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An Analysis of Occupational Therapists' Listening Behaviors
During Treatment Sessions

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree

Master of Science in Occupational Therapy

School of Health and Nursing Science

Dominican University of California

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This thesis, written under the direction of the candidates' thesis advisor and approved by the Chair of the program, has been presented to and accepted by the Faculty of the Occupational Therapy department in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy. The content, project, and research methodologies presented in this work represent the work of the candidates alone.

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Abstract

Background and purpose. Given the importance of listening in establishing a therapeutic relationship between healthcare providers and clients, there is a lack of research investigating the listening behaviors occupational therapists (OTs) use in clinical settings. The purpose of this study was to analyze what verbal and nonverbal listening behaviors OTs employ in clinical treatment sessions.

Subjects. Convenience and snowball sampling were used to recruit five OTs and five clients working with those OTs.

Methods. An observational study was used to investigate the verbal and nonverbal listening behaviors OTs employed during the first five minutes of each clinical treatment session. Each session was videotaped and transcribed verbatim to measure listening behaviors of OTs when working with clients. Data was collected using the IJLCI. Interrater reliability was evaluated with the ICC. SPSS was used for data storage, tabulation, and generation of descriptive statistics.

Results. Listening behaviors of five OTs were observed. All participants used six specific listening behaviors. OTs' beliefs about listening were consistent with observed listening behaviors. Video analysis revealed six major barriers to listening.

Discussion and conclusion. Video analysis and tabulation were used to analyze verbal and nonverbal listening behaviors of OTs. Listening is essential to the patient-therapist relationship. It is, however, an underexplored area particularly within the occupational therapy context.

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Introduction

The United States Department of Health and Human Services' *Healthy People 2020* initiative states the necessity for improved client satisfaction with healthcare providers. One objective that *Healthy People 2020* listed under healthcare goals is to, "Increase the proportion of persons who report that their healthcare provider always listened carefully to them" (U.S. Department of Health and Human Services, 2011). Listening is a critical skill that influences the perceptions that clients develop regarding the quality of healthcare received. The Accreditation Council for Occupational Therapy Education (ACOTE) establishes standards for occupational therapy education programs, which include a principal goal of using nonverbal communication with "the client, family, significant others, communities, colleagues, other health providers, and the public in a professionally acceptable manner" (American Occupational Therapy Association, 2010). Based on these two mandates, listening is crucial to professional proficiency in healthcare contexts (Roter & Hall, 2006). Practitioners who listen effectively to clients improve client satisfaction and quality of life (Jonas-Simpson, Mitchell, Fisher, Jones, & Linscott, 2006; Wanzer, Booth-Butterfield, & Gruber, 2004).

Given the evidence supporting the significance of listening, it is problematic that patients continue to report dissatisfaction with healthcare practitioners' listening (Davis et al., 2008; Hayes, 2007; Jonas-Simpson et al., 2006; Lester & Smith, 1993). Additionally, there is a lack of research investigating the listening behaviors OTs use in clinical settings. In occupational therapy, therapeutic listening is highly valued, yet it remains unclear what listening behaviors OTs use and the outcomes of those behaviors. Listening is essential to establishing a therapeutic relationship between the therapist and client. The

International Listening Association (ILA) defines listening as “attending, receiving, interpreting, and responding to messages presented aurally” (International Listening Association, 2008). Occupational therapists use of listening as a means of gaining deeper insight into the client’s experience is an integral component of a client-centered approach (American Occupational Therapy Association, 2002). Therapeutic listening is purposeful listening in which the listener must possess five fundamental skills: focusing attention, demonstrating attending behaviors, developing a supportive communication climate, listening with empathy, and responding appropriately (Wolvin & Coakley, 1996). Poor practitioner listening can lead to decreased client satisfaction, loss of client information, and increased litigations (Beckman & Frankel, 1984; Davis, et al. 2008; Lester & Smith, 1993; Rhoades, McFarland, Finch, & Johnson, 2001).

The purpose of this research was to investigate the listening behaviors OTs employ during clinical treatment sessions. Literature revealed that there are benefits to listening when used effectively and negative consequences when applied ineffectively. Additionally, the literature disclosed several critical barriers to listening including personal, environmental, and organizational factors that can inhibit a positive therapeutic outcome (Betcher, 2010; Clarke & Ross, 2005; Ruusuvoori, 2001; Turner et al. 2000). The intended outcome of this research is was to establish a foundation of knowledge regarding listening behaviors occupational therapists employ in a clinical context.

Literature Review

Listening behaviors vary, as each healthcare context is unique and requires specific or appropriate listening behaviors. This study will utilize Imhof and Janusik’s

conceptualizations of listening. Conceptualizing listening facilitates the research process, as each concept used in this study is generalizable to the healthcare context. Imhof and Janusik (2006) developed a framework to conceptualize listening based on extensive studies on listening and literature from communication studies. The four concepts of listening are (a) organizing information, (b) listening as relationship building, (c) listening as learning and integrating information, and (d) critical listening (Imhof & Janusik, 2006).

Practitioner listening behaviors within a healthcare context

In the healthcare field, listening behaviors vary. Listening behaviors represent both the adaptive role of the practitioner listening and the healthcare context in which the practitioner practices. As a practitioner practices listening over many years, the practitioner begins to develop listening behaviors (Wolvin & Coakley, 1996). Simon et al. (2009) found that healthcare practitioners working in palliative care believed that listening behaviors such as personal authenticity and mindfulness were essential qualities needed in order to implement positive active listening in end-of-life care. Simon et al. (2009) also found that practitioners believed listening behaviors including physical presence such as touch, postural positioning, and eye contact were effective methods for care. Klagsburn (2001) reported that nurse's believed that listening to clients is the most critical role in nurses' caring functions. Listening behaviors exhibited by practitioners can be further conceptualized.

Imhof and Janusik's four types of listing conceptualizations are used to describe these listening behaviors used by practitioners (Davis et al., 2010). Listening as organizing information refers to the cognitive process of gathering information from the

client and focuses on information processing. It is part of the practitioner's role to gather this information regarding the client to enable a correct diagnosis and treatment plan. The practitioner must listen to the information the client is providing, to effectively provide effective care. Listening for relationship building focuses on bonding, accepting, helping, and welcoming others. Listening as learning and integrating information refers to analyzing and applying information as well as using the information to draw conclusions and compare information. The last concept, critical listening is intended to evaluate the purpose of the message and uncover any hidden messages. The speaker is trying to persuade the other person by attempting to influence the sender's attitudes, beliefs or actions in order to provoke clarity in the information being shared (Davis et al. 2010; Davis et al. 2008; Imhof & Janusik, 2006).

There are many reasons to listen in the healthcare contexts. One crucial reason to listen is to build a therapeutic relationship. In the context of occupational therapy, therapeutic listening is essential as it is a central component of therapeutic communication (Taylor, 2008). Therapeutic listening encompasses focusing attention, demonstrating attending behaviors, supportive communication, listening with empathy, and responding appropriately. Focusing attention is the listener's ability to give the sender full attention while avoiding distraction. Demonstrating attending behaviors is the ability of the listener to use the body to show engagement in the interaction. This is accomplished by maintaining eye contact, upright body position, facial expressions, and verbal expressions. A supportive communication climate involves creating an atmosphere that permits the sender the opportunity to develop a sense of safety, freedom, and the comfortability to share. Listening with empathy is the listener's ability to put the

self in the sender's point of view and remain nonjudgmental. The last skill is responding appropriately, which stimulates and grants the sender the opportunity to further examine personal problems (Wolvin & Coakley, 1996).

According to Taylor (2008), therapeutic listening is vital to the origination and preservation of the client-therapist relationship. The purpose of therapeutic listening is to deliver ample validation and support for the client's viewpoint (Taylor, 2008). Therapeutic listening is used by OTs as a means of gaining deeper insight into the client's experience, an integral part of a client-centered approach (American Occupational Therapy Association, 2003). This information is then used to compile an occupational profile and design appropriate interventions for the client.

Therapeutic listening is composed of four activities: empathic listening, guided listening, verbal prompts and sounds, and enrichment questions (Taylor, 2008). Empathic listening involves the therapist's ability to truly understand the client and any underlying issues. Guided listening is an approach used to to organize and mold the client's responses. The therapist attempts to influence what the client is saying by making summary-type statements, which aim to limit or organize what a client is saying. Verbal prompts and sounds are utterances that the therapist uses during listening to reassure the client that he or she is listening. Enrichment questions are used to foster further communication (Taylor, 2008). Therapists using therapeutic listening increase these skills with years of practice. Improvement in listening skills naturally occurs as therapists use therapeutic listening (Wolvin & Coakely, 1996).

Active listening skills are a component of therapeutic listening and play an essential role in building a therapeutic relationship. Active listening is a set of specific

communication skills, which involves giving free and undivided attention to the speaker (Rogers & Farson, 1957). Active listening involves both verbal and nonverbal communication. According to Rogers and Farson (1957), active listening can be effective if certain techniques are used: listening for total meaning, responding to sender's feelings, and noting all cues. The listener must listen for total meaning in the sender's message. This includes the content as well as the underlying emotions. The listener responds to the sender's feelings when the subject matter is less imperative than underlying emotions. As not all communication is verbal, any cue exhibited by the sender should be noted during the message. In order for these techniques to assist the sender, the listener must be able to drop one's worldview and take on the sender's, while remaining value free in order to avoid any stereotypes or judgments against the sender (Rogers & Farson, 1957).

According to J. Davis, when actively listening the practitioner uses a variety of listening skills (personal communication, September 28, 2011). These skills are observing, encouraging, reflecting, restating, and validating (J. Davis, personal communication, September 28, 2011). When observing clients, the practitioner considers facial expressions and nonverbal communication such as body language and proxemics. Reflecting is a skill where the therapist reflects on the importance of the message being sent and the underlying emotion. An example of reflecting is, "this seems really important to you." This allows the sender an opportunity to sort out any feelings he or she may have or is withholding. Restating involves choosing different words to check for important points made during the discussion. For example, the client may state, "I wish my partner believed what I said." A restatement response may look like,

“So you would like your partner to trust you more.” This shows the speaker the therapist is listening and checks for understanding of the message. Validating is verbalizing appreciation and gratitude for the sender sharing information. Validation may sound like, “I appreciate that you shared this information with me.” This expresses the practitioner’s good will and promotes trust (J. Davis, personal communication, September 28, 2011).

Lang, Floyd, and Beine (2000), suggest that active listening is a skill used to identify and explore a client’s cues during a medical interview. Active listening is a necessary first step toward client-centered care, which aims to elucidate the reason for the visit from the client’s viewpoint (Lang et al., 2000). Active listening promotes a client-centered approach to care where clients and practitioners collaborate in decision-making, problem solving, and goal setting. Research has found that active listening assists the physician in understanding the client’s perception of illness and increases client satisfaction (Lang et al., 2000; Fassaert et al., 2007). It also elevates emotional health and wellness, and may significantly contribute to the client’s quality of life. Currently, there is limited research on the use of active listening by OTs (Davis et al., 2008). Yet there are numerous benefits to therapeutic and active listening in healthcare contexts.

Significance of therapeutic listening in healthcare

Taylor (2008) defined therapeutic listening as the therapist’s efforts to collect information from a client in a way that encourages better understanding of the client’s experience. Taylor further added that therapeutic listening intends to provide the client with as much validation and support for his or her perspective as possible. Research by Cole and McLean (2003) reaffirmed the significance of listening within a therapeutic relationship in occupational therapy contexts. Results of their study provided an alternate

definition of a therapeutic relationship: “a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect” (Cole & McLean, 2003, p. 29). A therapeutic relationship is highly dependent on listening as concepts in the definition suggest. Communication, empathy, and understanding can only occur if the therapist listens to his or her client. Respondents in Cole and McLean’s survey emphasized the importance of rapport in promoting positive outcomes, open communication, and empathy in a therapist-patient relationship. It is only through listening, that a therapist is able to establish such rapport with his or her client.

There are significant benefits to listening in healthcare as it has been found to be a fundamental element to client satisfaction (Davis et al., 2008). Wanzer, Booth-Butterfield, and Gruber (2004) found that behaviors, such as active listening, were linked to client satisfaction with care and healthcare communication. Results of this study indicated that immediacy behaviors (e.g., smiling and eye contact), empathy, and listening were the prevalent predictors of client satisfaction with physicians’ and nurses’ communication. Moreover, Hayes (2007) reported that client satisfaction with nurse practitioners was enhanced when nurse practitioners listened to the views the clients had regarding the need for medication or testing. The clients reported that they were grateful that the nurse practitioners took a moment to listen to their concerns and provided them with health resources they needed. Furthermore, Harris and Templeton (2001) found that at the time of diagnosis, active listening and eye contact were identified to be most helpful behaviors used by physicians treating women with breast cancer. Results of this study also revealed that listening was ranked the most desired behavior in a

physician. The women valued physicians who listened attentively, did not interrupt them, maintained eye contact, and used clarification. The outcome of these behaviors can imply client satisfaction with their physicians.

Another benefit of listening in healthcare is increased quality of life for clients. Jonas-Simpson, Mitchell, Fisher, Jones, and Linscott (2006) suggested that listening to older adults in long-term care settings was essential to quality of life in older adults. Participants reported that being listened to transform feelings of upset and anger to feelings of contentment, respect, and nurturance. Moreover, Traynor (2005) found that if nurses carefully listen to the stories of older clients, they could identify psychological or emotional supports needed when clients encounter such obstacles as depression, trouble-maintaining intimacy through friends and family, and managing the process of change associated with aging. Through listening, psychological or emotional supports needed by older clients can be achieved, and thereby, perhaps increase older clients' quality of life.

On the other hand, practitioners who do not demonstrate listening to their clients may face negative consequences. Davis et al. (2008) report that although benefits of effective listening have been established, research in healthcare reveals that a lack of listening on the physician's part can lead to misunderstandings and misdiagnoses. Beckman and Frankel (1984) found that one consequence of physician interruptions in clinical treatment sessions is a loss of client information. Most of the interruptions recorded in their sample occurred between 5 to 50 seconds after the physician's preliminary request for information. Results of the study showed that only 1 out of 52 clients was able to complete a statement of concern. As a result, the physician

interpreted those initial pieces of clinical information as the client's fundamental concern or complaint (Beckman & Frankel, 1984).

A more recent study by Rhoades, McFarland, Finch, and Johnson (2001) examined physician-client interruptions in communication during office visits with family practice and internal medicine resident physicians. Results revealed that clients received an average of 12 seconds to speak without being interrupted after resident physicians entered the room. Resident physicians interrupted one fourth of the time before clients finished speaking. Rhoades et al. (2001) suggest interruptions function as nonverbal cues that indicate lack of willingness to listen. According to Rhoades et al. (2001) physicians need to allot time to listen in order to understand clients' perspectives, as clients and physicians tend to have dissimilar interpretations of symptoms and effectiveness of treatments.

Terminating the client's opening statements prematurely generated a more physician-centered focus than a client-centered focus (Beckman & Frankel, 1984). Researchers have also found that a lack of communication between physicians and clients contributed to the initiation of malpractice lawsuits (Lester & Smith, 1993). Participants reported that physicians who used negative communication behaviors were rated as "less professional, caring, friendly, trustworthy, and competent and significantly more to blame, more negligent, and more liable" (Lester & Smith, 1993, p. 270). Practitioners who do not listen to their clients may make mistakes, which might result in medical difficulties leading to litigation (Wanzer, Booth-Butterfield, & Gruber, 2004).

To summarize, research suggests that when practitioners listen to their clients, there is an upsurge in client satisfaction and physicians are at less risk for malpractice litigation (Davis et al., 2008). Within the healthcare context, listening is vital to professional competence (Davis et al., 2008; Jonas-Simpson et al., 2006). Establishing a therapeutic relationship is dependent on the practitioner's ability to effectively communicate with the client (Davis, Foley, Crigger, & Brannigan, 2008). Occupational therapy is a client-centered practice, which means that clients are active participants in goal setting and treatment planning. Occupational therapists who use effective listening behaviors and skills in the treatment of clients, may have better treatment outcomes. However, some factors may be out of the control of the OT. There are both internal and external barriers to listening that must be taken into consideration.

Barriers to active listening

Researchers have indicated a number of personal, environmental and organizational barriers that inhibit a healthcare practitioner's ability to actively listen to their clients (Betcher, 2010; Clarke & Ross, 2005; Ruusuvuori, 2001; Turner et al., 2000; Wolvin & Coakley, 1996.). Personal barriers affecting listening include both physical and psychological states, stress, attitudes, interests, and time (Wolvin & Coakley, 1996), while environmental barriers include physical space, noise, and other distractions (Clarke & Ross, 2005; Ruusuvuori, 2001). In addition, organizational barriers are barriers placed upon the practitioner by the institution in which they are employed, and include organizational attitudes towards listening and productivity (Clarke & Ross, 2005; Ruusuvuori, 2001).

Personal barriers, such as practitioner attitudes have been identified through research as inhibiting a practitioner's ability to listen effectively in a healthcare setting. Clarke and Ross (2005) found that many practitioners believed that some conversations, such as an end of life conversations, were too personal. Listeners are also influenced by multiple dimensions of time, such as the amount of time available to engage in a therapeutic or otherwise meaningful conversation, and also the time of day in which the communication takes place (Wolvin & Coakley, 1996). If the listener is rushed, the listening process will be flawed. Further, time of day plays a significant role in the amount of information from a conversation the listener is able to retain. For example, research indicates that individuals are better able to retain verbal information they heard in the afternoon (Wolvin & Coakley, 1996).

Brownell (1994) further defined barriers as filters, identifying a number of filters that interfere with an individual's ability to listen effectively in a conversation, including the individual's organizational role (their role in the communication- such as husband and wife, manager or other title), attitudes (including personal, cultural, familial, social), previous experiences (with the listener or a similar situation), values (personal, social, cultural) and individual bias. In utilizing the Hurrier Model of Listening Instruction, Brownell asserted that these filters interfere with an individual's ability to function efficiently and objectively in all components of the listening process, including understanding, evaluating and interpreting (Brownell, 1994).

Physical and psychological states are factors that can promote or inhibit effective listening. Wolvin and Coakley (1996) asserted that stress was the most salient physical or psychological condition affecting listening. Clarke and Ross (2005) identified

healthcare practitioners that felt the listening process was exhausting, and admitted to avoiding the topic altogether. Furthermore, some practitioners admitted to ignoring verbal cues from the patient, changing the topic of conversation, and being emotionally unavailable when patients discussed their medical diagnosis (Clarke & Ross, 2005). However, research has identified an inverse relationship in the link between listening and listener blood pressure, identifying that when the listener's concentration increases, listener blood pressure decreases below baseline (Wolvin & Coakley, 1996).

Environmental factors such as physical space can influence the healthcare practitioner's ability to listen therapeutically (Clarke & Ross, 2005; Ruusuvaori, 2001). In Ruusuvaori's research in communication and listening, the researcher discovered that isolated physical space is more inviting for a confidential discussion and assists in developing trust between the practitioner and client (Ruusuvaori, 2001). Further, Clarke and Ross indicated that overcrowded hospitals have eliminated the kind of space inviting practitioners and clients to communicate privately in an effort to eliminate inefficient space (Clarke & Ross, 2005).

In addition to personal and environmental barriers, organizational barriers such as the attitude of an organization towards listening can affect the healthcare practitioner's ability to listen (Clarke & Ross, 2005; Turner et al., 2000). Clarke and Ross (2005) identified practitioners working in medical hospitals who stated that the hospital environment promoted the physical care of the client over the client's psychosocial needs (Clarke & Ross, 2005). According to Turner et al. (2000), many practitioners agreed they understood the importance of active listening in establishing a relationship with their clients, but felt that their colleagues, supervisors, and administration diminished the

importance of this practice; further adding that verbal communication in a hospital environment was considered time wasted. Similarly, other practitioners reported feelings of conflict between opposing job demands, and the priority of taking care of the patient's physical health (Turner et al., 2000). Limited research on active listening exists in the healthcare literature (Fassaert et al., 2007), indicating an organizational barrier diminishing the importance of active listening within a healthcare context.

Statement of Purpose and Research Questions

The purpose of this research was to determine what listening behaviors OTs use during clinical treatment sessions. This research will contribute to a growing body of knowledge about listening behaviors within the context of occupational therapy. It is problematic that, given the importance of listening, there is limited research on the topic of listening in occupational therapy. Additionally, without an understanding of how OTs conceptualizes listening and what listening behaviors are used in clinical treatment sessions, it is impossible to discover the outcomes of listening behaviors in various clinical contexts. A foundation of knowledge regarding listening behaviors OTs employ within the clinical context may be helpful in determining training needs of occupational therapy students and informing clinicians on the state of listening in the area of occupational therapy rehabilitation. The research questions for this study are:

1. What are OTs' listening behaviors in a clinical context?
2. Is there a relationship between OTs' beliefs about listening and their listening behaviors?
3. What barriers exist in the clinical setting that impedes therapeutic listening?

Theoretical Framework

To further support the significance of listening behaviors within the occupational therapy profession, symbolic interactionism was used to guide the research in explaining how and why OTs listen. Additionally, the Person-Environment-Occupation (PEO) theoretical model of practice was combined with symbolic interactionism to discuss occupational fit and understand the interaction between listening as an occupation in a healthcare environment.

Symbolic Interactionism

Herbert Blumer developed symbolic interactionism. Scholars such as George Herbert Mead, W. I. Thomas, and Charles Horton Cooley contributed to its intellectual foundation (Blumer, 1969). Symbolic interactionism presents a sociological perspective, and theorizes that (a) individuals act toward things based on the meanings those things have for them, (b) the meanings of those things develop from social interaction, and (c) these meanings are modified through interpretation of the individuals interacting with each other (Blumer, 1969). The first premise of this theory focuses on meaning and addresses *things*, which include everything that the individual may notice in his or her world-physical objects, including:

Trees or chairs; other human beings, such as a mother or a store clerk;
categories of human beings, such as friends or enemies; institutions, as a school
or a government; guiding ideals, such as individual independence or honesty;
activities of others such as their commands or requests; and such situations as
an individual encounters in his daily life. (Blumer, 1969, p. 2)

The second premise is concentrated on language that provides human beings with a means by which to barter meaning through symbols. Blumer (1969) believed that naming assigns meaning to things and experiences, the foundation of human society and scope of knowledge. This is demonstrated by engaging in acts of speech with other individuals or social interaction, where individuals begin to associate meaning or naming to build language. The third premise emphasizes thought, which is the factor that changes the individual's interpretation of symbols. This thought is a mental dialogue requiring the individual to assume roles or visualize various points of view.

Symbolic interactionism aims to discern the meanings of social situations in which individuals engage. The fundamental principle of symbolic interactionism is that the interaction between society and individuals are the result of interpersonal communication (Blumer, 1969). In effect, individuals do well in interpersonal communication to the extent that the individuals involved in that particular communication exhibit comparable meanings to objects and processes within their environment. This theory emphasizes active, interpretive, and constructive abilities of individuals in the conception of social reality (Blumer, 1969). Particularly, symbolic interactionists argue that individuals have the aptitude for thought, which is formed by social interaction. Thus, symbolic interactionism attempts to elucidate social behavior as the consequence of the meaning exhibited by individuals throughout social interaction. Listening within the healthcare context is a key component of the client-practitioner relationship (Davis et al., 2008). Communication involves interaction, listening, and understanding of symbols. Occupational therapist's beliefs about listening may lead to specific listening behaviors. This is key because listening is important in

clinical treatment sessions and can have a significant impact on the therapeutic encounter (Davis et al., 2008).

Symbolic interactionism was used as a framework for looking at listening behaviors of OTs and the meaning that listening has for them. For example, if an OT believes in the importance of listening, it follows that they will exhibit positive listening behaviors. Our research focused on the aspect of symbolic interactionism that explains the critical relationship between meaning of objects and things like listening and behavior. Specifically, it explains the relationship between listening beliefs and listening behaviors of OTs, and how that impacts the therapeutic relationship. An OT may be in a therapeutic relationship with their client and intend to be client-centered. If being client-centered is important and has value to the OT, he or she may exhibit key listening behaviors that promote the social relationship between the therapist and client. This theory was used to guide the research in exposing OTs' beliefs about listening and their use of listening behaviors (Benzies & Allen, 2001). Because active listening is a significant component of interpersonal communication and assures that the speaker's feelings, nonverbal cues, words, and body language are recognized and understood, this research focused on listening behaviors and listening beliefs.

Person-Environment-Occupation (PEO)

The Person-Environment-Occupation (PEO) model describes the ever-changing relationship between persons, environments, and occupations as they interact to generate an occupational fit (Law & Dunbar, 2007). PEO was used as a framework from which to view listening in a healthcare context. PEO assumes that the occupational performance of individuals and groups should be analyzed through the interactions between person,

environment, and occupation components (Law et al., 1996). The outcomes of these complex interactions influence the person's occupational performance.

Person is the first component of the PEO model. Within the context of PEO, the person is a unique individual who concomitantly manages several roles and participates in many activities. Each person exhibits specific physical, emotional, cognitive, and spiritual characteristics (Law et al., 1996). These characteristics affect individuals' role preferences as they progress through their lifetime (Law & Dunbar, 2007). The person component involves the individual's personal beliefs, attitudes, needs, preferences, and knowledge of himself or herself (Rigby & Letts, 2003).

Environment is the second component of the model. According to PEO, environment is comprised of social, political, economic, institutional, physical, and cultural factors (Law et al., 1996). Environments can form and affect behavior. For instance, play environments such as playgrounds and parks typically encourage laughter and noisy behaviors in contrast to classroom environments that are often quieter (Law & Dunbar, 2007). Likewise, work environments can influence employees to concentrate more on tasks than they would at home.

Occupation is the third component of the model. PEO defines occupation as clusters of functional tasks and activities that the person independently engages in over his or her lifespan (Law et al., 1996; Rigby & Letts, 2003). The person takes part in occupations to fulfill his or her internal needs, self-maintenance, expression, and to fulfill his or her various roles. Occupations are initiated within the context of the person's roles and environments (Law et al., 1996).

Three-linked circles symbolize the Person-Environment-Occupation model. Each circle symbolizes one component of the person, environment, and occupation relationship. The area of overlap among the three circles represents the client's occupational performance (Law et al., 1996). The greater the overlap, the more optimal the occupational performance will be, thus representing a positive relationship. The lesser the overlap, the less optimal the occupational performance will be, hence representing a negative relationship.

PEO was used to develop an understanding on how occupational fit is related to listening behaviors of OTs. Furthermore, PEO will be used in the research to illuminate barriers to effective listening in a clinical context, which compromise OTs' listening. For example, if the OT does not believe in the importance of listening they may not create an environment where the client achieves occupational fit because they lack critical information provided. The model will direct the researchers to focus on the relationship between the person, occupational therapy environment (treatment session), and occupation (listening) components. In particular, the model will guide researchers to examine the person factors of the OTs, such as personal beliefs and behaviors. Furthermore, PEO served to guide researchers to explore the influence of cultural, social, and organizational factors on listening behaviors that OTs use in the clinical environment. The model was used to guide researchers in focusing on the dynamic relationship between the person (OT), his or her environment, and the occupation of therapeutic listening.

Methodology

Design

An observational study was undertaken during OT treatment sessions in various healthcare settings in which researchers videotaped OTs with the goal of identifying and tabulating the listening and nonverbal behaviors of OTs used with their clients. The study used a questionnaire to determine how participants conceptualized listening within the context of healthcare.

Participant Description

The source of the participant sample is willing OTs working at adult, physical disability settings and willing clients of these OTs. Criteria for study participation included being an OT who met the following criteria: (1) licensed to practice in California, (2) fluent in the English language, and (3) in agreement to participate in the study. Clients of OTs must be oriented to person, place, and time, have a sufficient understanding of English and be able to express themselves verbally. Clients were adults over the age of 18, who were cognitively able to provide informed consent. The client's cognitive function was evidenced by their ability to reciprocate appropriately when conversing with the therapist.

Ethical and Legal Considerations

Ethical principles, including fidelity, veracity and beneficence will be critical in guiding this research. These three ethical principles provide a relevant basis for this project, which seeks to help its participants gain an understanding of what listening behaviors are being utilized during clinical treatment sessions.

The Occupational Therapy Code of Ethics and Ethics Standards raises awareness that the principle of fidelity requires researchers to treat OT participants and client participants with dignity, respect, integrity and truthfulness (AOTA, 2010). Any and all information to be obtained from OT participants and client participants will be kept confidential. Researchers will present all findings in a truthful manner to ensure the validity of the data.

The Occupational Therapy Code of Ethics and Ethics Standards raises awareness that the principle of veracity requires OTs to be honest, truthful, and disclose all information (AOTA, 2010). The researchers will obtain informed consent from both OT participants and client participants. Informed consent will include pertinent information as to the purpose, background, procedures, benefits, and risks regarding this research. The researchers will ensure each participant understands what information is conveyed.

The Occupational Therapy Code of Ethics and Ethics Standards states beneficence shows concern for the safety and overall well-being of all participants (AOTA, 2010). Participants will not be discriminated based on gender, age, race, socioeconomic status, political views, disability or religion. Researchers will make every effort to advocate for the health and well being of all participants.

As stated in the Consent to be a Research Subject form, no physical risk was associated with participation in this research. However, psychological risks such as emotional discomfort due to participants disclosing feelings and also being video recorded. To protect participant anonymity, all research materials were stored in the locked office of the Thesis Advisor (See appendix B). Researchers received full board

approval from the IRBPHS for application 9062 on February 24th, 2012 (See appendix A). All permissions granted to Dominican University of CA to use this copyrighted item in any medium it determines appropriate.

Data Collection Procedures

Participants were recruited from OT settings specializing in adult physical disabilities in the western part of the United States. Chief Executive Officers of these settings were contacted in order to explain the research and solicit participants. Site selection forms were completed and signed by all parties. Next, OTs at these selected sites were contacted directly and a willing client was recommended. Both the willing OT and client were given a consent form explaining the research. Once consent forms were signed, the researchers set up a convenient time to videotape a treatment session between OT and client (See appendix B for Consent Forms). Researchers videotaped one typical treatment session between OT and client. A Flip UltraHD video camera was used to record the treatment session. Because of ethical constraints, the researcher, who was present during the treatment sessions, manually operated the camera. Once the treatment session was over, the OT was asked to fill out a questionnaire on his or her beliefs about listening. The client had no further obligation once the videotaping was completed. Data was collected on such verbal and attending listening behaviors as clarification, responsive facial expressions, etc. (See appendix C and D). Researchers then viewed the first five minutes of each video recording, identifying and tallying every verbal and attending listening behavior utilized by the OT during treatment and the frequency with which they utilized those behaviors. The overarching concept we were looking to investigate is therapeutic listening, defined by Taylor (2008) as, “Therapeutic listening involves the

therapist's efforts to gather information from a client in such a way that it promotes greater understanding of the client's experience.”

Instruments

Data was collected using the Imhof/Janusik Listening Conceptualization Instrument (IJLCI) (See appendix E). The Imhof/Janusik Listening Conceptualization Instrument is an instrument in the public domain and is an itemized Likert scale survey that elicits conceptualizations or beliefs about listening. The IJLCI have been revised to streamline the instrument to 15 questions. The IJLCI is empirically based and has undergone rigorous reliability and validity testing. According to Imhof and Janusik (2006), the instrument was designed to ascertain an individual's beliefs about listening. These beliefs are considered a presage for the quantity and quality of effort expended on the process of listening. The IJLCI has been used in many research studies in health care.

The following four factors that make up the IJLCI are each associated with a set of concepts related to listening in the literature on communication. The four factors are: Factor 1: Listening as organizing information (gathering, organizing, storing, comparing, retaining), Factor 2: Listening as relationship building (bonding, accepting, comforting, socializing), Factor 3: Listening as learning and integrating information (interpreting, analyzing, selecting, decoding), and Factor 4: Critical listening (arguing, inquiry, obeying, testing, conceding, answering). These four subscales are empirically based, allow for aspects of listening concepts to emerge, and quantify the beliefs about listening of participants.

Data Analysis

Data gathered from the videotapes was analyzed by tabulating the non-verbal and listening behaviors of the OTs. Before data analysis began, researchers established statistical reliability through training of raters and use the intraclass correlation coefficient (ICC) to evaluate interrater reliability. The Statistical Package for the Social Science (SPSS) was used for data storage, tabulation, and for generation of descriptive statistics. Descriptive statistics was used to identify the specific listening behaviors used by the participants as well as their non-verbal behaviors.

Results

SPSS analysis indicated a high degree of interrater reliability between researchers for both the identification of listening and attending behaviors utilized and for tabulating the frequency with which each listening and attending behavior was utilized by each OT during the clinical treatment session for videos 1-5 respectively: 1) .991, 2) .990, 3) .996, 4) .989 and 5) .993. Selected methods were utilized by researchers to ensure a high degree of interrater reliability, including determining accepted definitions of active listening terms and multiple training sessions were held in which researchers viewed the video recordings and identified various listening behaviors seen. Further, the thesis advisor assisted throughout the process of identification and tabulation.

The majority of the five OT participants in this current study were between 40 to 60 years old, with an exception of one participant who was age 30. The participants were 60% female and 40% male. Most of the participants were Caucasian. Seventy-five percent of the participants had 12 or more years of practice experience. The majority (80%) had no special training in listening. A total of five occupational therapy treatment

sessions were videotaped and transcribed verbatim. For the first five minutes of each videotaped session, analysis of listening behaviors was completed with descriptive statistics by use of The Statistical Package for the Social Sciences (SPSS). The results showed that all five participants used one of these listening behaviors the most during a clinical treatment session: clarifying, open-ended questions, closed-ended questions, commands, eye contact and head nodding. Validation, probing, reflecting, and restating were used the least among the five participants.

TABLE 1
Listening Behaviors of Occupational Therapists

<i>Most Used</i>	<i>Least Used</i>
Clarifying	Validation
Open-ended questions	Probing
Closed-ended questions	Reflecting
Commands	Restating
Eye contact	
Head nodding	

Results from the IJLCI indicated that all five OTs conceptualized listening as learning and integrating information.

TABLE 2
Descriptive Statistics: Listening Conceptualizations of Occupational Therapists

<i>Conceptualizations of Listening</i>	<i>Occupational Therapist</i>
	<i>Mean</i>
Relationship Building	3.08
Organizing Information	3.75
Critical Listening	3.08
Learning & Integrating	3.95

Discussion

The first research question investigated what listening behaviors OTs used in a clinical context. Results indicated that all five participants in this study used clarifying, open-ended questions, closed-ended questions, commands, eye contact, and head nodding the most during a clinical treatment. The use of effective listening behaviors, especially clarification and eye contact have been found in the literature to be linked with client satisfaction, increased quality of care, and identified as desirable behaviors among practitioners (Wanzer, Booth-Butterfield, and Gruber, 2004; Jonas-Simpson, Mitchell, Fisher, Jones, and Linscott, 2006; Harris and Templeton, 2001). These findings support the importance and use of effective listening behaviors in clinical treatment sessions between the therapist and client.

Results in this current study also showed that validation, probing, reflecting, and restating were used the least among the five participants. These findings do not coincide with the literature. According to J. Davis, when actively listening the therapist uses a variety of listening skills such as observing, encouraging, reflecting, restating, and validating (J. Davis, personal communication, September 28, 2011). Active listening skills are a component of therapeutic listening and play an essential role in building a therapeutic relationship (Rogers & Farson, 1957). In a study by Lang et al. (2000) results implied that active listening is a necessary first step toward client centered care, it also elevates emotional health and wellness, and may significantly contribute to the client's quality of life. Future studies may want to examine listening as context dependent or as a value of the individual, as it was a barrier for researchers in this current study to determine why the therapists did not use those listening behaviors listed under Least

Used in Table 1.

The second research question examined if there was a relationship between OTs' beliefs about listening and their listening behaviors. Findings from the IJLCI indicated that all five OTs conceptualized listening as Learning and Integrating information. This is consistent with five of the top six behaviors observed to be most used by the participants. However, findings are not consistent with the use of commands, one of the most utilized behaviors- as commands are an artifact of treatment. While commands are a necessary component of clinical treatment between a skilled therapist and client, overutilization of commands could potentially limit the opportunity for attending behaviors, thereby increasing the need for skillful listening behaviors. Commands promote decreases in interaction and client-centered relationships. These findings are consistent with those of Turner et al. (2000), who identified practitioners who experienced difficulty balancing what they viewed as opposing demands between taking care of the client's physical care and psychosocial needs. These same practitioners felt the organization they worked for valued the physical care as first priority.

The third research question sought to determine what barriers exist in the clinical setting that impede therapeutic listening. Environmental barriers such as physical space, background noise and other distractions, including a knock on the door, cell phones ringing, and verbal interruptions were significant barriers observed to interfere with OTs' listening during treatment sessions. Results in the current study are congruent with Rhoades et al. (2001), who found that environmental barriers such as a knock on the door, beeper interruptions, computer use, and verbal interruptions affected communication between the physician and client. These results are also consistent with

both Ruusuvuori (2001) and Clarke & Ross (2005) who both found that isolated physical space was more conducive to a practitioner's ability to listen therapeutically. Barriers to listening can impede therapeutic listening and affect client perception of the treatment session. Therefore, it is important that OTs focus on reducing the number of interruptions during treatment sessions with clients to maximize productivity and client satisfaction.

Limitations

A number of limitations were presented within the data collection and analysis processes, many of which the researchers were neither able to predict or control. The most salient of limitations was the paucity of clinicians and client participants comfortable with being videotaped. As this research required consent of both client and OT, locating a combination of both willing to be videotaped proved to be the most difficult aspect of the research process. The small N of 5 participants evidences this truth, and prohibits researchers from generalizing the results to a larger body of OTs across the state or nation.

This lack of willing participants caused researchers to conduct the research across a variety of settings and with different populations. While this approach would provide meaning and validity to studies with a larger sample size, having 1-2 video recorded sessions per setting with a total of 3 settings further decreases the reliability and validity of this research. In one case, a client was identified as being willing to participate in the research, however it proved impossible because of a medical condition that caused his speech to be almost unintelligible. A limitation presented during the process of data analysis included the difficulty in achieving inter rater reliability due to the

subjectiveness of what was heard and seen by researchers on the video recording. This limitation was negated through the development of accepted definitions of the target listening behaviors. Further, the clinician's knowledge of being video recorded could have altered their performance from that of an organic nature to that described in the Hawthorne Effect as a change in participant behavior due to knowledge of their participation in a research study.

Participant age and years in practice may have influenced participation and performance, creating a division in the basic profile of the OT sample. One further limitation identified in this research was the confounding variable presented by any specialized training in listening or therapeutic communication the practitioner may have previously received. While researchers were able to ascertain the number of practitioners having received previous training in this area, researchers were unable to exclude such practitioners from participation due to the difficulty of locating a combination of therapist and client who were willing to be involved in such an undertaking. While the survey and background information collected from OT's acknowledges the truth that 20% of participants had received previous training, it remains unclear how this training influenced the data and analysis this research endeavored to undertake.

Throughout the data collection process, a number of barriers to listening were identified. For the purpose of this research, barriers to listening were accepted by the researchers as external events that distracted the occupational therapists from engaging in therapeutic listening during the treatment session. The most salient of distractions were: 1) cell phone ringing, 2) knock on the door, 3) background noise, and 4)

interruption. These distractions are delineated on the table below by frequency and mean occurrence per treatment session.

TABLE 1
Listening Behaviors of Occupational Therapists

	<i>Frequency observed</i>	<i>Mean occurrence per session</i>
Cell phone ringing	7	1.4
Knock on the door	1	.2
Background noise	1	.2
Equipment noises (beeping)	10	2
Other conversations taking place in treatment area	20	4
General interruption	17	3.4

For the purpose of quantifying the frequency of other's conversation interfering with the OTs' ability to listen, other's conversations lasting the length of the 5-minute videos observed received a tally for every 30 seconds. Thus, if the external conversation was 5 minutes in length, it received 10 tallies under that category. As noted on the above table, other conversations taking place in the treatment area accounted for the largest number of barriers to listening observed during treatment, followed by general interruptions (which included turning a cell phone off and talking to the camera). It follows that competing conversations accounted for the largest of barriers to listening, as OTs often treat clients in communal settings- such as therapy gyms or general treatment rooms. Clinical treatment sessions video recorded in communal therapy gyms where a minimum of 6 people were present in the general area accounted for 40% of the sessions videotaped for this research.

Implications for Practice

The results of this study also have implications for occupational therapy education programs and practitioners. Occupational therapy faculty and clinical instructors charged with teaching therapeutic listening will want to understand their student's prior knowledge and beliefs about listening as understanding these beliefs may influence curricula development in occupational therapy programs and in training prospective practitioners. Educators may want to differentiate specific listening skills needed for different treatment contexts. Evidence from this research highlights the function and importance of listening in the OT context. By conducting this research we may improve OT listening skills, which may further improve future treatment outcomes and client satisfaction.

Conclusion

The purpose of this research was to determine what listening behaviors occupational therapists used during clinical treatment sessions. Literature revealed that there are benefits of listening when used appropriately and effectively as well as negative consequences when performed ineffectively. There are various critical barriers to listening, which impede a positive outcome. Healthy People 2020 values listening as an essential skill practitioners must possess as it is directly related to client satisfaction (U.S. Department of Health and Human Services, 2011). Given the importance of listening, there is little research on this topic in occupational therapy. The purpose of this study was to increase the knowledge of OTs' listening behaviors in the healthcare context.

The results of this study are promising concerning listening behaviors used in the healthcare context. Our results indicated that OTs are using effective listening behaviors

in a clinical treatment session. The behaviors used further lead to client satisfaction and quality of care (Wanzer, Booth-Butterfield, and Gruber, 2004; Jonas-Simpson, Mitchell, Fisher, Jones, and Linscott, 2006; Harris and Templeton, 2001). Findings from the IJLCI may contribute to a wider body of knowledge concerning how OTs conceptualize listening and if there is a relationship between these listening beliefs and behaviors. Although we cannot generalize our findings to a wider OT audience our data can serve as a focal point in the research of OTs listening behaviors. Data found in this research and from similar studies in regards to listening in the healthcare context may influence the training of prospective OTs and curricula development in occupational therapy programs.

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APPENDICES

APPENDIX A



February 24, 2012

Andreanna Rodriquez

Dear Andreanna:

I have reviewed your proposal (An Analysis of Occupational Therapists' Listening Behaviors During Treatment Sessions) submitted to the Dominican University Institutional Review Board for the Protection of Human Subjects (IRBPHS Application, #9062). I am approving it as having met the requirements for a full board review.

In your final report or paper please indicate that your project was approved by the IRBPHS and indicate the identification number.

I wish you well in your very interesting research effort.

Sincerely,



Martha Nelson, Ph.D.
Chair, IRBPHS

cc: Janis Davis

Institutional Review Board for the Protection of Human Subjects

Office of the Associate Vice President for Academic Affairs 50 Acacia Avenue, San Rafael, California 95901-2298 415-485-3278
www.dominican.edu

APPENDIX B

Steven DeVilbiss
Andreanna Rodriquez
Maria Tolentino
Occupational Therapy
Dominican University of California
50 Acacia Avenue, San Rafael, CA 94903

DOMINICAN UNIVERSITY OF CALIFORNIA**CONSENT TO BE A RESEARCH SUBJECT**Purpose and Background

Steven DeVilbiss, Andreanna Rodriquez and Maria Tolentino, graduate students in the Dept. of Occupational Therapy at Dominican University of California, are conducting a research study to find out what listening behaviors occupational therapists are utilizing during clinical treatment sessions with their patients, and how these behaviors promote a therapeutic relationship.

Procedures

1. I will be asked to video record one or more clinical treatment sessions.
2. I will be asked to complete an anonymous survey, identifying concepts I see as being similar to listening.
3. I will be asked to respond to the question: "What listening behaviors do you believe to be vital in creating a positive therapeutic relationship?"

Risks and/or Discomforts

I understand that my participation involves no physical risk, but may involve some psychological or emotional discomfort, as I will be asked to disclose personal opinions and feelings in addition to being video recorded.

As I will be responding to questions that may be considered personal, I may refuse to answer any question that causes me distress or that I feel is an invasion upon my privacy. I may elect to stop the survey or video recording at any time and may refuse to participate before or after the study started, without any adverse effects.

Benefits

While there may be no direct benefit to me from participating in this study, I may gain insight in to what listening behaviors are effective during clinical treatment sessions; potentially leading to more effective therapeutic relationships between clients and myself.

Costs/Financial Considerations

There will be no cost to me for participating in this study.

Payment/Reimbursement

An incentive with the value of \$0 will be given to me for participating in this study.

Questions

I have talked to the researchers and/or Dr. Janis Davis about any questions I have and have obtained answers. I may call Dr. Janis Davis at (415-458-3788). If I have any questions or comments about participation in this study, I should first talk with the researchers. If for some reason I do not wish to do this, I may contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS Office by phone at (415-257-0168), or in writing at Office of Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

Consent

I have been given a copy of this consent form, signs and dated, to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to participate in the study, or to withdraw at any point.

My signature below indicates that I have read the research participant's bill of rights and agree to participate in this study.

Signature of Participant

Date

Steven DeVilbiss
Andreanna Rodriquez
Maria Tolentino
Occupational Therapy
Dominican University of California
50 Acacia Avenue, San Rafael, CA 94903

DOMINICAN UNIVERSITY OF CALIFORNIA

CONSENT TO BE A RESEARCH SUBJECT

Purpose and Background

Steven DeVilbiss, Andreanna Rodriquez and Maria Tolentino, graduate students in the Dept. of Occupational Therapy at Dominican University of California, are conducting a research study to find out what listening behaviors occupational therapists are utilizing during clinical treatment sessions with their patients, and how these behaviors promote a therapeutic relationship.

Procedures

1. I will allow one or more of my clinical treatment sessions with my occupational therapist to be video recorded.

Risks and/or Discomforts

I understand that my participation involves no physical risk, but may involve some psychological or emotional discomfort, as I will be asked to disclose personal opinions and feelings in addition to being video recorded.

As I will be responding to questions that may be considered personal, I may refuse to answer any question that causes me distress or that I feel is an invasion upon my privacy. I may elect to stop the survey or video recording at any time and may refuse to participate before or after the study started, without any adverse effects.

Benefits

While there may be no direct benefit to me from participating in this study, I may gain insight in to what listening behaviors are effective during clinical treatment sessions; potentially leading to more effective therapeutic relationships between clients and myself.

Costs/Financial Considerations

There will be no cost to me for participating in this study.

Payment/Reimbursement

An incentive with the value of \$0 will be given to me for participating in this study.

Questions

I have talked to the researchers and/or Dr. Janis Davis about any questions I have and have obtained answers. I may call Dr. Janis Davis at (415-458-3788). If I have any questions or comments about participation in this study, I should first talk with the

researchers. If for some reason I do not wish to do this, I may contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS Office by phone at (415-257-0168), or in writing at Office of Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

Consent

I have been given a copy of this consent form, signs and dated, to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to participate in the study, or to withdraw at any point.

My signature below indicates that I have read the research participant's bill of rights and agree to participate in this study.

Signature of Participant

Date

Audio and Video Consent Form
For Dissemination of Outcomes of Study

You have already agreed to participate in a research study entitled: *An Analysis of Occupational Therapists' Listening Behaviors During Treatment Sessions* by Dominican University Occupational Therapy students and thesis advisor, Janis Davis, PhD, OTR/L.

You have also agreed to allow us to audio and video-tape you as part of that research study. This consent form is to allow the researchers to use parts of the recording(s) when the results are disseminated to a larger audience such as professional occupational therapists or OT students by the thesis research team in the Occupational Therapy Department of Dominican University of California. The recording(s) will include images and voices of those recorded. All names used in the recording will be deleted before recording are heard or shown.

The recording(s) will be stored in a locked file cabinet and linked with a code to subjects' identity and will be retained for no longer than 3 years.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Signature of Participant

Date

Questions

I have talked to the researchers and/or Dr. Janis Davis about any questions I have and have obtained answers. I may call Dr. Janis Davis at (415-458-3788). If I have any questions or comments about participation in this study, I should first talk with the researchers. If for some reason I do not wish to do this, I may contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS Office by phone at (415-257-0168), or in writing at Office of Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

APPENDIX C

Verbal and Attending Listening Behaviors Tally Sheet

Technique	Minute 1 Tally	Minute 2 Tally	Minute 3 Tally	Minute 4 Tally	Minute 5 Tally	Row Total
Verbal Behaviors						
Minimal encouragers						
Summarizing						
Restating						
Reflecting						
Giving feedback						
Emotional labeling						
Probing						
Validation						
“I” Messages						
Redirecting						
Clarifying						
Perception checking						
Open-ended questions						
Closed Questions						
Commands						
Attending Behaviors						
Eye contact						
Leaning forward						
Gesture						
Head nodding						
Maintaining responsive facial expressions						
Touch						

APPENDIX D

Listening Behaviors Accepted Definitions**Verbal Behaviors**

Minimal encouragers: Effective prompts that ensure continued conversation: I.e.... “Oh?”, “Then?”, “And?”

Summarizing: Compiling together the facts and points of the problem to ensure understanding. I.e.... “So it sounds like . . .” Or, “Is that correct?”

Restating: Demonstrating the listener is following the conversation by repeating the important points of conversation back to the speaker by paraphrasing what the listener heard in their own words. I.e.... “Let’s see if I am clear about what you said. . .”

Reflecting: More than simply repeating, reflecting on the words in the terms of their feelings. I.e.... “This must be very important to you”.

Giving Feedback: When the listener informs the speaker what their initial thoughts are regarding the subject. Offering observation, experience and insight and then listening to ensure accuracy.

Emotional labeling: Putting the speaker’s feelings in to words. I.e.... “I get the idea you are feeling frustrated”

Probing: Asking the speaker additional questions to draw out meaningful information. I.e.... “Will you please tell me more about that?”

Validation: A general or specific acknowledgement of the speaker’s problems and feelings. I.e.... “I appreciate your willingness to talk about such a difficult subject”.

“I” Messages: A way of focusing on the problem, but not necessarily the speaker. I.e.... “I know that you want to share more, but we need to be moving on”

Redirecting: Shifting conversation topics when the speaker appears to become aggressive or otherwise monopolizes conversation in an inappropriate or irrelevant manner.

Clarifying: Bringing unclear information in to focus.

Perception checking: A request from the listener to the speaker to verify the perceptions of the listener.

Open-ended questions: Expanding a discussion through questions that begin with the following: How, What, Who, Where, Which?

Closed Questions: Questions that frequently prevent further conversations, leading to one-word responses. I.e.... “Did you have a good day?”

Command: To direct with authority; give orders to.

Attending Behaviors

Eye contact: Tallied from point of initial eye-to-eye contact with client until client or therapist breaks contact through turning head.

Leaning forward: Physically moving one’s body forward to any degree as a component of conversation, not in evaluating physical performance.

Gesture: The utilization of one’s hands as a component of expression in conversation.

Head nodding: Alerting the speaker the listener is attentive through intentional movements of the head.

Maintaining responsive facial expressions: Utilization of facial expressions during conversation, representing one’s attentiveness.

Touch: Utilization of the listener’s hands to physically touch client as a component of interaction and not for the purpose of improving physical performance.

APPENDIX E

LCI – 15

Listening is a rich and multifaceted concept and may be represented in various ways, e.g., depending on each individual's experience and culture. Since everybody has their own expertise in listening, the object of this questionnaire is to gain a survey of listening concepts.

Please answer the following questions:

My age: _____ I am Male Female My undergraduate degree _____

Check one: Caucasian Black Latino/a Pacific Islander Asian
Other _____

How long have you been practicing: -3 yrs. -6 yrs. -12 yrs. 2-more yrs.

Have you had specific training in communication: Yes No

If so, please indicate: _____

And now please consider the degree to which the following activities are similar to **listening**:
(Place an **X** in the appropriate box.)

	not at all similar	somewhat related	rather similar	almost identical	identical
1. Storing information					
2. Helping					
3. Learning					
4. Arguing					
5. Drawing conclusions					
6. Comforting					
7. Analyzing					
8. Being Critical					
9. Becoming Aware					
10. Bonding					
11. Interpreting					
12. Conceding					
13. Retaining Information					
14. Understanding					
15. Answering					

Question for participant:

What listening behaviors do you believe to be vital in creating a positive therapeutic relationship?

Thank you for completing this questionnaire.