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Article 17

**Pilot Study: The Impact of a Brief Motivational Interviewing Training
on a Measure of Participants' Empathy**

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Acknowledgement to the 2011 International Association of Addictions and Offenders Counseling (IAAOC) Research Grant.

Acknowledgement to Jodi Bills, who taught the MI class.

Becoming competent as a counselor is a complex process. Competence includes diverse knowledge, skills, abilities, and attitudes, uniquely integrated to "to perform a myriad of clinical tasks" (Spruill et al., 2004, p. 742.). A person-centered, facilitative style, offering empathy, unconditional regard, and genuine acceptance, is related to success in counseling and is part of an effective therapeutic alliance (Bodenhorn & Starkey, 2005; Greenberg, Watson, Elliot, & Bohart, 2001; Miller, 2000; Ohrt, Foster, Hutchinson, & Ieva, 2009). Ackerman and Hilsenroth (2003) completed a comprehensive literature review of practitioners' characteristics and found attributes such as enthusiasm, lucid communication, and empathy (warmth, helping, and understanding) positively impacting the therapeutic alliance. Research findings suggest that relationship factors in counseling correlate more highly with client outcome than do specialized treatment techniques (Norcross & Lambert, 2011). Lambert and Barley (2001) stated that "factors such as therapist credibility, skill, empathic understanding, and affirmation of the patient, along with the ability to engage the patient... direct the patient's attention to the affective experience [and] were highly related to successful treatment" (p. 358).

Given the importance of facilitative conditions for successful treatment outcomes, research that focuses on training in relationship skills is important for the counseling profession (Spruill et al., 2004). Continuing education for both novice practitioners and experienced professionals needs to emphasize all the factors related to enhancing the

therapeutic relationship (Lambert & Barley, 2001; Norcross, 2001). Training in empathy may enhance practitioners' abilities to adapt their response style to each client's experience. The ability to empathize with others is undeniably a valued attribute in our society (Rogers, Dziobek, Hassenstab, Wolf, & Convit, 2007). Even though empathy in counseling is important, counselor education training traditionally may focus more on external measurable and observable counseling skills rather than on the internal processes of empathy (Greason & Cashwell, 2009). This creates a potential gap in training due to an apparent absence of assessment and training in important internal empathy levels. Students will benefit by having the "affective experience of empathy considered necessary for the development of genuine empathy" (Greason & Cashwell, 2010, p. 5).

Research demonstrates that training can impact a counselor's ability to adapt their response style in accordance with each client's experience. Because Motivational Interviewing (MI) training supports empathy development, it seems reasonable to assume that a MI training experience might result in an increased level of empathy in the participants. Consequently, this pilot study was designed to investigate whether a brief MI training might impact participants' measured empathy levels. First, we briefly provide an overview of empathy and MI. Then, we describe our study in which we compared pre- and post-MI training participants' measured empathy levels.

Empathy

There are numerous ways to define empathy (Bodehnorn & Starkey, 2005). Empathy can refer to the reaction to the experiences observed in others (Davis, 1980). In addition, empathy can include both the cognitive ability to understand another's situation and the emotional ability to feel another's emotions (Cliffordson, 2002; Greason & Cashwell, 2009; Ohrt et al., 2009). Rogers (1980) defined empathy as the counselor's ability and willingness to understand a client's thoughts, feelings, and struggles from the perspective of the client. Clarke (2010) suggested that empathy includes subjective, interpersonal, and objective dimensions. For empathy to occur, a counselor needs to be emotionally present, authentic, connected, and moved by his or her clients' experiences (Ohrt et al., 2009). Recent research suggests that empathy may go beyond measurable external behaviors and also involve mirror neurons including "neuroanatomically based subprocesses" (p. 43) of *emotional simulation* (mirroring-limbic system), *perspective-taking* (prefrontal and temporal cortex), and *emotional-regulation* (ability to soothe; Elliott, Bohart, Watson, & Greenberg, 2011).

How empathy works in counseling is not clearly understood. The process could involve numerous factors such as being a relationship condition or offering an emotionally corrective experience. Nevertheless, higher levels of empathy are reported to enhance client's ability to think more productively and promote self-healing, global improvement, and client satisfaction (Greenberg et al., 2001). Empathy can enhance counseling outcomes; even a single empathetic counseling session has substantial impact (Miller, 2000). Although done many years ago, Chafetz et al. (1962) reported that after just one single empathetic counseling session, patients with alcohol problems were 10 times more likely to seek treatment, and 40 times as likely to stay in treatment compared

to those who did not have the empathetic encounter. When counselors understand their client's concerns, counseling outcomes are improved (Greenberg et al., 2001).

Empathy can be learned (Nicolai, Demmel, & Hagen, 2007); consequently, there is a need for counselor educators to develop creative means for teaching empathy (Bodenhorn & Starkey, 2005; Ohrt et al., 2009). Empathy development strategies can include perspective taking activities and expressive arts such as music, theater, and media. Carlozzi, Bull, Eells, and Hurlburt (1995) considered empathy a measure of affective sensitivity, found that it was positively related to creativity, and suggested that educational strategies that nurture creativity may help students to develop empathy. Greason and Cashwell (2009) reported that empathy may be related to mindfulness in that increased mindfulness training could positively impact empathy. Although there may not be a consensus about if and how empathy can be learned or taught, Motivational Interviewing (MI) includes empathy in both its approach and training.

Motivational Interviewing

Motivational Interviewing is described “as an empathic counseling approach to evoke change in individuals at early stages of readiness” (Miller, 2000, p. 9). Although the therapeutic style and alliance are a central focus of MI (Madson, Campbell, Barrett, Brondino, & Melchert, 2005), over the last 26 years, it has continued to evolve. Miller and Rollnick (2009) identified that MI is *not*:

- (1) the transtheoretical model of change;
- (2) a way of tricking people into doing what you want them to do;
- (3) a technique;
- (4) decisional balance;
- (5) assessment feedback;
- (6) cognitive-behavior therapy;
- (7) client-centered therapy;
- (8) easy to learn;
- (9) practice as usual; and
- (10) a panacea. (p. 129)

In fact, MI is “a collaborative, person-centered form of guiding to elicit and strengthen motivation for change” (Miller & Rollnick, 2009, p. 130). The therapeutic style of MI respects client's autonomy, is collaborative, and parallels client-centered counseling (Miller & Moyers, 2006). Ultimately, MI aims to provide a non judgmental and collaborative (person-centered) relationship with a client as well as express empathy, identify discrepancies, and encourage motivation (self-efficacy) to change (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).

Research supports MI as an evidence-based intervention (Ball et al., 2007; Hohman & Loughran, 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). In addition, MI is reported to be an effective approach to integrate into diverse challenges such as cardiovascular rehabilitation, diabetes management, hypertension, management of chronic mental disorders, problem drinking, gambling, smoking, and coexisting mental health and substance use disorders (Aston, 2005; Lundahl et al., 2010; Miller & Rose, 2009).

There are numerous goals included in a MI approach such as enhancing engagement, increasing intention to change through resolving ambivalence, and focusing on internal motivation and existing level of commitment (Hohman & Loughran, 2003; Lundahl et al., 2010). Even with the numerous MI strategies such as rolling with resistance and listening to change talk, empathy is considered a core condition and cited as necessary for success in MI interventions. What appears to be most important in impacting client's change in MI work is the counseling professional's ability to

empathize with a client, not the training background or technique (Lundahl et al., 2010; Miller, 2000). The therapeutic interpersonal skills with empathetic understanding, genuineness, and warmth support the spirit of MI and are what make it work (Moyers, Miller, & Hendrickson, 2005).

The origins of MI arose from counseling training. While measuring the impacts of a clinical trial of behavioral therapy for individuals with problem drinking, Miller trained nine practitioners in both behavioral and client-centered skills. Following the training completion and observing the interventions, the outcomes, which were not anticipated, indicated the counselor's level of empathy predicted two-thirds of the variance in client drinking 6 months later. Counselors' empathy was found to be more impactful on client change than behavioral interventions (Miller & Rose, 2009).

Although MI does include the skill of empathy with reflective listening, the training and practice involve a complex set of skills comparable to learning to play a musical instrument (Miller & Rollnick, 2009). Training in MI includes a number of procedural and technical processes such as using open-ended questions, summarizing, affirming, and eliciting self-motivational statements (change talk—to enable clients to argue for their own change). The procedural skills are considered important to its efficacy (Gaume, Gmel, Faouzi, & Daepfen, 2009; Miller & Rollnick, 2002). Both the technical and relational components of MI training are important; counseling research supports that a combination of specific technical and nonspecific relational components influence outcome (Miller & Rose, 2009).

There is considerable research investigating the impact of MI training on participants. Madson, Loignon, and Lane (2009) reviewed 27 studies of MI training and reported overall favorable results in the trainees evidenced by increased knowledge, interest in learning more, and intention to use. However, they did note that training could not guarantee the maintenance of skill acquisition over time. From their review, they stated they lacked sufficient information about the specific MI strategies used in training and lacked psychometrically validated measures of MI. Soderlund, Madson, Rubak, and Nilsen (2010) completed a systematic review of 10 studies that evaluated different aspects of MI training for use by general health care providers. They found too much diversity in MI training outcome measurements to assess the competencies of the clinicians and suggested the development of a consensus for how to measure clinical use of MI. Proficiency in MI may be gained through workshop training; however, additional training may be needed to retain skills over time (Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Madson et al. (2009) reported that no one has examined MI training in graduate mental health fields such as psychology or social work; thus, they proposed that graduate mental health training programs study MI training for future professionals. Because MI training includes empathy development, one result of a MI training experience might be increased levels of empathy measures.

The purpose of this study was to investigate the impact of MI training on empathy levels in participants in a single, 15-hour, two day MI workshop. This pilot study had one primary research question:

1. Will empathy levels increase in participants who complete a 15-hour, two day MI class?

Methodology

Participants

The population would be students enrolled in a single, 15-hour, two day, weekend MI training class who were either counselors-in-training or counselors-in-practice. The study sample consisted of students and counselors who agreed to complete an instrument that measured empathy both before and after the course.

Procedures

The study was approved by the Institutional Review Board (IRB). All of the potential participants were provided an informed consent and invited to complete a pre- and post-class empathy measure, the Interpersonal Reactivity Index (IRI; Davis, 1983a). Brief demographic and background information was requested and included age, gender, racial identification, educational level, degree specialization, and number of years working in the counseling profession.

The class was titled Motivational Interviewing and was a 1 credit hour course held on a weekend during a summer school session in a Rocky Mountain university setting. In the course description, MI was described as an evidence-based practice, focusing on increasing client intrinsic motivation through developing discrepancy and resolving ambivalence to increase the likelihood of instigating behavior change. The primary goal identified in the course syllabus was to provide students with a foundation of MI principles and core skills. The educational strategies included presentations, discussion, role playing, and small group decision-making, all designed to enhance the practical application of MI knowledge and skills to clinical work. The class instructor was a PhD level counseling graduate student who had completed extensive MI training and used MI in her counseling practice. Topics included the four key aspects of MI (empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy); core relationship skills (open-ended questions, affirmations, reflective listening, and summaries); change talk (desire, ability, reason, need, and commitment); and the phases of motivational interviewing (building motivation for change, strengthening commitment to change, and developing a plan). Stages of readiness (pre contemplation, contemplation, preparation, action, maintenance, and relapse) were reviewed and the major part of the class included practicing the MI aspects and skills. A more detailed description of the course materials can be provided by the primary author.

Instruments

The pre- and post-class empathy level changes were measured using the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983a, 1983b) instrument. Davis (1980) developed this self-report measure of empathy to reflect both cognitive and affective components of empathy. The cognitive measures include the Perspective Taking and Fantasy scales and the affective dimensions include Empathic Concern and Personal Distress scales. Davis viewed Perspective Taking and Empathic Concern as reflective of the most advanced levels of empathy. The IRI is a widely used measure of empathy (Beven, O'Brien-Malone, & Hall, 2004; Cliffordson, 2002; Greason & Cashwell, 2009).

More specifically, the IRI contains four 7-item subscales, each tapping a separate facet of empathy. The Perspective Taking scale measures the reported tendency to

spontaneously adopt the psychological point of view of others in everyday life. (e.g., “I sometimes try to understand my friends better by imagining how things look from their perspective”). Perspective Taking has been found to be related to measures of interpersonal functioning and social competence (Davis, 1983a). The Empathic Concern scale assesses the tendency to experience feelings of sympathy and compassion for unfortunate others (e.g., “I often have tender, concerned feelings for people less fortunate than me”). High Empathic Concern scores have been found associated with some shyness, social anxiety, emotionality, and a selfless concern for other people (Davis, 1983a). The Personal Distress scale measures the tendency to experience distress and discomfort in response to extreme distress in others (e.g., “Being in a tense emotional situation scares me”). High Personal Distress scores have been found associated with emotional vulnerability, fearfulness, poor interpersonal functioning, and lower self-esteem (Davis, 1983a). The Fantasy scale measures the tendency to imaginatively transpose oneself into fictional situations (e.g., “When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me”). Higher Fantasy scores have been found to correlate with a tendency to be more sensitive toward others and experience emotional reactivity (Davis, 1983a).

Significant reviews, evidence of adequate reliability, and uses of the IRI can be found in the literature (Beven et al., 2004; Cliffordson, 2002; Christopher, Owens, & Stecker, 1993; Davis, 1980, 1983a, 1983b; Greason & Cashwell, 2009; Rogers et al., 2007; Spraggins, Fox, & Carey, 1990). The IRI has been found to have adequate construct validity correlating with other measures of empathy (Davis, 1983b). Research has found internal consistency in reliabilities in the four subscales that range from .70 to .82 (Davis, 1980). In addition, measured over a 2-month time period, test-retest reliabilities range from .62 to .71 (Davis, 1980). Because of the small sample, reliability was not measured in this study.

Data Analysis

This was a single group pretest-posttest design and the data were analyzed using the IBM Statistical Program for Social Sciences (SPSS) version 19.0. This study used paired t-tests to measure for pre- and posttest differences and sub scale differences.

Results

A total of 15 participants completed the class and the pre- and posttest IRI. Of the 15 participants, four (27%) were counseling master’s students, two (13%) were counseling doctoral students, and eight (53%) were counselors-in-practice. In addition, one was in the nursing profession. Eight (53%) participants were female and seven (47%) were male, ranging from 25 to 71 years of age ($M=42.4$, $SD=15.2$). The majority of the participants identified as Caucasian ($n=11$), while only four indicated an ethnic minority status. The educational levels ranged from bachelor degree to PhD with degree specializations in social work, counselor education, nursing, public health, and psychology. The years of experience ranged from none (counselor-in-training) to 25 years ($M=8.4$, $SD=7.5$).

For the research question, inquiring if measured empathy levels might change following completion of MI training, there were no significant ($p < .05$) changes in measures on the pre- and posttests on all four subscales (See Table 1).

Discussion

The primary goal of this study was to assess the impact of MI training on empathy levels in participants from one MI training. This study did not provide empirical support for changes in empathy levels on any of the four subscale empathy areas of focus following completion of a 15-hour, two day MI workshop. Our findings were similar to the findings of Bodehnorn and Starkey (2005) who found no increase in empathy measures on the IRI following empathy training; however, they used theater training to enhance empathy. There may be a number of reasons for a lack of measured change in empathy in this study.

Table 1

Results from Pre- and Posttest IRI Scores: Means and Standard Deviations of Pre- and Postscores on the IRI

| Measure | Pre-score mean (standard deviation) | Post-score mean (standard deviation) | t-statistic | p-value |
|-----------------------------|---|--|-------------|---------|
| Fantasy scale | 3.15 (0.46) | 3.18 (0.48) | 0.32 | 0.751 |
| Perspective-taking scale | 2.49 (0.40) | 2.54 (0.36) | 1.10 | 0.288 |
| Empathetic concern scale | 2.72 (0.50) | 2.67 (0.59) | -1.05 | 0.313 |
| Personal distress scale | 1.74 (0.47) | 1.81 (0.72) | 0.72 | 0.482 |

Note. All scales are measured on the following scale: 0 = *does not describe me well* to 4 = *describes me very well*. N = 15. IRI = Interpersonal Reactivity Index. A p-value less than .05 is needed for significance.

Similar to the findings reported by Soderlund et al., 2010, the methodological integrity of this study may be significantly compromised due to a number of factors including the small sample size, lack of a control group, and assessing outcomes at a single point in time. Even with the lack of pre- and posttest significant changes in empathy measures, there are some considerations that may be of interest. It could be that empathy per se is not increased by MI training as much as a *reduction* in non-empathetic responses (confrontation). In their study on the impact of MI training on clinicians, Miller et al. (2004) reported changes were “not so much a substantial increase in MI-consistent responses (e.g., reflective listening), but rather, a reduction in MI-inconsistent responses (e.g., confrontation)” (p. 1059). Thus, a follow-up consideration would be to measure reductions of confrontational-type responses in MI training participants.

Training in MI can be variable; consequently, a single workshop might not truly represent the effects of MI training on empathy in helping professionals (Spraggins et al., 1990). Replication across a number of MI training experiences would provide more evidence if a MI training might impact on empathy measurements. An additional consideration is to include additional methods of measuring empathy such as qualitative

measures (Bodehnorn & Starkey, 2005), or alternative scales like the Affective Sensitivity Scale (Carlozzi et al., 1995).

The IRI may not measure empathy in counseling; instead, it may assess cognitive and affective empathic responses in everyday life, which may or may not be reflective in a counseling relationship (Greason & Cashwell, 2009). Consequently, counseling-related training, like MI, may not always be reflected in the empathy measures of the IRI. Research to measure the effects of MI training on empathy needs to be replicated because a responsibility of counselor educators is assist students to develop a successful therapeutic relationship with an ability to empathize (Bodehnorn & Starkey, 2005; Greason & Cashwell, 2009). If MI training were to be shown to enhance empathy, it could justify its inclusion in counselor training. Motivational Interviewing is a widespread and evidence-based practice; therefore, one study would be far too limiting to determine its impact on empathy.

Implications for Counselor Preparation

Results of this study need to be examined within the context of the limitations presented. Despite the limitations, researching both empathy and MI training is important. Empathy is an attribute that is reported to be related to effectiveness in counseling (Bodehnorn & Starkey, 2005; Ohrt et al., 2009; Rogers, 1980). Motivational Interviewing is widely used; consequently, outcome measurements of the impacts of training are needed (Soderlund et al., 2010).

Motivational Interviewing emphasizes empathy in its training and MI has been widespread in its effectiveness ranging from addictions to health problems (Lundahl et al., 2010; Madson et al., 2009; Miller & Rollnick, 2009). Traditionally, addictions counseling has used non-empathetic, confrontational styles such as persuading, non-listening, and directing (Miller & Mount, 2001). Empathy, regard, and acceptance were styles reserved for mental health interventions, not for addictions-related work. Research in the addictions field supports the use of MI (Ball et al., 2007; Lundahl et al., 2010). The therapeutic relationship is replacing the confrontational interventions with empathy, rolling with resistance, and working with ambivalence (Miller & Moyers, 2006). Empathy is an important therapeutic condition for all counseling training and training in MI may enhance empathetic skill development.

Future Research

Replicating this study is important as this was only a pilot study considerably limited by numerous factors such as the small sample size and single training. One training event may not be adequate to improve skill level and impact empathy. The efficacy in MI is enhanced over time, not by one training episode. Empathy improves when feedback and coaching are added to training (Miller & Rose, 2009; Miller et al., 2004). Replications could measure empathy over a longer time period. Research indicates that community-based counseling practitioners can learn to provide MI based interventions; however, variables such as the experience level, skill, adherence to the model, and training over time need to be included when evaluating the impact of any training (Ball et al., 2007; Miller & Rose, 2009). Perhaps a comparison study could measure the perceived empathy of counselors by clients of counselors who had received MI training and those who had not. The IRI may not adequately reflect empathy in

counseling. Alternative measures of empathy such as the Helpful Responses Questionnaire (HRQ; Miller et al., 2004) or the Rating Scales for the Assessment of Empathic Communication in Medical Interviews (REM; Nicolai et al., 2007) may provide alternative ways to evaluate if empathy changes. A future study might investigate whether counselors experience a reduction in confrontational interventions as an indication of gains made in MI training.

The ultimate goal of training is improved client outcomes; and research reports outcomes are enhanced with the engagement style of MI (Miller & Mount, 2001). Inclusion of client impact related to counselors' empathy levels would add an important justification for this area of research. Research on the impact of MI training on counseling practitioners needs to continue. MI is an intervention that will continue to be used by counseling practitioners in practice and counselor educators need empirical support to justify MI in training programs. Ongoing research regarding empathy and its sensitivity to change from MI training is needed. The benefits of raising the level of empathy in a counseling relationship are undisputed and worthy of our best efforts.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm