exploration of literature related to therapeutic listening, which has been applied in interpersonal relationships will be discussed. Presentation of the practical application of therapeutic listening will be followed by literature pertaining to techniques and barriers. Finally, a section relating to developing effective training will be presented, which will include some basic components to contributing thought on adult learning and small group communication perspectives. Findings from the areas of this literature review will be used to design a training session geared towards
adults in a care giving ministry who use therapeutic listening as a primary tool of their ministry and are required to engage in continual education efforts as a stipulation of their service in the ministry.

PHILOSOPHICAL ASSUMPTIONS AND THEORETICAL BASIS

Significance of Therapeutic Listening

Therapeutic listening is an essential component to creating and maintaining therapeutic interpersonal communication (Cooley, 1998; Covey, 2004; Davis, Foley, Crigger, & Brannigan, 2008; Hall, 1997; McLeod 2007; Nichols, 2009; Rogers, 1951). Therapeutic listening is used as a tool by individuals in health and human service fields, which rely on interpersonal communication as being central to the holistic wellbeing of clients or care receivers (Welch, 2003). Over the past several decades, research and exploration of therapeutic listening techniques have added to the field and demonstrates the value in caring relationships ranging from professional-formal, to semi-formal, and informal (Browning & Waite, 2012; Welch, 2003). Listening experts and social scientists agree that both individuals and collective society benefit from the healthier systems created when people act as an intentional presence in the lives of the people they have caring relationships with (Covey, 2004; Nichols, 2009). Therapeutic listening as a component to intentional presence does not just happen; the techniques are learned, practiced and refined and require a continual involvement of the mind, body, and spirit (Covey 2004; Stephen Ministry 2000; Welch 2003).
As the level of education, experience, expertise, and formal training among care givers varies greatly, individuals serving in formal yet unpaid care giving roles may find it advantageous to first understand what therapeutic listening is and from where it is derived.

**Therapeutic Listening Defined**

Therapeutic listening is a commonly used tool in formal caring relationships. It is referred to by many names including responsive, active, or empathetic listening. In its essence it requires action on the part of the listener and employs empathy as a means to attempt to assume the role of the other (Stewart, 1983).

Action and empathy are unique components to this effective therapeutic tool used in interpersonal communication (Covey, 2004; Rogers, 1951; Welch, 2003). Small group communications experts Larry L. Barker, Kathy J. Wahlers, and Kittie W. Watson (2001) describe this form of listening as “the selective process of attending to, hearing, understanding, and remembering aural (and at times visual) symbols” including “evaluating and responding” and is not complete without “response and feedback” (p.70). This definition reflects listening as it appears on the active listening end of a spectrum for types of listening behaviors ranging from passive to active.

Listening behavior can be differentiated by looking at it as a continuum from passive to social and courteous to more active, such as empathetic, reflective, therapeutic, and critical listening behaviors (Long, 1996). Long discusses one variation of this continuum consisting of five basic listening types: (1) nonlistening is hearing without paying attention; (2) pretend (also known as false or manipulative) listening happens when listeners attempt to appear they are listening through verbal and nonverbal cues; (3) selective listening happens when the listener
only pays attention to part of the conversation; (4) self-focused listening uses the speaker’s words as a bridge to what they want to say about themselves, and; (5) empathetic listening takes place when the listener is focused on the meanings in the speaker’s words and nonverbal cues, as well as seeks to understand the speaker on many levels, such as emotionally and with regard to their unique situation. It is this latter form of listening that is of interest as it relates to therapeutic styles of listening used in caring relationships.

Empathetic listening as a form of active listening is the type which engages action: paying attention, asking questions, and reflecting what the speaker is communicating verbally and nonverbally (Stephen Ministry, 2000). An example of how this may look can be found in a conversation during a meeting with a care receiver who is struggling with the loss of a spouse. Upon settling in, the minister notices that the care receiver is less upbeat than usual and states, “You seem sad today. Would you like to talk about how you are feeling?” To which the care receiver proceeds to force a smile as she turns away and wrings her hands. After several moments she flatly replies, “I am fine.” In this situation the care giver utilizing empathetic listening skills may reflect what they are sensing and attempt to gather more information, such as with a reply of, “You seem to be distracted. Has anything changed since we last met?”

According to Stephen Ministry training materials, active listening is a way of understanding what others communicate, and helping them understand themselves better within the caring relationship (Stephen Ministry, 2000, pp.44-45). Having gained an understanding of what therapeutic listening is we move to examining contributing foundational thought.
Background: Interdisciplinary Theory

Therapeutic listening styles are one method of creating connections and constructing meaning with others. The roots of this active form of listening can be traced back to contributors of many social sciences, and disciplines utilizing the phenomenological communications tradition (Griffin, 2009). According to Carl Rogers (1951), elements of therapeutic listening are useful in promoting a sense of identity and belonging in the care receiver. Therefore, it is important to examine various theoretical contributions. Through this lens a more holistic understanding of therapeutic listening; intrapersonal, interpersonal, and societal implications can be gleaned.

In the 1930’s, humanistic psychotherapist Carl Rogers discovered a process of minimally invasive and reflective therapy later to be named Rogerian or client-centered therapy (McLeod, 2007). Rogerian counseling relies on the promotion of self discovery and developed self reliance in promotion of healing in individuals (Rogers, 1951). While working with patients, Rogers came to believe that the patient was his own expert on what was best for him and how to go about healing himself through self actualization encouraged by therapeutic listening focused on the client (Hall, 1997). Rogers believed that this form of listening was a tool for self awareness and healing on the part of the individual, but was facilitated through intentional employment of techniques (McLeod, 2007; Rogers, 1951). Essentially, Rogers (1951) believed that effective communication between individuals could only occur through attentiveness on the part of the listener, which conveyed to the speaker that he or she is important. Careful listening, Rogers asserted, was critical to developing and fostering safety and growth within the individual and required attending to him or her partially by removing the focus from self interest. This process is aided through conscious focused attention on the part of the listener, which was demonstrated
through paraphrasing and reflecting the speaker’s thoughts and feelings (Rogers, 1951).
Additionally, through a process of employing empathetic behavior towards the client, Rogers believed that the care giver placed a greater amount of control in the form of self-evaluation and assessment on the care receiver.

Just as Rogers believed that the way a listener responds to a speaker shapes the perceptions of self on the individual, Charles Horton Cooley also believed that social interaction greatly impacted one’s own sense of self (Cooley, 1998). Cooley (1998), known for his concept of the Looking Glass Self (a theoretical perspective stating individuals come to understand themselves in terms of what others reflect back to them), held that our sense of self is connected and shaped through the responses of others:

The growth of personal ideas through intercourse implies a growing power of sympathy, of entering into and sharing the minds of other persons. To converse with another through words, looks or other symbols, means to have more or less understanding or communion with him. (p.93)

Cooley (1998) asserted that our individualistic tendencies are products arising from these communions or societal influences and gained through communication. He described communication as being, “…all the symbols of the mind…expression of the face, attitude, and gesture, the tones of the voice, words…and whatever else may be the latest achievement in the conquest of space and time” (p.100).

It is in these assertions that we can see how intentional focus on the listener as Rogers (1951) discusses become essential to effective communication. Additional support for this stance is given by Cooley. Cooley (1998) believed that both the individual within society, as
well as the impact of society on the individual, were equally legitimate and impactful. It is through Cooley’s stance on reciprocal influence of self and society that we gain a deeper understanding of the importance of Rogers’ assertion that the listener’s actions are crucial to true communication (Rogers, 1951) and as a necessary part of societal life (Cooley, 1998). Cooley (1998) also believed that human beings come to understand themselves and develop continually through this reciprocal communication. Therefore, it stands to reason that the actions of individual members of society help to continually shape and reshape norms and practices, which contribute to the overall health of the societal system (Cooley, 1998).

Albert Bandura is another scientist who believed that individuals learn about themselves within the context of society and others (Bandura, 1977). He held that individuals learn through interactions with significant others by the observation of a specific behavior. Bandura (1977) asserted that an individual’s behaviors are in large part the product of modeling behaviors demonstrated by others, but consciously selected on the part of the individual. Bandura also discussed the influences of both positive and negative reinforcements from others and from self as a result of the individual’s behavior. He stated, “Most human behavior is maintained by anticipated rather than immediate consequences” (Bandura, 1977, p.109). He also said, human behavior is, “therefore, regulated by the interplay of self-generated and external sources of influence” (Bandura, 1977, p.129).

According to Bandura (1977), individuals encountering novel information organize and form ideas of how to recreate the desired behavior. Reflective listening provides a medium for the introduction of novel information about one’s self and one’s actions (Rogers, 1951; Stephen Ministry, 2000). Therapeutic listening promotes an environment in caring relationships for reflection leading to self awareness and self discovery lending to the individual’s ability to
develop their own solutions to their concerns (Rogers, 1951; Stephen Ministry, 2000; Welch, 2003). In considering these things, social learning theory provides support for the impact of interactions with others and their responses to us.

In continuing to look at the impact individuals have on one another, we examine the perspective of Herbert Blumer. Blumer (1969) asserted that through the confirmation of self, which is gained through the verbal and nonverbal responses of others, identity is conceived and understood. His view of interrelatedness of the human species was stated as, “…human association is an interaction of attitudes” (Blumer, 1969, p.112). He held that our interactions are fluid and are in constant reconstruction through our observations and interpretations of others around us, in essence we consider each other beyond presence and response to the other (Blumer, 1969). We are constantly defining and redefining ourselves through the way we define and judge others and through our appraisals of others (Blumer, 1969). Through the process of actively listening to the other and communicating deeper more empathetic responses through facial expressions, tone of voice, and inquiry and reflection we move beyond casual interaction in to this transactional experience Blumer speaks of, “…we become “intertwined” through the actions of the other” (Blumer, 1969).

Similar to the assertions of Cooley (1998), Bandura (1977), and Blumer (1969), Martin Buber (1970) believed that our identity and self concept was understood largely in terms of our interactions and perceptions of others and their responses to us. Buber (1970) believed that concept of self or “I” is understood within the context of awareness of other or “thou”. Through the exploration of spirituality and self as related to assigned meanings of words and societal constraints and concepts, paramount to individual development or understanding of I, you, and the in-between, or spirit, was a complete understanding of self within one’s experience with
others (Buber, 1970, pp.82-90). His stance that, “All actual life is encounter” (p.62) is reflective of the significance of human interaction. If, as Buber (1970) claimed, “I” cannot exist without relation to “you” we must consider the individual elements of our communicative behavior on others. This is further emphasized in the work of George Herbert Mead. Mead (1964) contended that the only sense of “I” could be found in reflection and based upon the experiences one had with others. It was his observation that, “The attitude assumed in response to another becomes a stimulus to him to change his attitude…” (p.136). Mead (1964) stressed that through gestures as primarily received in the early stages of social interactions, individuals evoke responses to one another and that, “The self arises in conduct, when the individual becomes a social object in experience to himself. This takes place when the individual assumes the attitude or uses the gesture which another individual would use and responds to it himself” (p.243).

With this statement Mead presents evidence for the effective use of active and reflective listening within interpersonal relationships.

In reviewing theoretical contributions we gain a better understanding of how individuals may impact others and ultimately society. Rogers (1951) helps to establish the foundation individual behavior has on others, specifically in the form of listening behaviors. The work of Bandura (1977), Blumer (1969), Buber (1970), Cooley (1998), and Mead (1964) presents perspectives illustrating the importance of self in relation to others and implications of our interpersonal interactions. From this foundation we move to examining the specific use of therapeutic listening styles in formal relationships.
THE LITERATURE

Therapeutic Listening Applied

As we have seen, a great deal of what we know of ourselves may be gathered from our interactions with others and how we view those interactions (Bandura, 1977; Blumer, 1969; Buber, 1970; Cooley, 1998; Mead, 1964; Rogers, 1951). From the first uses of therapeutic listening in psychotherapy by Carl Rogers, we begin to see its impact on caring relationships. Active listening practices help to promote positive interactions with others and may ultimately nurture healing in individuals (Rogers, 1951; Stephen Ministry, 2000; Welch 2003). Therapeutic listening skills employed on the part of caregivers build trust, provide an opportunity for a more holistic treatment plan, and helps to maintain ethical relationships with care receivers (Davis, Foley, Crigger, & Brannigan, 2008). Graybar and Leonard (2005) assert, “Listening and being listened to are the cornerstones of psychological development, psychological relatedness, and psychological treatment (p.3). This sentiment is important as a review of related literature demonstrating the use of therapeutic practices in caring relationships is reviewed.

Browning and Waite (2010) claim that active listening is a process that lends to enhanced health and well-being in patients on the part of healthcare providers, specifically nursing staff. They provide training and education to nursing staff on the critical nature of “JUST Listening” in the therapeutic relationship. Through the practice of active listening they maintain that patient-practitioner relationships are improved, along with helping patients to comply with recommended treatment plans (Browning & Waite, 2010). Similarly, Robbins (2005) provides a case study of a family dealing with a member who has attention deficit hyperactivity disorder (ADHD), and depicts the value of a role play exchange therapy method used in the training of
individuals to incorporate active listening skills referred to as Imago Relationship Therapy (IRT). IRT includes: initiation, mirroring, validating the other, and empathizing. The results of Robbins’ study indicated that the use of praise and validation along with use of active and reflective communication strengthens familial relationships (Robbins, 2005). Furthermore, findings support the highly beneficial component of mindfulness in the parent-child relationship (Duncan, Coatsworth, & Greenberg, 2009). The practice of therapeutic listening, especially mindfulness, was shown to increase family “satisfaction and enjoyment” through the improved relationship between parent and child. Duncan et al. (2009) note that the use of mindful parenting practices, which include attentive listening practice, was proven to be helpful in improving the outcome of family-focused preventative and intervention practices with children.

The bond between parent and child is highly emotional as is spiritual care giving (Stephen Ministry, 2000). The spiritual caring relationship was examined by Edwards, Pang, Shiu, and Chan (2010). Edwards et al. (2010) reviewed literature including narratives and surveys that demonstrated support for the importance of presence and involved listening methods on the dying individual during end-of-life care and found that, “intimate, fulfilling, meaningful relationships were at the heart of spirituality”. Patients relied on intimate relationships to provide strength, comfort and meaning during these times (Edwards et al., 2010). Similar findings were discussed in terms of the benefits of therapeutic listening in caring relationships through a study conducted by Miers, Abbott, and Springer (2010) with survivors of teen suicides. Survivors reported the need for the opportunity to simply talk and express feelings (Miers et al., 2010). Providing a forum in which others listened intently and empathetically to family members of suicide victims provided much needed healing and respite for the survivors through a sense of support and care (Miers et al., 2010).
Lewis and Manusov (2009) explored the impacts on speakers and listeners in their discussion on the value of listening in distressing situations. In this study, the impact of listening to distressing information as a participant of an informal, close, and ongoing relationship was examined. Findings from the sample indicated that it was less distressing for speakers to receive responsive listening behaviors from others than it was to receive advice (Lewis & Manusov, 2009). Additionally, responsive listening by people close to the individual in distress created greater distress for the listener than it may for those in formal roles that allowed for distancing, such as with counselors (Lewis & Manusov, 2009). Feelings of personal responsibility often associated with informal caring relationships, were more likely to cause distress for listeners, who then would attempt to mitigate their distress by offering advice, which resulted in the increase of distress to the speaker (Lewis & Manusov, 2009). Findings from this study present support for the formal use of caring relationships utilizing trained individuals during times of crisis. In a final example of therapeutic listening in caring relationships, a study on dyadic relationships, an interaction adaption model, by Duggan and Bradshaw (2008) examined the impact of nonverbal and verbal impact on the patient-physician relationship. Findings showed the use of nonverbal behaviors, such as eye contact, open body language, and appropriate head nodding encouraged disclosure of concerns and expectations on the part of the patient (Duggan & Bradshaw, 2008). Also noted was the association between expectations with roles that may have impacted the perceptions of the patient in terms of positive and negative responses (Duggan & Bradshaw, 2008).
RATIONALE

Therapeutic Listening Tools

Therapeutic listening involves conscious action and awareness of techniques that may improve the effectiveness of its use (Rogers, 1951; Welch, 2003; Williams & Menendez, 2007). Likewise, it is important for care givers to be aware of some of the barriers that may hinder the effectiveness of their role in caring relationships (Graybar & Leonard, 2005; Davis, Foley, Crigger, & Brannigan, 2008; Welch, 2003). This section will examine the use and impact of therapeutic listening techniques and barriers in caring relationships to help provide understanding of the significance of formal training. Finally, as an often overlooked and underestimated component to interpersonal communication, exploration of literature on nonverbal communication will be discussed within techniques and barriers, and will independently conclude the section.

Techniques.

Therapeutic listening skills are learned tools, which provide an increased likelihood of psychological and physical health benefits to individuals (Browning & Waite, 2010; Davis, Foley, Crigger, & Brannigan, 2008; Miers, Abbott, & Springer, 2010; Welch, 2003). Listening techniques contribute to the health and wellbeing of the care receiver in a caring relationship (Rogers, 1951; Stephen Ministry, 2000; Welch, 2003). Listening with the client and listening with heart or empathy and intuition and with tone and body resonate with clients, providing a safe therapeutic avenue for self exploration and self-disclosure (Williams & Menendez, 2007).

Techniques of therapeutic listening styles are consistent and primarily employ three qualities as illustrated in Stephen Ministry training materials: desire, commitment, and patience.
The use of open-ended questions, open body language, empathetic and emotional responses when appropriate, and withholding judgment are other techniques of therapeutic listening in the caring relationship (Stephen Ministry, 2000). Stephen Covey (2004), in his well known book, *The 7 Habits of Highly Effective People*, explains that we build and maintain relationships through active listening which contain engaged and empathetic behavior with the people in our lives. He asserts that we express this behavior by first stopping what we are doing and by then engaging fully with our loved ones because, respect, value, care, and concern are conveyed by seeking to genuinely listen to and understand the other (Covey, 2004).

In this active process we employ the use of appropriate body language and empathetic responses, which promote an acceptable forum for vulnerability which leads to greater self-disclosure (Covey, 2004).

Specific steps to active listening are given in an article presented by E.J. Cichon (2001) in *Communication Teacher*. Cichon (2001) states that there are several steps to active listening and provides a streamlined process for teaching and using active listening in interpersonal communication. First, the listener must “stop” and focus on the speaker. Second, the speaker should “look” for nonverbal clues. Third, the listener should “listen” without interrupting. Fourth, the listener should attempt to understand what the speaker is saying by seeking clarity through “asking questions”. Finally, the listener should paraphrase what the speaker is saying and seek to empathize with them (Cichon, 2001). Demonstrating that you have not only heard, but are seeking to understand, is essential to the therapeutic process because, when people feel they are not being listened to it causes emotional hurt (Nichols, 2009, p.11). Therefore, effective listening provides a means of self respect in the individual (Nichols, 2009, p.27). Some techniques given by Nichols on the use of therapeutic listening are: be aware of emotional
triggers, withhold judgment or comment until the speaker is finished, avoid turning the
conversation back to you, and show care and concern for the person as valuable through use of
appropriate verbal and nonverbal responses at appropriate moments in the conversation (Nichols,
2009).

As an alternative to the empathetic approach to listening, Stewart (1983) presents the
concept of listening as an interpretive process. Empathetic listening assumes that we attempt to
take the place of the other (Rogers, 1951). Stewart (1983) argues that an alternative to this
approach can be found in the understanding of language meaning between individuals. Through
being in the reality that is created by the other through words, a more accurate and effective
interaction is created (Stewart, 1983). The co-construction of meaning is created with the
speaker through a reproduction and interpretation of their world as illustrated by their own
words, “Thus the listener is not simply “open to what the other means,” so that he or she can
reproduce it; instead the listener is open to the meanings that are being developed between
oneself and one’s partner” (Stewart, 1983, p.384). The interpretive listening model as an
alternative to the empathy model provides additional resources for employing the use of
therapeutic listening in caring relationships. Stewart demonstrates that techniques differ between
the empathetic listening perspective and the interpretive perspective: empathetic listening
focuses on other’s internal experience, interpretive listening focuses on mine and other’s verbal
and nonverbal actions; empathetic listening goals are to get inside of the other’s experience and
to suspend my own prejudices to reproduce others experience within in me; interpretive listening
goals are to be present to the other and be aware of the other’s presence to me and to affirm and
use my prejudices as I co-produce shared meaning; empathetic listening is enacted in a problem-
solving manner by identifying achievable goals and striving towards them using steps;
interpretive listening is enacted in a to-and-fro manner, not expecting closure, but rather staying open and moving in different directions at once; and finally, the empathetic listening outcome is empathy, and the interpretive listening outcome is a two person built subjective understanding, with “understanding-viewed-as- a-tensional event” (Stewart, 1983, p.388).

**Barriers.**

Equally important to understanding techniques of therapeutic listening is being aware of potential barriers. Barker, Wahlers, and Watson (2001) discuss potential “pitfalls” in listening, stating they are those things that create a breakdown, or a “deaf spot”, ultimately leading to potentially harmful problems for the speaker, listener, and organization. Given barriers are: becoming overly emotionally involved or concerned with self, mentally preparing to answer before fully understanding the speaker, tolerating or failing to deal with distractions, allowing emotional language to interfere with listening, and allowing prejudices and deep convictions to impair our understanding and comprehension (Barker et al., 2001, pp.73-75). It is also helpful to avoid talking about self or emitting body language that is closed or inattentive, such as crossing ones arms over the chest (Williams & Menendez, 2007). Additionally, closed questioning (questions which elicit a yes, no, or one-word response) disrupts the flow of information given by the speaker and can lead to a lack of openness in the therapeutic relationship (Stephen Ministry, 2000).

Many of the barriers previously stated are confirmed by Welch (2003) in the assertion that we must be aware that our nonverbal communication is “the eye” or “window to the soul” in that it reflects what is going on internally. Welch (2003) provides an extensive list of nonverbal cues which interfere with the therapeutic environment: pointing fingers, shaking fists, frowning,
fidgeting, and low or no eye contact, shrugging shoulders, mumbling, and apathetic or delayed responding (2003, p.64). Anxious signals emitted when the listener is awaiting the chance to speak about themselves, preparing stories of one-upmanship, or waiting to offer advice can also create barriers to the flow of communication (Welch, 2003). These anxious signals convey to the speaker that we are more interested in promoting ourselves, which deteriorates trust, safety, and feelings of value in the speaker (Covey, 2004; Nichols, 2009; Rogers as cited by Hall, 1997 & McLeod, 2007).

**Nonverbal communication.**

Most of what we are saying to others comes not from our words, but through our nonverbal communication (Navarro & Karlins, 2008). Therefore, it is essential that caregivers understand nonverbal cues being sent by care receivers, as well as what their own nonverbal cues may be conveying. Oftentimes the simple presence, the gentle holding of a hand, or sharing of tears that come from a caring other can be immensely beneficial to a person in crisis (Stephen Ministry, 2000). Welch (2003) explains that watching for nonverbal truth cues will create a more accurate picture of what is going on inside the care receiver, for example, tense body language, playing with hair, and touching ones face or hands are all indications of discomfort, whereas, the use of open body postures and natural or emotional tone of voice indicate truth in relaying personal events (Welch, 2003, p.73). Additionally, nonverbal body cues play a great part in the perceptions or judgments of interpersonal relationships according to Burgoon and Le Poire (1999). In a study of interpersonal “pleasantness” cues, the perceptions of participants and observers during interpersonal interactions were evaluated for consistency in interpretation and increased smiling, increased gaze, vocal pleasantness, and more closely aligned body movements were all indications of a greater degree of intimacy and less formality within the interpersonal
relationship (Burgoon & Le Poire, 1999). These cues were consistently identified and relied upon by both the observers and the participants of the interpersonal interactions demonstrating a universality of interpreting certain body cues (Burgoon & Le Poire, 1999). As a final note, nonverbal body cues are very difficult to accurately interpret even for experts, but especially when they are looked at apart from other cues (Navarro & Karlins, 2008). Experts contend that body language cues are more accurate when read in clusters of behaviors and as compared to deviations from the normative behavior (Navarro & Karlins, 2008). Therefore, nonverbal body cues should be used as a tool in conjunction with other techniques (Navarro & Karlins, 2008; Stewart, 1983; Welch, 2003) to aid the therapeutic listener in providing care.

**Eye contact.**

Eye contact conveys significant meaning in interpersonal exchange (Givens, 2010; Navarro & Karlins, 2008; Welch, 2003). Feelings of “warmth and interest” are created when people make eye contact and people feel “valued and liked” when others make eye contact with them (Weisbrod, 1965, as cited in Gore, 2009; Hall, 1963; Muirhead & Goldman, 1979; Reece and Whitman, 1962). Careful observation of the eye area can provide emotional insight (Givens, 2010; Navarro & Karlins, 2008). The pupil of the eye will give off clues as to how a person is really feeling (Givens, 2010). For example, when the pupil is dilated it may indicate a state of emotional arousal, whereas a constricted pupil can show a more relaxed emotional state (Givens, 2010; Navarro & Karlins, 2008). Furthermore, rapid blinking may indicate “emotional stress” and raised eyebrows can show surprise or disbelief, while deeply lowered brows may point to feelings of anger or disagreement (Givens, 2010; Navarro & Karlins, 2008).
In looking at the implications of nonverbal cues in physician-patient relationships, nonverbal behaviors of eye contact, smiling, head nodding, and sentence disfluencies were explored to determine the implications of nonverbal actions on meeting desired goals of this type of caring relationship (Duggan & Bradshaw, 2008). Indirect eye contact and indirect facial orientation were noted as negative eye behaviors and were shown to occur twice as often with the physician than they did with the patient (Duggan & Bradshaw, 2008). Yet, Givens (2010) informs us that when a person looks to the side during a conversation it shows he or she is processing information, reflecting, and are in thought (p.41). This helps to explain the inconsistency with previous research indicating that subordinates are more likely to perform negative eye contact behaviors (Givens, 2010).

In a study conducted by Gore (2009) on verbal and nonverbal content between same sex interactions, Gore found that during interactions between women, women looked away from the listener while offering personal information, which seemed to convey to the listening female that the information was highly emotional and therefore, they should pay attention. This helps to explain why observations showed women were less likely to offer their own personal information during one on one conversation in which the other speaker was sharing intimate details (Gore, 2009).

**Hands.**

Hands are another truthful indicator of emotional state and provide insight for the careful observer (Givens, 2010; Navarro & Karlins, 2008). Placing the hands behind the head may convey high levels of comfort or may be used to indicate feelings of superiority (Navarro &
Karlins, 2008). Whereas, hands placed on the hips indicate a move to assert dominance and may appear as an act of aggression to others (Givens, 2010).

Hands act as a barometer of internal emotional state (Givens, 2010; Navarro & Karlins, 2008). Use of the hands and arms to instinctually protect susceptible areas displays feelings of insecurity or vulnerability, as seen when women place their hands on their abdomen during pregnancy and near their throats during times of distress (Navarro & Karlins, 2008). Additionally, concealing the hands, playing with jewelry, and twisting or manipulating the fingers is often exhibited during times of emotional distress (Navarro & Karlins, 2008). When hands begin to touch the face or throat, this is another indication of high levels of discomfort as rubbing or stroking motions with the hands are pacifying mechanisms (Givens, 2010). Discomfort may be shown when a person strokes the thighs or rubs the hands repeatedly over the upper arms, as doing so soothes nerves (Givens, 2010). Positive emotional indicators are demonstrated by hands, such as with hands that move with the speaker to exemplify a point, thumbs pointed upward, and upward facing palms as they all indicate internal comfort, amicability, and feelings of wellbeing (Givens, 2010; Navarro & Karlins, 2008). Finally, finger pointing may be used by speakers to exemplify a point, but this action is most often perceived as a sign of disrespect or aggression and may create negative feelings in the message receiver (Givens, 2010).

**Head movements.**

Similar to the often overlooked movements of the hands and arms are head movements such as nodding, turning away, and tilting, all of which carry clear messages to the receiver. To turn the head away from the other during a conversation is a mechanism used to create distance
and is often associated with high levels of discomfort or negative emotions to what is happening (Givens 2010; Gore 2009; Navarro & Karlins, 2008). Duggan and Bradshaw (2008) discovered that after initial introductions, doctors nodded their heads more slowly and less frequently when conversing with a patient, which may indicate to the patient dominance. Likewise, Gore (2009) found that rapid head nodding during same sex conversations may indicate to the other that the listener is attempting to move the conversation along. Frequent head nodding or head shaking has also been shown to indicate disagreement or confusion (Duggan & Bradshaw, 2008; Givens, 2010; Navarro & Karlins, 2008). Head nodding, although conventionally more common among females, was demonstrated to increase during interruptions from others of the same sex in both genders, and can be associated with frustration or annoyance (Farley, Ashcraft, Stasson & Nusbaum, 2010). Finally, although head nodding can be associated with negative feelings, a slow nod in understanding (Duggan & Bradshaw, 2008) or a head tilt with eyes focused on the listener is commonly understood to convey interest and empathy (Givens, 2010).

Shoulders, feet, and legs.

As we have seen, nonverbal actions of the extremities may further help to clarify internal state of emotion during interpersonal communication (Givens, 2010; Navarro & Karlins, 2008; Welch 2003). Some other nonverbal examples include the shoulders, feet, and legs. The simple rise and fall of one’s shoulders can allude to a great deal of unspoken information (Givens, 2010). For example,shrugging the shoulders while making a verbal statement can indicate that the speaker does not necessarily agree with what they are saying (Navarro & Karlins, 2008). Additionally, if one shoulder is shrugged either alone or with a response when a person is asked a question, it may suggest a lack of confidence with ones answer (Givens, 2010).
Feet also express a great deal about one's internal state of mind expressing comfort or indicating a desire to exit the interaction (Navarro & Karlins, 2008). When feet are still and pointed in the direction of the listener this may show comfort and willingness to engage in the interaction, just as feet that are shaking or pointing away during an interaction present a strong indication that the person would like to be or needs to be somewhere else (Navarro & Karlins, 2008). Lastly, discomfort may be suspected in others when we see them playing with, massaging, or hiding their feet, such as with locking them behind a chair or by tucking them under the body (Givens, 2010). These actions also indicate a desire to flee or may be an exhibition of stress emotions (Navarro & Karlins, 2008).

Due to the importance of nonverbal communication in caring relationships, face-to-face interaction is the desired mode of communication (Stephen Ministry, 2000), yet at times technology may facilitate care through other means, such as with using the telephone. In a study conducted by Halbe (2012) on the differences between communicating in meetings conducted via face-to-face and by telephone, it was found that meetings via the telephone contained more interruptions and back channel utterances, such as “mhmm” and “mh” that may be attributed to the lack of mitigating and clarifying body language that is present. For this reason, Stephen Ministry training materials address this matter specifically, underscoring the importance of nonverbal body language in the stance that care giving ministers demonstrate their care through the simple act of presence (Stephen Ministry, 2000). Regardless of whether contact occurs in person or on the telephone, eliminating distractions is essential to therapeutic listening (Covey, 2004, Stephen Ministry, 2000; Welch, 2003). When physical presence is not possible, and contacts are made through via telephone, ministers are instructed to move to a quiet and private space to facilitate focus on background cues in the conversation (Stephen Ministry, 2000). Additionally, Stephen
Ministry encourages trainees to become comfortable with allowing silences, but to be aware of the importance of expressing attentiveness through the use of reflective listening steps, such as paraphrasing (Stephen Ministry, 2000).

The verbal component to interpersonal communication is only a small part of what we convey to others (Givens, 2010). Nonverbal cues are expressed in everything from our breathing rate, to the inflection of our voice, and the movements of our various body parts (Givens, 2010; Halbe, 2012; Navarro & Karlins, 2008; Stephen Ministry, 2000). Therapeutic listening cannot be effectively employed without the knowledge of nonverbal body cues and their use in conveying the entire message (Rogers, 1951; Welch 2003; Williams & Menendez, 2007).

**DESIGN QUESTIONS**

**Elements of Training**

Theoretical basis, practical use, and techniques and barriers of therapeutic listening aid in the production of training materials. Specifically, training resulting from this review will be conducted with adults in a small group setting. Therefore, this final section will look at literature related to theoretical perspective on teaching elements specific to the needs of adults, as well as elements of small group communication theory. Within both sections, design elements for adult specific learning modules are also presented.

**Adult learning.**

Malcom Knowles is touted as the father of andragogy, or adult learning, in America and therefore, a review of Knowles’ perspective on learning and education will be examined first. A summary of Knowles’ stance on education as lifelong learning is presented in his article for The
Training and Development Journal (Knowles, 1980). There are key assumptions and elements that must be made in order to enact a model for lifelong learning including the ability to

- engage in divergent thinking;
- ask questions, which are able to be answered through inquiry;
- identify data required to answer different types of questions;
- locate the most reliable and relevant sources;
- select and use the most efficient means for data collection;
- organize, analyze, and evaluate data to obtain valid answers to questions; and
- generalize, apply, and communicate the answers to the asked questions (Knowles, 1980, p.40 & 41).

Knowles was a great supporter of self directed learning, and believed that successful learning in adulthood was largely related to one’s motivation and readiness to learn beyond formal institutions (Hall, 1997; Moreland, 2003). Moreland provides excerpts of primary components to Knowles’ theoretical approach to adult learning and presents key components for training adults, based upon adult learning theory, which are

- adults need to be involved in the process of planning and evaluating the training;
- experience and mistakes provide the basis for training activities;
- adults are more interested in learning about subjects that have immediate relevance on the job and life; and
- adult learning is problem-centered as opposed to content oriented (Moreland, 2003).

Taken directly from Knowles, Moreland provides training elements for design of adult learning activities including
• Provide an explanation of why specific things are being taught, such as commands;

• Present learning in the context of application to real and common scenarios;

• Create activities that take into account the various degrees of education and knowledge of learners and include a range of learning materials and activities to accommodate for these differences, such as role playing, case studies, and self evaluation tools; and

• Provide an opportunity for adults to learn on their own with guidance and support (Knowles as cited in Moreland, 2003).

Adult learning should be a collaborative effort, and accommodate for differing learning styles, containing opportunity for hands on and active involvement by the participants (Scheffler, 2008). Furthermore, both implicit and explicit techniques work with adults under given circumstances, but as adults are equipped with an ability to problem-solve, explicit problem directed components to training materials are effective (Scheffler, 2008).

One design for nontraditional and online students presented by Lynott (1998) asserts that when adults are allowed to learn with their instructor, critical thinking, conceptual development, interdependence, and creative problem-solving are all increased (1998, p.21). Encouraging group discussion and collaborative efforts exposed learners to differing perspectives and scenarios, aiding in a greater degree of learning (Lynott, 1998). Content design for five modules containing elements proven to be successful with nontraditional learners was given: (a) communication, which includes role play; (b) listening, which aids in effective listening skills through the use of reflective and observational journaling; (c) communicating in a diverse world, including discussion elements, such as issues related to age, race, gender, and ethnicity; (d) understanding the fundamentals of communication demonstrated by the use of learning through self and other information exploration activities; (e) communicating effectively
in interpersonal settings, which includes role play to provide opportunity for students to learn appropriate self-disclosure levels; (f) communicating effectively in groups, in which students work in groups to learn to resolve conflict and perform team building exercises; and (g) developing effective oral presentations, in which students plan, organize, practice, and present an oral presentation, as well as develop their own visual aids (Lynott, 1998).

Adult learning theory suggests that adult learning is facilitated through a variety of engaging, reflective, cooperative, and hands-on learning elements (Knowles, 1980; Lynott, 1998; Merriam, Caffarella, & Baumgartner, 2007). Adults often learn through self-direction and informal learning, which is often facilitated through experiences (Merriam et al., 2007). It is important to encourage a collaborative and goal oriented environment among adults in order to help promote a greater opportunity for learning (Merriam et al., 2007). Finally, providing an encouraging and supportive adult learning environment helps to promote confidence in learners and provides greater positivity towards learning as a lifelong process (Knowles, 1980; Lynott, 1998; Merriam et al., 2007; Morland, 2003).

**Small group communication.**

Formal adult education is often conducted in a group setting (Barker, Wahlers, & Watson, 2001). The intended client for this project consists of a small group of no more than nine ministers at a given time. Therefore, a look at literature related to small group training is beneficial to informing training on therapeutic listening in caring relationships.

Small groups consist of informally assigned or assumed roles (Barker et al., 2001). Roles carry various power balances and can have an impact on the energy and flow of the group in the training situation (Barker et al., 2001). These power balances are often co-created during the
group interactions and through complying and resisting a leader’s control often as a result of the leader’s attempt to share power and control of the group (Galanes, 2009). Handling challenges can come in the form of getting people involved and when appropriate, give the opportunity to express thoughts, feelings, and knowledge about a given aspect of the training (Barker et al., 2001). Through the sharing of power, collaboration is improved and the empowerment of individuals aids in promoting positive feelings amongst the group (Knowles as reported in Morland, 2003; Lynott, 1998; Barker, et.al., 2001).

Balance between process oriented goals and outcome focus must be weighed within a group (Barker et al., 2001). In small group settings, often networks are formed, and feelings of safety and trust are built through the facilitation of sharing personal experiences and information (Barker et al., 2001). This can help group cohesion and deepen relationships, but it can also present a barrier to meeting the goals of the session (Barker et al., 2001). Galanes (2009) explores related topics in *Dialectical Tensions of Small Group Leadership*. Through findings supporting the dialectical theory of communications, Galanes (2009) discovered dialectical tensions are frequent and common occurrences within the small group and divergent opinions, sharing of personal experiences and information, and side bar conversations were common impedances to meeting goals. These communication events are at times beneficial to the group, such as by helping to develop an idea, despite interfering with the primary goals of the session (Galanes, 2009). Effective strategies for balancing goals and interpersonal connections come from employing a variety of approaches. For example, providing a clear agenda prior to the session and including allotted time frames for topics helps to set appropriate boundaries (Galanes, 2009).
Encouraging the group to share and reflect in a fashion that is comfortable, the learning process is impacted as members model, support, and guide each other, an area where small group leaders can enact their role by providing guidance and nurturing of the group members (Olusola, 2011). When leaders work to help each of the individual group members to discover and nurture their individual gifts and give them a forum of expression, the entire group benefits (Olusola, 2011).

Finally, according to Barker et al. (2001) several learning activities are helpful to training small groups. First, trainers may use the buzz session, in which the group is broken into smaller groups and asked to discuss a given topic for a small amount of time. The groups rejoin the larger group for discussion. Role playing activities may also be used in small groups. The activity is comprised of six steps: (a) group members identify the problem; (b) members craft a plot, setting, and characters for the problem scenario; (c) the group assigns roles with consideration to individual comfort levels; (d) an observer, someone to take notes, is assigned; (e) the instructor allows players to present their interpretation of the problem; and (f) the group discusses what occurred in terms of who, what, where, when, why, and how; if there are disagreements teams are given the opportunity to reenact the scenario with different players. Finally, assigning listening teams is a useful small group learning activity, most beneficial after a lecture, presentation, or film, for example. Groups or teams are assigned prior to the event with listeners being given specific listening tasks or items to listen for. Afterwards the groups are allowed time to organize and document their thoughts. The group refocuses and a discussion on the topic is carried out, with individual listeners being asked to contribute on their specific item.

Understanding special considerations of small groups, as well as being aware of training techniques helpful in the small group setting are beneficial for trainers. Activities found to be
useful in adult group training sessions are also helpful. Finally, awareness of potential concerns associated with leading small groups can help to prepare the trainer to best meet the needs of the group.

**Elements to Effective Training**

There are several elements that can assist in making training more effective according to Barker et al. (2001). First, the facilitator should seek to analyze the group, which can be done through a series of questions: What do the participants know about the topic? Do the participants want to attend the meeting or are they required to attend? What special skills or training do participants have that will help the group? (Barker et al., 2001, p.222). Next, the environment should be attended to with special attention to lighting, air temperature, equipment function, and availability, and seating arrangement, such as the informal round table (2001, pp.222-224). Rooms should be comfortable and preferably cooler, necessary equipment should be available and tested, and seating arrangement should be conducive to the type of learning (2001, p.225). Finally, preparing meeting materials and an agenda ahead of time and according to the needs of the session should be completed to help alleviate distractions (2001, p.224).

In addition to the sentiments discussed above, Silberman and Auerbach (2006) state that the trainer needs to attend to certain areas early on. First, the trainer should begin by building rapport with the group, followed by reviewing the agenda (2006). Rapport building can be established with the trainer beginning to talk about themselves: credentials, experience, and relating to the group, followed by a recognition and praise of efforts and qualities of the members, which leads to asking members to share their experience, background, and any concerns (2006, pp.220-221). Setting a positive tone for the session within the first thirty
minutes is important and can be achieved by starting on time, establishing a community feel, emphasizing confidentiality, setting ground rules, allowing participants to discuss how the training will impact them in the real world, and by demonstrating competence while avoiding “pretending” to have all the answers (2006, pp.222-223).

Silberman and Auerbach (2006) offer additional tips for effective trainer facilitation in regards to controlling negative behavior: (a) control the behavior right away and throughout the meeting with gentle reminders of adhering to the ground rules or asking, (b) allow the participant to share their views while verbally acknowledging their position (be willing to agree to disagree), (c) use good-natured humor, (d) take interest in the individual on a personal level, (e) seek to engage and involve everyone and discourage monopolizing power, and (f) provide positive explanations for what has occurred (pp.238-239).
Chapter 3. SCOPE AND METHODOLOGY

THE SCOPE OF THE PROJECT

Scope

The sample for this project is a small group of caregiving ministers serving under the umbrella of an internationally recognized caregiving ministry where minister’s roles are clearly defined (Stephen Ministry, 2000). The two major components to the role of minister in this group are presence (walking alongside of the care receiver) and ability to effectively utilize active listening skills to facilitate healing through the work of the Holy Spirit in the life of the care receiver (2000). This sentiment is reflected in the ministry through the assertion that ministers are the caregivers and God is the “curegiver” (Haugk, 1984, pp.19-23).

Ministers in this program share a desire to love and care for others in their time of need and hold that they have been called to serve others and God through this love and care. Ministers are selected through an application process consisting of an interview with the pastor and a background screening. No formal education or previous experience in related fields is required. Trainees are required to complete 50 hours of initial training, designed by the overseeing program and carried out by trained leaders of the program within the church (Stephen Ministry, 2000). Upon completion of initial training, a formal commissioning by the pastor of the acting church with support given by the body of the church takes place. In order to remain as an active minister, individuals must maintain regular attendance of group meetings, which is considered critical to the support of fellow ministers, and must receive continuing education related to their role as a caregiving minister (2000). Ministers are required to serve a minimum of two years, but often serve for many more years and sometimes go on to perform in a leadership capacity.
The role of members in this group is to serve in a one-to-one capacity with a single care receiver: an adult of the same sex who is currently experiencing or has recently dealt with personal crisis, including death of a family member, pregnancy or childbirth, or diagnosis of a disease or terminal illness, to name a few. The relationship is formal, yet unpaid, and volunteer based. Ministers act in a role unique to this ministry, and set apart from other professional physical, mental, and social health service providers (Stephen Ministry, 2000). Ministers are not mental health providers, nor are they counselors (2000). Ministers have two primary functions within the caregiving relationship: they act as a representation of the physical presence of Jesus Christ and by providing guidance and support to the care receiver through active listening (2000). The relationship is process oriented in that ministers help promote healing through reflective and empathetic listening and presence carried out at the care receiver’s pace. The duration of assignment (or length of formal relationship) ranges from about six months to one and one half years. There is a formal process of closure when either party moves to end the relationship (Stephen Ministry, 2000).

The sample group is directly affiliated with a religious organization and is formally considered a part of the Pastoral Care Unit and therefore, is distinguished by its religious association. Ministers are encouraged to allow the care receiver to be the one to bring up issues of religion and faith (Stephen Ministry, 2000). These components are not required on the part of the care receiver in order to receive care, nor do they ever need to be verbally recognized as components to the caring relationship (2000). However, ministers are trained to self-acknowledge their unique role as spiritual care givers relying on spiritual tools, such as prayer and scripture (Haugk, 1984). As therapeutic listening skills originate from a secular base, and are used in both religious and secular health and social organizations and with no differentiation
in the applied knowledge, this group can be recognized as being representative of the larger group of caregivers as a whole.

**METHODOLOGY OF THE PROJECT**

**Rationale**

The sample group is comprised of less than ten active members at a given time. Group members are adults ranging in age from early twenties to early seventies. Experience, formal education, and religious affiliation vary widely among individuals. Most of the members maintain friendships outside of the ministry and many have previously known one another. The group feel is informal and supportive. Emotions and experiences are readily shared and comfort and advice are freely given. The group is highly cohesive and it is common for sidebar conversations to exist. Verbal input and inquiry aimed at the leader are not discouraged and are viewed as helpful in developing understanding in many cases. As a final note, many underlying norms of the group are constructed through traditional “respect thy elders” thought. Wisdom that comes with age and experience are highly valued and therefore, training that is conducted in a suggestive manner with an authoritative (firm, yet respectful) style, as opposed to a required manner with an authoritarian (rigid and controlling) style has a greater potential for success. In considering these points, the following elements of the project were selected for their specific value to training.

**Contributing Information**

Confidentiality is paramount within the sample group. Ethnographic information was not available due to privacy restrictions. Therefore, available data provided background on the topic and was used in the production and development of training materials. Literature on adult learning, andragogy, and small group communication theories support the use of therapeutic
listening styles in care giving settings, and elements of effective therapeutic listening including techniques, barriers, and nonverbal communication were all researched.

Given the scope and limitations of this project, a roughly one and one half hour training session on familiarizing ministers with techniques and barriers to effective therapeutic listening, as well as nonverbal communication was created. These topics are chosen for their critical aspect to the therapeutic listening relationship. With the limited time available for this session, the project will consist of a class overview, a list of suggested readings, class handouts, and the use of active learning strategies. A Microsoft Power Point presentation will be used to create a visual outline and highlight key and take home points of the training session. Additionally, a voice script accompanies the presentation for online training and for the use of future reference.

**Procedures**

**Developing a Plan**

After becoming familiar with the needs and goals of the client, the next step is to establish lesson design goals by developing a plan including elements of teaching procedural knowledge, declarative knowledge, or a combination (Foshay, Silber, & Stilnicki, 2003). For this project a simple table was developed to achieve this goal and to help identify several areas: elements to be addressed (topic), source of the information, type of lesson (declarative, procedural, or combination), active learning strategies to be used (learning aids), and to identify topics for the Power Point presentation, which need supporting information or a title slide only (see Appendix-D).

**Teaching Concepts**
This project will focus on teaching declarative knowledge through connecting concepts. The model provided by Foshay et al. (2003) was selected for its systematic approach to connecting concepts, “the building blocks of all knowledge” (p.80). There are five critical elements to concepts: (a) elements are groups of things (objects, events, ideas); (b) groups are related to one another through critical features, which may need to be defined due to variable attributes; (c) concepts have a prototypical example (preference is that multiple examples are given) as a critical element to learning, storing, and retrieving concepts; (d) concepts are related to other concepts in several ways (coordinate, subordinate, and superordinate); and (e) concepts fit together creating knowledge structures and making connections easier (Foshay et al., 2003, pp. 79-85).

Teaching concepts can be done through a process of: (a) selecting the information to attend to including lesson elements, attention (gain and focus on new information), highlighting WIIFM (what’s in it for me), and encouragement using YCDI (telling the learner “You can do it.”) elements; (b) linking the information using recall (relating old and new information); (c) organizing the information (show relationships among new concepts); (d) assimilate new knowledge into existing knowledge (compare and contrast and show logical relationships; and (e) strengthen the new knowledge in memory (use examples, realistic contexts, include context and irrelevant information so learner can select relevant information) and finally, let learners know how well they have done, ask what problems they are having, and why (Foshay et al., 2003, pp.86-91). This final concept is especially effective after the utilization of active learning strategies.
Active Learning Strategies

When training adults, active learning (alternatives to lecturing) assists in the absorption of material by allowing the opportunity to practically apply the knowledge being delivered (Silberman & Auerbach, 2006). Two active learning strategies were used in this project. The first strategy is guided teaching. This activity is used because it favors teaching to an audience of varying skill and knowledge levels (2006). In this process, the facilitator poses a question with several possible answers and allows participants to report how they would answer the question (Silberman & Auerbach, 2006). This method also allows group members to discuss and analyze the answers given by others. Additionally, Barker et al. (2001) discuss several activities useful in small group training sessions, of which role playing was selected for several reasons. Role play provides the opportunity for ministers to make connections between what is being discussed and how to apply it to real-life scenarios (2001). Role play also helps ministers to gain understanding of potential meaning, motives, and intentions related to the techniques and barriers (Barker et al., 2001). Through awareness and practice, ministers have the chance to become more comfortable with the use of techniques, avoiding barriers, and understanding nonverbal communication (2001). Finally, action learning presents the opportunity for the facilitator to present real-world situations that may be challenging to ministers and have them reason through how they would handle it using the skills they are learning (Silberman & Auerbach, 2006, ch.6).

Sequencing

Strategies for appropriately structuring the training session are critical to the learning process (Silberman & Foshay, 2006). The use of sequencing steps is utilized here to assist in ensuring that the design structure promotes learning. Guidelines for developing appropriate structure are: (a) build interest and introduce new content before elaborating; (b) warm up by
presenting easier activities and information first; (c) vary the length and type of activities and have participants move around; (d) group together concepts; (e) break down complex issues into small parts and teach subskills first; and (f) end the training with “so what” and “now what” which helps participants understand the implications of the training and which steps they will take next (Silberman & Auerbach, 2006, pp.165-166).

Design Template

Existing design elements and/or templates as noted were used in the creation of this project and were adapted where noted, to meet the needs of this session. These elements are included as Appendices A-H. Appendix A, Training Module Learning Plan (also referred to as an agenda or syllabus) will be distributed to participants at the start of the session and serves to establish expectations, illustrate training goals, provide a schedule, and promote suggested readings. Appendix B, Guided Teaching Reference, is an aid for the trainer when using the guided teaching method illustrated above (Silberman & Auerbach, 2006). This document will be used to collect participant’s suggestions and concerns as they are presented during discussion, and to be used as a guide when creating role play scenarios. Appendix C is a template of a model used for teaching concepts taken directly from Writing Training Materials That Work (Foshay et al., 2003). Detailed information, including lecture notes and sequencing information for the session will be presented here. Appendix D, Preliminary Training Plan, is a basic template to be used as a guide to map out the session elements and contributing materials (Conrad & Poole, 2005; Foshay et al., 2003; Silberman & Auerbach, 2006). Appendix E, Feedback and Suggestions, used to identify strengths and weaknesses of the session, is a handout to be distributed at the close of the session. This handout is used to collect feedback from participants for the intended purpose of identifying areas of improvement, areas of success, and
suggestions for future training sessions (Foshay et al., 2003; Silberman & Auerbach, 2006).

Appendix G, *Open Ended Questions Resource Sheet*, is a reference guide for trainees. Appendix H, *Summary of Techniques, Barriers, and Nonverbal Communication*, is a referral handout for trainees highlighting key take home points useful in utilizing therapeutic listening skills. Finally, Appendix F, *the Power Point Presentation*, is the culmination of the project and is used to organize information and visually and aurally represent the training elements.

**Bias**

In conclusion, it is important to recognize any potential for bias on the part of the researcher that may influence the data collection and project design as they pertain to this study. First, the researcher is a member of the small group being studied. Affiliation with the study group could pose the potential for a less objective or more skewed interpretation based upon intimate familiarity with the topic and the client’s needs. Next, the researcher is not currently in a care giving relationship, but previously served in this capacity. This fact may influence the research and design methods sought and applied. The researcher is expected to participate and engage with other ministers in a supportive role as a member of the group. Serving in a dual capacity could diminish objectivity and unbiased data collection, as well as present role confusions among members. Other considerations for potential bias can be found in the age variation between the researcher and the participants. Age discrepancy may promote linguistic barriers or social and contextual misunderstandings. In addition to age, the researcher’s education within the realm of communications and the social sciences must be considered as informing the design of training materials and interactive learning opportunities. Consideration should be made to effectively account for the variances in education, experience, and beliefs of the participants. Finally, the involvement of the researcher within the greater religious and
spiritual organization should be considered with regard to how the project is presented, specifically with regard to maintaining feelings of trust and safety built through openness and authenticity as a special privilege of the membership of this group.
Chapter 4. THE PROJECT

INTRODUCTION

Project Description

This project is designed as a pilot training session, a single continuing education module, for a small (less than 10 person) caregiving ministry program. Estimated time for training is one and one half hours. The time allowed is somewhat flexible, which allows for additional group work if necessary.

EXAMPLES OF THE WORK

Adult learning theory and small group communication theory as previously described in greater detail and within the body of this work, served as the basis for the design of this training module. The final product, an approximately one hour Microsoft Power Point training presentation and accompanying class handouts, was the result of literature findings, learning models, teaching tools, and training aids. The individual components of the project are broken down and presented here as Appendices A-H. First, the Preliminary Training Plan was used in the initial stage of the planning process and allowed for compiling and noting sources for material and data to be used in the creation of the final product (see Appendix-D). Following the preliminary gathering of information and sources, the Teaching Concepts Plan teaching matrix was critical to the final production of the Power Point presentation and supplementary handouts and was used to record script notes for the production (see Appendix-C). The training session begins with the distribution of the Training Module Learning Plan and outlines training goals, provides an estimated timeline for the session, and offers a list of suggested readings (see Appendix-A). Next, the Power Point presentation is used to present the training session and serves as a visual aid and provides aural script of the training session (see Appendix-F). A
Guided Teacher's Reference is used during the training session as an aid to record and organize questions and concerns from participants related to each segment of training and allows the trainer a quick reference of areas to address and incorporate during active learning events (see Appendix-B). As a learning aid and reference tool, two handouts were compiled for distribution during the appropriate segment of training with the first being a reference guide on open ended questioning methods and examples (see Appendix-G) and the second being a summary of techniques, barriers, and nonverbal communication elements (see Appendix-H). Finally, a questionnaire, Feedback and Suggestions, was created for distribution at the close of the session to allow for participant input (see Appendix-E).
LIMITATIONS OF THE STUDY

One of two major components to the caregiving ministry role is to effectively utilize active and empathetic listening skills (Stephen Ministry, 2000). The initial 50 hours of ministry espouses the importance of these skills, yet contains very little information on how to effectively utilize the skills (2000). Additionally, ministers’ experiential knowledge, formal education, and training levels are significantly varied. All members of the sample group are new to the ministry and only one has served in a similar capacity. Furthermore, time allotted for continuing education is a single, one-to-two hour session per month. These considerations present opportunities for developing greater depth of knowledge on topics related to caregiving and through the realm of continuing education. These considerations can also present limitations, such as having a lack of time to allow for in-depth training on a single topic, lack of available and specific information helpful in meeting the needs of caregivers and care receivers, as well as the potential for training information to be too elementary or too advanced.

Adult learning theory suggests that effective models for training adults builds upon existing knowledge by connecting previous knowledge, and linking it to new knowledge being taught to trainees (Foshay, Silber, & Stilnicki, 2003). Taking this point into consideration, differences in the sample group must be accounted for, because as previously noted, education and training levels vary among group members. Therefore, continuing education will require that information be summarized to address pertinent aspects of practical use only and thus appealing to a wider audience. However, this does not necessarily meet all of the needs of the ministers and allows for the potential of diminished application to real-life relationships, retention, and recall, which are essential concepts of adult learning (Foshay et al., 2003).
Additionally, the scope of this paper did not allow for exhaustive research of the literature. Only literature suited to meeting the needs of this project, which is to say literature that addressed active listening as beneficial to caring relationships, was used. Other interpretations and conclusions on the effectiveness of therapeutic, or active, listening exist. Additionally, theoretical perspectives, teaching methods, and instructional design elements are vast, and many differing perspectives exist on listening in interpersonal communications, all of which may offer a different outcome than the one presented here.

**FURTHER STUDY OR RECOMMENDATIONS**

Through the process of developing this training session and an awareness of the project’s limitations, it was discovered that training on the elements of therapeutic listening will require multiple sessions and a variety of learning approaches. The best test of effectiveness would be longitudinal. Therapeutic listening skills, especially as presented herein, require application, reflection, and refining of the techniques, barriers, and use of nonverbal communication. Therefore, a better awareness of effectiveness of the information presented and the effectiveness of the training approach used would be determined over an extended period of time in the caring relationship.

Furthermore, elements provided in this session serve as a basic foundation of knowledge and use of critical components to the tool of therapeutic listening as used in caring relationships. Exploration and utilization of different teaching plans, learning activities, and greater depth of information, especially in terms of nonverbal communication, would all present areas for further study and application. As a final note, ethnographic research on the real-world use of therapeutic listening elements as they are actually employed, altered, and influenced through contact with
extenuating influences of interpersonal, psychological, emotional, and other factors, would provide areas for future research on the use of therapeutic listening in caring relationships.

**CONCLUSIONS**

When individuals feel that they are heard, respected, and valued by the people in their lives, they feel healthier, and more satisfactory social, familial, and interpersonal systems can be the result (Covey, 2007; Graybar & Leonard, 2005; Lewis & Manusov, 2009; Miers et al., 2010; Rogers, 1951; Stephen Ministry, 2000; Welch, 2003). Therefore, emotional, psychological, physical, and spiritual health of individuals is impacted by use of effectively trained caregivers (Browning & Waite, 2010; Rogers, 1951; Stephen Ministry, 2000; Williams & Menendez, 2007). Active listening is a critical element to these therapeutic caring relationships (Rogers, 1951; Stephen Ministry, 2000) and impacts the mind, body, and spirit of the care receiving individual (Buber, 1970; Duncan et al., 2009; Edwards et al., 2010; Mead, 1964, Miers et al., 2010; Olusola, 2011; Robbins, 2005; Stewart, 1983). Additionally, we find that therapeutic listening varies from casual forms of listening and requires intentional action and training to effectively enact (Covey, 2004; Haugk, 1984; Rogers, 1951; Stephen Ministry, 2000; Welch, 2003). Furthermore, the training of adults in the specific elements of therapeutic listening and within the small group setting also requires understanding of adult learning theory, small group communication theory, and interpersonal communication theories to name a few. Therefore, training providing insight into effectively designing a training session for adult learners in small group settings is crucial (Barker, 2001; Galanes, 2009; Knowles, 1980; Long, 1996; Merriam et al., 2007; Moreland, 2003; Poole & Hollingshead, 2005; Silberman & Auerbach, 2007). Finally, insight into contributing thought on interpretive listening (Stewart, 1983) and within the realm of spirituality (Edwards et al., 2010) and family systems (Duncan et al., 2009) provides substantial
direction for further exploration of therapeutic listening within caring relationships. For example, differences which exist between interpretive listening methods and active listening methods may prove to be more or less therapeutic depending on the type of interpersonal relationship they are applied to. Additionally, exploration on the differences between the caregiver’s spiritual views and the care receiver’s views may provide insight into adaptation of therapeutic listening elements demonstrated within the caring relationship.
References


APPENDIX A- Training Module Learning Plan

Techniques, Barriers, and Nonverbal Communication in Caregiving Relationships:

Expectations, a.k.a. learning objectives:

YOURs:

- 
- 

MINE:

- To provide insight into techniques of and barriers to effective therapeutic listening in caring relationships
- To provide greater awareness of the nonverbal element of communicating care in interpersonal relationships and how this element plays into both techniques and barriers

Schedule:

5:00: Introduction and learning objectives. Present background.

5:15: Present and discuss the concepts of effective techniques and potential barriers in communicating therapeutic listening. Present and discuss nonverbal communication and its connection to techniques and barriers.

5:50: Group Work: Practice what you have learned.

6:15: Wrap up session. Review what we have learned. Distribute the Feedback and Suggestions questionnaire.

6:30: Session ends.

Suggested Readings: You may find the following suggested readings helpful in gaining a deeper understanding of the topics presented in tonight’s training session:


This document was created using suggestions from Foshay et al. (2003) and Silberman & Auerbach (2006) and was adapted from the following template used for training session outlines: http://www.afswiki.org/index.php/Training_Session_Template
APPENDIX B - GUIDED TEACHING REFERENCE

<table>
<thead>
<tr>
<th>LEARNING TOPIC:</th>
<th>QUESTION POSED</th>
<th>PARTICIPANT IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Techniques and Barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonverbal communication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This teacher’s aid was designed using the elements discussed in Silberman & Auerbach (2006).
### APPENDIX C-TEACHING CONCEPTS PLAN

<table>
<thead>
<tr>
<th>Lesson Element</th>
<th><em>Example</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select the Information to Attend to Attention</strong></td>
<td>“This training session will introduce you to some practical applications of techniques and awareness and application of barrier elements to effective therapeutic listening and nonverbal communication cues in care giving relationships. We will discuss and practice these areas.”</td>
</tr>
<tr>
<td></td>
<td>- Overview of therapeutic listening</td>
</tr>
<tr>
<td></td>
<td>- Techniques</td>
</tr>
<tr>
<td></td>
<td>- Barriers</td>
</tr>
<tr>
<td></td>
<td>- Nonverbal communication</td>
</tr>
<tr>
<td><strong>WIIFM. Tell learners “What’s in it for me?”</strong></td>
<td>“These are the things you can hope to gain….what it means to use active listening, knowledge of the skills presented in the “focus” area, better recognition of barriers, and awareness of nonverbal communication.”</td>
</tr>
<tr>
<td><strong>YCDI. Encourage the learners by telling them: “You can do it.”</strong></td>
<td>“Think positively (note previous accomplishment). We are together today because of your shared love for others and your desire to gain skill in your role. We will meet for just a brief amount of time and will cover a lot of information at a pretty rapid pace. You will likely have more questions than I can answer here, but have confidence in your ability to recall and use information as you need it. You already have a foundation from your basic ministry training and experience working with others. In fact, many of you are already familiar with the concepts and are likely using some of them in your caring...”</td>
</tr>
</tbody>
</table>

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1 Template used in the organization and structuring process of the teaching module and contains background and lecture *examples* used to guide (but are not necessarily represented in) the final product (see Appendix-F). Model is a direct reproduction of Foshay, Silber, & Stilnicki’s (2003) Figure 6.5 *Job Aid for Teaching Concepts* (2005, pp.92-95). Note, this model does *not* include all information as provided in the text, and therefore it was modified to meet the needs of this training session. For detailed training elements and information on each of the areas presented refer to pages 92-95.

*Purchase of this text grants permission for reproductive use in training materials.*
relationships. You are here today as ministers because you have answered the call. Even still we may feel inadequate at times and this training is one way we become better equipped to care for others on a more skilled level. One or two of you may find this information to be a refresher, for others, this will introduce you to valuable care giving tools.

We will also encourage and support one another here as we practice what we are learning. When we walk away, we have gained where we were once lacking.”

2. **Link the New Information with Existing Knowledge**

*Recall* concept structures that the learner needs to understand what you are teaching.

“This is a caregiving ministry, based upon presence and care through active listening. Let’s discuss what caregiving *is* in this ministry. What is active listening: action, employs empathy, engaging the other, stay focused on them, avoid giving advice, focus on the process, and we utilize spiritual tools. (Discuss more in more detail when presenting). As we have mentioned, you are already familiar with the basic principles of therapeutic listening with its need to engage the care receiver, listen carefully and empathetically, and to stay focused.”

“What caregiving *is not*…a casual relationship, about ‘you’, about attaining a goal and it is not about *taking care* of our care receiver.”

*Relate* the concepts you are teaching to their places in the concepts structures the learner already knows.

“Let’s relate what we have recalled. Active listening is: therapeutic (discuss in more detail). Requires: action, uses appropriate questions, holistic approach to care, uses appropriate verbal and nonverbal responses, and is a tool. –Discuss the ‘therapeutic’ component. It promotes self awareness, aids in healing, develops one sense of self-efficacy, helps in healing process, and provides sense of worth and value (discuss).”

3. **Organize the Information**

*Structure the Content.* Show the relationship between up to five to nine concepts.

“The adult learning process differs from childhood learning. As adults we want to know that what we are learning has a practical use. We need to relate it to what we already know. We need to practice the skills and refine them. The process is: state the goal or objective, recall information, relate it to the new information, and practice and refinement.”

**Objectives**

“Therapeutic listening requires…techniques…barriers…and nonverbal
**4. Assimilate the New Knowledge into Existing Knowledge**

*Present New Knowledge and Present Examples.*

Show concepts, using a sequence which includes prototype examples.

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**Background:**

Therapeutic listening defined: Commonly referred to as active, empathetic, and responsive listening, it involves intentional action on the part of the listener and requires empathy (Stewart, 1983). Action and empathy are unique components to the use of listening as a tool in the therapeutic relationship (Welch, 2003).

Therapeutic listening has many uses. Psychotherapist Carl Rogers’ is most famous for his use of active listening in his Client-Centered therapy approach. Rogers believed the client was the best expert on what they needed. He held that the process of active listening was beneficial as a means to promote self awareness and healing, and establish a sense of identity and belonging in care receivers (Rogers, 1951).

Briefly introduce: Cooley, Blumer, and Bandura.

Yesterday and today, many social scientists and health practitioners espouse the benefits and effectiveness of active listening. Active listening is a key element in social learning theory, small group communication theory, adult learning theory, and symbolic interactionism, to name a few (Bandura, 1977; Poole & Hollingshead, 2005; Merriam, Caffarella, & Baumgartner, 2007; Blumer, 1969). Therapeutic listening is also used as a means to promote personal growth, dynamic change, and promote greater self efficacy (Rogers, 1951; Welch, 2003; Williams & Menendez, 2007) and helps care providers to better meet the needs of their clients by promoting better over-all health and wellbeing (Browning & Waite, 2010). The general perspective here is that through our interpersonal interactions, how we engage with others and them with us, our view of self and our view of our world is created and maintained.

To gain a better understanding of what this means, consider the following example:

You are meeting with your care receiver, a young
woman who has just had her first child. The young woman is struggling with new motherhood. She has lacked loving and supportive relationships her entire life. Now as a new mother she doubts she has the ability to lovingly care for her child. Through an active listening approach a skilled care giver can help her to understand these feelings and help her on a path of healing and towards a new image of herself as a capable mother.

**Techniques:**

You may be wondering what makes therapeutic listening different from the listening that occurs while simply being present and caring for another. First, there are many ways to hear and listen. Most of these are not honed skills, tools of trained individuals. Therapeutic listening is highly beneficial, a trained skill requiring continual and intentional action, application, practice, and refinement. The following scale provides more detail:

1. Nonlistening is hearing without paying attention;
2. Pretend (also known as false or manipulative) listening happens when listeners attempt to appear they are listening through verbal and nonverbal cues;
3. Selective listening happens when the listener only pays attention to part of the conversation;
4. Self-focused listening uses the speaker’s words as a bridge to what they want to say about themselves, and;
5. Empathetic listening takes place when the listener is focused on the meanings in the speaker’s words and nonverbal cues, as well as seeks to understand the speaker on many levels, such as emotionally and with regard to their unique situation (Long, 1996).

An example of active listening as compared to selective listening may look like this: You have been working with a care receiver who has acknowledged a problem with an alcoholic adult child living in the home. At your next visit you ask how things are going with the child. The care receiver then responds with a shrug and says harshly, “I am not worried about that problem anymore.” Selective listening may cause you to believe that the care receiver has worked out this concern. Whereas, using the active listening
approach would likely prompt you to seek to gain more information and to reflect to the care receiver what you are observing.

Here is a list of other aspects that separate skilled therapeutic listening from casual listening, such as that which occurs in friendships:

- Active listening employs the use of both paraphrasing and asking of open-ended questions (closed questioning typically begins with, “who”, “what”, “where”, and “when”). An open-ended question seeks to draw detail from the speaker: “What do you think would happen if…?”
- Therapeutic listening seeks to connect emotionally with the other, also known as empathy.
- Eliminating distractions and engaging fully with your care receiver through your verbal responses, tone of voice, facial expressions, and body cues.
- In process oriented listening, be OK with silence and allow the speaker freedom to guide the conversation. This is a great time to really focus on their nonverbal communication: tone of voice, breathing, facial expressions, and body cues.
- Finally, the overarching objective is to attempt to understand the care receiver and their concerns through their perspective, while maintaining the ability to see beyond the situation through skilled training.

“We have just looked at some specific elements to skilled listening. Let’s briefly talk about your thoughts on these points and note any questions you may have.”

Barriers:

“As important to understanding how to employ therapeutic listening skills is awareness of common barriers to promoting therapeutic listening environments and relationships. The following is a list of common pitfalls:”

- Giving advice. The focus should be on care and concern directed toward the care receiver.
• Feeling the need to have all the answers. Your role is to encourage the care receiver to discover their own answers.
• Emotional triggers: be aware of your own deep convictions or prejudices that could interfere with understanding or comprehension.
• Dominant, territorial, and disagreeable facial and hand gestures.
• Commenting or passing judgment before the speaker has finished talking.
• Use of closed body language and body language that indicates lack of interest (we discuss this more in nonverbal communication).
• Turning the conversation back to you. Sharing personal examples is most useful for illustrating points that shed light on the situation but always, our goal as caregivers is to provide a uniquely different relationship built upon trust and attained through an environment of safety as we show undivided interest and focus on the care receiver.
• Inappropriate verbal and nonverbal responses (this is discussed in more detail in nonverbal communication).

“We have just looked at some specific barriers to therapeutic listening. Let’s briefly talk about your thoughts on these points and note any questions you may have.”

Break up material through use of impromptu audience participation to demonstrate what the cues would look like from the others perspective. Brief role play (action learning).

Nonverbal Communication:

“You may have noticed that many of the techniques and barriers presented contain the critical element of nonverbal communication. A great deal of our communication comes through our nonverbal cues, our body language. There is much to learn about the element of nonverbal communication and so for the sake of brevity today we will focus on indications of comfort and discomfort as seen in common cues from face to feet. However before we begin it is
essential to note that experts warn that nonverbal body cues are very difficult to accurately interpret and therefore, it is essential to look at them as a guide. A more accurate assessment can be made by looking at signals in clusters of cues and deviations from what is normal for the person you are communicating with.”

**Positive Cues:**

- Increased eye contact or gaze (this evokes feelings of warmth, value or liking)
- Open eyes and elevated brows
- Focus on care receiver
- Increased smiling
- Vocal pleasantness
- Closely aligned body movements between the care receiver and care giver
- Natural or emotional tone of voice (also an indication of truth in disclosing personal events)
- Head tilted to the side while listening
- Open body postures, such as facing the speaker, unguarded torso, and open or upward pointed hand gestures
- Constricted pupils may indicate a state of relaxation
- Looking to the side while listening indicates a processing of information, as does slow paced head nodding

“This is an image of positive or comfortable body language between the speaker and listener. Awareness of these cues can provide insight into the care receiver’s emotional state, but they are also useful to the care giver as tools to convey meaning and support in the listening process. Could I have two volunteers to demonstrate what these cues may look like?”

**Negative Cues:**

Care Giver:

- Pointing
- Shaking fists
- Frowning
- Fidgeting
- Shoulder shrugging
• Mumbling
• Delayed or apathetic responses
• Pursed lips
• Rapid Head shaking
• Closing the eyes
• Anxious signals emitted due to waiting for a turn to speak

Care Receiver or Care Giver

• Dilated pupils may indicate emotional arousal
• Rapid eye blinking is a sign of emotional stress
• Raised eyebrows may indicate surprise or disbelief
• Deeply lowered brows are a sign of anger or disagreement
• Indirect facial orientation or eye contact may be a sign of discomfort or disagreement. It is often done to create distance between the speaker and the listener. However, in female to female conversations this is common when sharing highly personal or emotional information and displays respect.
• Rapid head nodding may show frustration, annoyance, or an urgency to move the conversation forward.
• Placing the hands behind the head may be comfortable for some, but displays a sense of superiority to the other.
• Hands on the hips demonstrates dominance and is a territorial display
• Concealing the hands or feet is often associated with feelings of emotional distress and discomfort.
• Guarded postures, such as crossing the arms over the chest convey distance or discomfort.
• Using the arms or hands to cover the face, throat, and abdomen signify vulnerability.
• When individuals stroke, touch, or manipulate various parts of their bodies, such as the hands, arms, face, throat, and thigh area they are doing so to soothe nervous or discomforating emotions, as these are pacifying gestures
- When feet are directed away from the speaker it may be indication that the person needs to be or would like to be somewhere else.

  Also, attention to the speaker’s rate of breath, tone of voice, and open or constricted facial gestures may be indicators of their emotional state.

“Could I have two volunteers to demonstrate what some of these cues may look like?”

“I am certain you have all seen these cues at some point in your interactions with others. However, understanding what they may be conveying is critical to gaining deeper insight into what your care receiver is feeling. It is also important for care givers to be aware of their own use of these cues and what they may be saying to the care receiver. Now that we have had the opportunity to explore some common nonverbal cues we will have the opportunity to practice the techniques, barriers, and nonverbal communication elements we have just learned. Before we begin, does anyone else want to offer an example? Are there questions or comments about this section?”

### 5. Strengthen the New Knowledge in Memory

**Practice.**

This will be accomplished through impromptu role play and discussion elements, after techniques and barriers section and then again after nonverbal communication. **Use Guided Teaching aid here to note questions and concerns.** Use information to support and construct role play scenarios to meet needs of ministers.

Use examples ONLY containing NEW elements. Stick to relevant information and REALISTIC examples.

Role Play action learning event following the final segment on nonverbal communication also serves to strengthen new knowledge on techniques, barriers, and nonverbal communication.

**Feedback.** Let the learners know how well they’ve done in using the knowledge, what problems they’re having and why. In wrong answer feedback, include the attribute missed. After techniques and barriers segment and then again after nonverbal communication segment discussions, have group engage in providing supportive feedback, instructor enforces what was done well and incorrect information is reframed.
**Test.** Have learners use the new knowledge again to offer evidence that they have met the objectives of the training.

Action learning segments: brief breaks to role play in dyadic relationship, after techniques and after barriers. Final segment will include all elements. “Now we will practice what we have just learned and discussed by putting all the concepts together. Let’s break into small groups of three ministers to role play some scenarios you may encounter. I will assign the first set of roles and present you with a scenario: care receiver (CR), care giver (CG), and observer (O). The CG’s goal is to use demonstrated techniques, barriers, and nonverbal communication to facilitate the process of therapeutic listening. The CR will send out nonverbal cues based upon scenario. The CG attempts to respond dynamically to the input of CR. O will observe and note what they are seeing and hearing in terms of techniques, barriers, and nonverbal communication and the action and reactions taking place. The first group will have five minutes to practice using the elements we have learned. After five minutes we will rotate the roles: CG becomes CR, CR becomes O, and O becomes CG until each has had the opportunity to observe.

When we have finished we rejoin and discuss what was observed.

To assist you in this process I will distribute a handout highlighting techniques, barriers, and nonverbal communication elements we covered.”

**Summary.** Show and summarize the “structure of content” material.

“This diagram illustrates what you have learned today: recall, relate, practice, refine, get support and feedback (encourage trainees to seek out additional resources). We have covered elements of therapeutic listening, techniques and barriers to effective therapeutic listening are presented, as well as elements of nonverbal communication. The handout you received at the beginning of this session provides suggestions for additional resources on what you have learned. Remember that this is a continual process and practice is critical to...”
becoming comfortable with using the tools presented today and the skills will feel more natural with time.

I encourage you to continue to practice and refine your skills as you work in your caring relationships. I am confident that you will find these skills very valuable.

Remember you can refer to your handouts and I highly suggest the books listed on the learning plan distributed at the start. Thank you for your participation today!

I am distributing a feedback questionnaire. If you would complete it and leave it here, your input is greatly appreciated.”

Let trainees know they can contact instructor when course is finished.
# APPENDIX D-PRELIMINARY TRAINING PLAN

<table>
<thead>
<tr>
<th>Topic</th>
<th>Source</th>
<th>Lesson Type</th>
<th>Accompanying Learning Aids and Activities</th>
<th>Power Point Informational slide (IS) or Title Only Slide (TO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overarching topic is therapeutic listening in caring relationships</strong></td>
<td>Various theoretical perspectives: Rogers, Bandura, Blumer, Mead, Blumer, and Buber</td>
<td>Concepts</td>
<td>Use of Guided Teaching method and Role Play action learning</td>
<td>IS-provide background information on value of therapeutic listening as a tool</td>
</tr>
<tr>
<td><strong>Techniques</strong></td>
<td>Welch, Cichon, Stephen Ministry, Nichols, Covey</td>
<td>Concepts: present element and engage trainees-ask questions</td>
<td>Guided teaching *use teacher’s aid</td>
<td>IS-provide bullets of techniques</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td>Barker, Wahlers, and Watson, Williams and Menendez, Welch,</td>
<td>Concepts: present element and engage trainees-ask questions</td>
<td>Guided teaching *use teacher’s aid</td>
<td>IS-provide bullets of barriers</td>
</tr>
<tr>
<td><strong>Nonverbal communication</strong></td>
<td>Navarro and Karlins, Welch, Burgoon and Le Poire, Givens, Gore,</td>
<td>Concepts: present element and discuss the connection between techniques, barriers, and nonverbal communication. Engage trainees-ask questions</td>
<td>Guided teaching *use teacher’s aid and Role Play.</td>
<td>IS-provide bullets of subtopic areas (eyes, hands, head, shoulder, feet, and legs) IS-close with recall and review</td>
</tr>
</tbody>
</table>
The final segment will tie together concepts of techniques, barriers, and the interplay of nonverbal communication through action learning (role play).

Role Play Activity:

Break larger group into 2 or 3 sub groups. Each group contains one care receiver (CR), one care giver (CG) and one observer (O). Provide each group with a different situational example using input from trainees during the previous guided teaching sections and based upon questions or concerns with technique and barrier information provided. CG receives instructions to utilize learned techniques, barriers, and nonverbal communication to facilitate the process of therapeutic listening. CR instructed to utilize nonverbal cues based upon scenario and communication output presented by CG. CG responds accordingly to input of CR. O instructed to observe and note what is observed in terms of techniques, barriers, and nonverbal communication and the action and reactions taking place.

This is repeated in three five minute blocks, each time rotating the roles: CG becomes CR, CR becomes O, and O becomes CG until each has had the opportunity to observe.

Upon completion of the activity, subgroups will return to form the larger group. Discussion on what was observed will follow with the instructor acting as facilitator. This activity allows for group learning and for the instructor to have the opportunity to answer questions. A whiteboard will be utilized in order to create visual representation of connected and recurring concepts and to keep track of questions.

This document was created using elements discussed in Conrad & Poole (2005), Foshay et al. (2003), & Silberman & Auerbach (2006).
APPENDIX E-FEEDBACK and SUGGESTIONS

Your input is very valuable. Completing this brief survey gives you a chance to express your opinions and helps me to know how I can do better.

Information is confidential (please do not record your name) and will be used for the sole purpose of identifying areas of improvement (i.e., things you didn’t like), areas of success (i.e., things you liked or found valuable), and suggestions for future training sessions.

Thank you for your help, I have enjoyed working with you today!

1. Which parts of this session did you find valuable and why?

2. Which parts of this session do you feel could use improvement?

3. Do you have any suggestions for improvement?

4. Are there any topics you would like to see in future training opportunities?

This handout was created using elements of adult learning theory and instructional training design methods (Foshay et al., 2003 & Silberman & Auerbach, 2006).
APPENDIX F-POWER POINT PRESENTATION

**NOTE: THIS PRODUCT IS A SEPARATE DOCUMENT. PRINTABLE SLIDES WILL ACCOMPANY THE FINAL VERSION OF THIS PROJECT. FOR ACCOMPANYING NARRATION CONTACT THE AUTHOR.**
APPENDIX G-CLASS HANDOUT

OPEN ENDED QUESTIONS RESOURCE SHEET

From: http://www.jhu.edu/gifted/teaching стратегий/анализ/openendedquestions.htm

Open-ended questions should begin with words such as "why" and "how" or phrases such as "What do you think about . . .". Open-ended questions should lead students to think analytically and critically. Ultimately, a good open-ended question should stir discussion and debate in the classroom sparking enthusiasm and energy in your students.

From: http://www.fortleavenworthmwr.com/cdsresource/OPNEND.html

Asking Open-Ended Questions

A question like "What color is that block?" evokes a one-word answer. But an open-ended question, "Tell me about the blocks you are using," encourages a child to describe the blocks or explain what she is doing. There is no right or wrong answer here. An answer to an open-ended questions gives us a window into what the child is thinking and feeling. And the response is sometimes wonderfully creative. In explaining or describing, children also use language more fully. Try to think of good “Open-Ended” questions to ask:
- Tell me about ________.
- What else can you do with the ________?
- What could you use to make the __________________?
- What do you think would happen if ________________?
- Is there another way to ___________________?

It is difficult to change the closed-end question habit. But when we ask open-ended questions, students reap great benefits as they think through their responses to express what they want to say. And with their answers, we find out more about what they think and feel.


Open-Ended Questions

Open-ended questions cannot be answered by yes or no. These questions begin with "who," "what," "why," "where," and "when." Some of the questions listed here will feel natural to you and you can practice using them in your work. Circle three or four that you feel most comfortable with and make them part of every small group session you conduct.

1. What kind of information on ________________ are you looking for?
2. What is it you want to know about ____________?
3. What would you like to know about this topic?
4. What do you mean by ________? 
5. Would you tell me more about....
6. What else can you tell me that might help us locate materials?
7. Could you tell me what you're working on?
8. I'd be interested in knowing....
9. Would you explain...?
10. Is there something specific about ________ that you are looking for?
11. Would you explain that to me in more detail?
12. I'm not certain I understand.... Can you give me an example?
13. I'm not familiar with _________.
14. What examples can you give me?
15. What do you already know about ________?
16. Do you know some key concepts, terms or vocabulary for this topic?
17. Where have you checked for information so far?
18. What would you like to know about ____________________?
19. When you say ______________, what do you mean?
20. Can you describe the kind of information you would like to find?
21. If I could find the perfect book to help you, what would that book have in it? Or, what would the title be?
22. Where did you hear or read about ________?
23. I'm not familiar with that person. Is he/she living or dead? What is he/she known for?
24. How will you use the information? That will help me with our search.
25. I'd like to help you find the best possible information. Can you tell me more about your subject?


**This document is intended to give you an idea of what open ended questions may look like. Modification will be necessary to appropriately apply the method to your caregiving relationships. A great number of additional resources are available online.**
APPENDIX H-SUMMARY OF TECHNIQUES, BARRIERS, AND NONVERBAL COMMUNICATION

Techniques:

The following is a list of aspects that separate skilled therapeutic listening from casual listening, such as that which occurs in friendships:

- Active listening employs the use of both paraphrasing and asking of open-ended questions. An open-ended question seeks to draw detail from the speaker: “What do you think would happen if…?”
- Therapeutic listening seeks to connect emotionally with the other, also known as empathy.
- Therapeutic listening requires eliminating distractions and engaging fully with your care receiver through your verbal responses, tone of voice, facial expressions, and body cues.
- In process oriented listening, be OK with silence and allow the speaker freedom to guide the conversation. This is a great time to focus on nonverbal communication: tone of voice, breathing, facial expressions, and body cues.
- Finally, the over arching objective is to attempt to understand the care receiver and their concerns through their perspective, while maintaining the ability to see beyond the situation by employing skilled training.

(This is a compilation of elements extracted from the following sources: Covey, 2004; Cichon, 2001; Rogers, 1951; Stephen Ministry, 2000; and Welch, 2003)

1 Experts warn that nonverbal body cues are very difficult to accurately interpret and therefore, it is essential to look at them as a guide. A more accurate assessment can be made by looking at signals in clusters of cues and deviations from what is normal for the person you are communicating with.

Barriers:

The following is a list of common pitfalls or barriers to promoting therapeutic listening environments:

- Giving advice. The focus should be on care and concern directed toward the care receiver.
- Feeling the need to have all the answers. Your role is to encourage the care receiver to discover their own answers.
- Emotional triggers: be aware of your own deep convictions or prejudices that could interfere with understanding or comprehension.
- Dominant, territorial, and disagreeable facial and hand gestures.
- Commenting or passing judgment before the speaker has finished talking.
- Use of closed body language and body language that indicates lack of interest (we discuss this more in nonverbal communication).
• Turning the conversation back to you. Sharing personal examples is most useful for illustrating points that shed light on the situation, but our goal as care givers is to provide a uniquely different relationship built upon trust and attained through an environment of safety as we show undivided interest and focus on the care receiver.
• Inappropriate verbal and nonverbal responses (this is discussed in more detail in nonverbal communication).

(This is a compilation of elements extracted from the following sources: Barker, Wahlers, & Watson, 2001; Covey, 2004; Nichols, 2009; Williams & Menendez, 2007; and Welch, 2003)

Nonverbal Body Cues:

These are commonly seen body cues and what they may indicate. Any of these can be displayed by the care receiver or the care giver, and the value (positive or negative) is only a general attribute for the purpose of grouping for quick reference.

Positive Indicators:

• Increased eye contact or gaze (this evokes feelings of warmth, value or liking)
• Open eyes and elevated brows
• Focus on care receiver
• Increased smiling
• Vocal pleasantness
• Closely aligned body movements between the care receiver and care giver
• Natural or emotional tone of voice (also an indication of truth in disclosing personal events)
• Head tilted to the side while listening
• Open body postures, such as facing the speaker, unguarded torso, and open or upward pointed hand gestures
• Constricted pupils may indicate a state of relaxation
• Looking to the side while listening indicates a processing of information, as does slow paced head nodding

Negative Indicators:

Care Giver:

• Pointing
• Shaking fists
• Frowning

Experts warn that nonverbal body cues are very difficult to accurately interpret and therefore, it is essential to look at them as a guide. A more accurate assessment can be made by looking at signals in clusters of cues and deviations from what is normal for the person you are communicating with.
• Fidgeting
• Shoulder shrugging
• Mumbling
• Delayed or apathetic responses
• Pursed lips
• Rapid Head shaking
• Closing the eyes
• Anxious signals emitted due to waiting for a turn to speak

Care Receiver or Care Giver

• Dilated pupils may indicate emotional arousal.
• Rapid eye blinking is a sign of emotional stress.
• Raised eyebrows may indicate surprise or disbelief.
• Deeply lowered brows are a sign of anger or disagreement.
• Indirect facial orientation or eye contact may be a sign of discomfort or disagreement. This is often done to create distance between the speaker and the listener. However, in female to female conversations this is common when sharing highly personal or emotional information and displays respect.
• Rapid head nodding may show frustration, annoyance, or an urgency to move the conversation forward.
• Placing the hands behind the head may be comfortable for some, but can display a projection of superiority to the other.
• Hands on the hips demonstrate dominance and is a territorial display.
• Concealing the hands or feet is often associated with feelings of emotional distress and discomfort.
• Guarded postures, such as crossing the arms over the chest convey distance or discomfort.
• Using the arms or hands to cover the face, throat, and abdomen signify vulnerability.
• When individuals stroke, touch, or manipulate various parts of their bodies, such as the hands, arms, face, throat, and thigh area they are doing so to soothe nervous or discomforting emotions, as these are pacifying mechanisms.
• When feet are directed away from the speaker it may be an indication that the person needs to be or would like to be somewhere else.

(This is a compilation of elements extracted from the following sources: Givens, 2010; Navarro & Karlins, 2008; Nichols, 2009; Stephen Ministry, 2000; and Welch, 2003) Experts warn that nonverbal body cues are very difficult to accurately interpret and therefore, it is essential to look at them as a guide. A more accurate assessment can be made by looking at signals in clusters of cues and deviations from what is normal for the person you are communicating with.)
Appendices

MENTOR AGREEMENT (To be submitted with Thesis or Project Proposal)

Mentoring: A deliberate pairing of a more skilled or experienced person with a lesser skilled or experienced one, with the agreed-upon goal of having the lesser skilled person grow and develop specific competencies.

You have been asked to serve as a Mentor for [JENNIFER] who is completing the requirements for her/his Masters Degree in Communication and Leadership Studies. As a mentor you are asked to share ideas with this student and read the next to final draft of their thesis. You are not expected to directly supervise this student’s work but rather meet with them as a “young colleague.” If you are willing to serve as a Mentor for him/her, please sign this agreement. Your Mentee will provide you with full guidelines of their requirements.

I am willing to serve as a Mentor for [JENNIFER] as she/he completes her/his thesis or project. As a Mentor I will provide help in the way of suggestions, ideas and resources and am willing to review drafts of their written work. I also agree to read the next to last draft of the student’s thesis or project and will sign my name on the signature page of their final draft. My signature on the thesis only indicates that I have read it and is no indication of the quality of the work. I will not be asked to assign a grade or make any evaluative comments to the course convener.

Signature [DAVID B. GIVENS]
Title [Adj. Prof.]
Email and telephone number [givens@gonzaga.edu]
Date [09/04/2017]