A Conceptualization of Therapeutic Communication: The WHAT Model

Gary Mihalyi Szirony, Walden University
and
Jason D. Kushner, University of Arkansas at Little Rock

Abstract

Communication forms a major component of the therapeutic process. With words serving as a primary medium, the process of communication during counseling or psychotherapy may be represented by the four-phase model presented the present study. In an effort to teach counseling technique, alleviate initial counseling session tension, as well as potentially increase counseling process efficacy and flow across theories, the WHAT Model is presented. In order to empirically test the viability of the WHAT Model in a therapeutic environment, Brief Counseling Self-Confidence Scale scores (BCSCS) were analyzed before and after presentation of the model to master's level pre-practicum students. Results of a paired samples *t*-test resulted in a significant difference found between groups, adding support for the model in improving scholarly productivity and counseling efficacy.

Keywords: Therapeutic Communication, Counselor Education, Communication Process, Communication, Counseling, Psychotherapy

A Conceptualization of Therapeutic Communication: The WHAT Model

The counseling process is built in large part upon effective psychotherapeutic communication. According to Wachtel (2003), “In the process of psychotherapy, words are our primary medium” (p. 3). In an effort to ameliorate symptoms, improve wellness, or act as a catalyst in the client or patient’s quest toward the achievement of a goal, to assist the client in finding a solution to a problem, or in the facilitation of movement toward a more fully functioning person, toward self-actualization, counseling involves group or individual interaction between client and counselor, with the helping relationship at the core (Capuzzi, Stauffer & Gross, 2016; Sommers-Flanagan, 2015). To facilitate growth, counseling and psychotherapy theories serve a common purpose of orienting therapists and other helping professionals with the common goal of helping people with psychological problems. The interaction between client/patient and therapist is fostered by a process of therapeutic interpersonal communication. Scharf (2012) offered this definition of psychotherapy and counseling:

> Psychotherapy and counseling are interactions between a therapist/counselor and one or more clients/patients. The purpose is to help the patient/client with problems that may have aspects that are related to disorders of thinking,

> emotional suffering, or problems of behavior. Therapists may use their knowledge of theory of personality and psychotherapy or counseling to help the patient/client improve functioning. (p. 4)

Because of the relative dearth of research on psychotherapeutic communication models and some confusion by students of counseling and psychotherapy when learning and first applying theory to the practice of counseling, the authors developed a simple yet comprehensive model of communication designed to guide students and professional practitioners through the process of counseling. The process of psychotherapeutic counseling can be thought of in terms of phases or stages of development beginning with building rapport through a process of active listening (Ingram & Robson, 2015; Rogers & Farson, 1957; Sommers-Flanagan, 2015). With a common goal of assisting clients/patients in working through issues, nonetheless, the helping relationship is built upon a process of effective therapeutic communication.

Common Factors, The Working Alliance, and Therapeutic Communication

Duncan, Miller, Wampold, and Hubble (2010), defined the role of common factors which can be identified as four principles that account for improvement in the process of effective therapy. Across a wide variety of theories, the salience of the therapeutic relationship remains a steadfast common factor. The working therapeutic alliance (also referred to as the therapeutic alliance or working alliance), appears frequently in the literature (Prever, 2015). The therapeutic relationship remains at the heart of counseling and psychotherapy. The client becomes a significant common factor. The therapeutic relationship, however, relies upon a process of interpersonal communication. Virtually all human interaction involves communication (Wachtel, 2011) and the communication process is embedded within and inextricably linked to counseling theory (Ivey, D'Andrea & Ivey, 2012). The therapeutic alliance, having its roots in psychoanalytic theory through transference (Prever, 2015), defines human interaction and refers to the relationship between counselor and client, and is considered to be a robust predictor of outcome (Cautin & Lilienfeld, 2015; Horvath, Del Re, Flückiger & Symonds, 2011; Knox & Cooper, 2015).

The working alliance can be described as an emotional bond between client/patient and therapist and is thought of as salient to nearly all forms of psychotherapy. The therapeutic working alliance, described by Bordin (1994), consists of three components; task, goal and bond. The therapeutic working alliance can be "…stated in forms generalizable to all psychotherapies" (Bordin, 1979, p. 253). According to Crits-Christoph et al. (2006), a positive therapeutic alliance is seen as crucial to counseling outcome efficacy, but not necessarily sufficient for therapeutic change. The authors suggest that counselors can be taught to improve in their abilities to build a therapeutic alliance with clients.

Therapeutic communication involves a process of watching or listening to the client, attending to the client's mood, affect, and tone, along with the content of the message, actively listening to what is said and what is not said, and, finally, acting as a

catalyst in the process of assisting the client in transcending beyond psychological and psychosocial blocks and issues in the process of therapeutic change. In nearly all theoretical counseling constructs, some combination of the aforementioned basic elements is necessary in order to facilitate building and maintaining a working alliance in order to help the client to affect therapeutic change (Corey, 2012; Ivey, D'Andrea & Ivey, 2012; Ivey, Ivey & Zalaquett, 2010; Kottler, 1991; Rogers, 1957; 1992; Truax & Carkhuff, 2008; Vacc & Loesch, 1994). Invariably, the counselor must, therefore, possess skills capable of delivering these above noted service components of effective observation, listening skills, attending skills, and, eventually, assisting the client in overcoming barriers in the process of change to a state of change favorable to the client. Building a strong and effective therapeutic alliance is often considered crucial to efficacious counseling outcome in most every counseling endeavor.

From the fusion of several theories, techniques, and approaches, four observable constructs may be common in the process of communicating, building rapport, and constructing a working alliance between counselor and client. Qualities attributable to counseling interaction include; (a) keen observation skills, (b) ability to listen carefully to what is being said and what is not being said, (c) genuine attention to the client's behavior, affect, and mood, and; (d) an ability to help the client take some form of action, move beyond barriers, or formulate intentionality, in an effort to make a transition beyond that which is blocking the client from progress. A framework such as the WHAT model may provide a technique of mindful awareness that would assist a counselor in learning about and improving counseling skills, as well as increasing the quality and depth of the relationship between client and counselor. In effect, the model may serve as a guide in moving through the counseling process in such a way that might be easier to remember and simpler to follow, thereby having the potential to improve counseling practice by gaining greater rapport, enhancing the flow of the counseling or psychotherapy process, and thereby expanding the therapeutic alliance through effective communication (Wachtel, 2011).

Anecdotal evidence exists for the viability of the WHAT Model. According to Szirony and Boden (2009), the WHAT Model showed evidence of improved communication in an adult education setting. Participants consisted of adult education graduate students at a mid-sized university in the Central United States. Following IRB approval, participants were informed of the voluntary nature of the study. The students who participated in the 2009 qualitative study were then exposed to the WHAT Model through conventional classroom lecture. Participants (N = 19) ranged in age from 27 to 56, with a mean age of 40.2. After a brief presentation explaining the components and practical application of the 4 elements of the model, the participants were then asked to complete a simple questionnaire. They were later interviewed about their thoughts about the model in relation to communications, peer learning factors, and perceptions of the WHAT Model. Data were transcribed and analyzed using the constant comparative method from which two themes emerged; *improved communication* and *peer learning*. Results supported the use of the WHAT Model as beneficial in a peer learning setting and to assist in improving communication, while helping to increase self-confidence and increase awareness of the communication process.

Ivey and Ivey (2010) emphasized what they referred to as the essential "Three V's + B," the Visuals, Vocals, Verbals, and Body Language - important in gaining trust and building rapport (p. 72). In the social milieu, interpersonal communication skills may be described as the ability to manage, encode and decode both verbal and nonverbal messages (Guerrero & Floyd, 2006). Interpersonal communication is often divided into two distinct tracts; verbal and nonverbal. Verbal messages rely more on symbols, such as words, and usually make use of a face to face interaction of vocal or aural processes. On the other hand, nonverbal or non-vocal communication involves gestures, posture, facial expressions, gaze, eye movement, and other such body language processes (Hargie, 2011).

Verbal and nonverbal communication. According to West and Turner (2010), nonverbal communication, sometimes referred to as the unspoken dialogue, encompasses all behavior other than the spoken word and can include what they label as body movement, facial expressions, personal space and touch, although the latter is rarely, if ever, applied or advised in a professional counseling setting. Nonverbal communication is an integral part of the communication process, communicating messages, and has what the authors refer to as 'shared meaning.' Specific to cultural aspects, nonverbal communication appears to be more universal than words alone. Guerrero and Floyd (2006) supported the importance of nonverbal communication, suggesting that between 60 and 65% of the meaning carried in a communication interchange is nonverbal. Some estimates suggest that body language accounts for about 55%, with 38% of the message being conveyed through nonverbal content and only about 7% of what is said verbally (Hargie, 2011). Foley and Gentile (2010) estimated the nonverbal component to convey between 60 and 65 percent of interpersonal communication. Nonverbal communication is, in and of itself, capable of displaying universal emotional characteristics, such as happiness, anger, sadness, and confusion.

The helping relation has been described as a dynamic process, constantly changing at both verbal and nonverbal levels (Capuzzi, Stauffer and Gross, 2016). To begin, information that transpires between and among people must be done through a process of communicating or intercommunicating, verbally, nonverbally, or a combination of the two (Thayer, 2003). According to Monaghan and Goodman (2007, p. 151), "Everything that is said must be said in some way." Everything said must be said in some tone of voice, some rate of speech, some intonation, some level of loudness, with some degree of pause or pacing. Verbal communication carries with it elements of pitch, tone, volume, rate of speech, accent and intonation. Verbal or vocal communication refers more to the content of what is said (Hargie, 2011; West & Turner, 2011). In the case of the WHAT Model (see figure 1), the aspect of most concern is the process of careful and applied listening, sometimes referred to as active listening or affective listening. Active listening is a key component in communication, is listed as one of 12 therapeutic skills (Ingram & Robson, 2015), is highly associated with counseling efficacy, and can be a salient factor in helping to form a therapeutic alliance (Bodie, Vickery, Cannava & Jones, 2015; Capuzzi, Stauffer & Gross, 2016; Gross & Capuzzi, 2011; Prever, 2015; Sommers-Flanagan, 2015).

Rogers (1992) argued for a fully functioning person. His premise was based upon the theory that the fully functioning individual seeks congruence between a sense of self and a sense of who they feel they should be; the ideal self. In his theory of psychotherapy, Rogers posited 3 necessary and sufficient conditions for interaction. Those conditions included genuineness, unconditional positive regard, and empathy. With those conditions in place, suggested Rogers, the counselor or psychotherapist can build rapport with the client and set the stage for growth and progress toward the fully functioning person. The three necessary and sufficient conditions presuppose a process of efficacy in therapeutic communication, with active listening proposed by Rogers and Farson (1957) as salient to the process.

In addition to verbal and nonverbal communication, the element of ecology influences communication. From a Gestalt perspective (Perls, 1969; Perls, Hefferline & Goodman, 1994; Scharf, 2012), the organism and the environment form an inextricable figure/ground relationship, combining to form a "gestalt." The setting, including the environment, level of light, source of light, temperature, noise level, positional arrangement of the individuals communicating, and comfort level of the seating or standing arrangement come into play. Even the position of chairs, tables, windows, doors and background may have an effect upon the communication process. The interchange between and among individuals, particularly in a counseling setting, is thought to be a complementary process, inextricably linked.

The WHAT Model

Four common constructs (elements) of effective psychotherapeutic communication process can be presented as the ability or skill set necessary to watch, hear, attend, and transcend, in that order. These four elements might be organized into the convenient acronym, WHAT." (see figure 1)

Figure 1.
A Model of Therapeutic Communication Process and Flow: The WHAT Model

The first three elements of the model, watching, hearing and attending, contain aspects of communication skills that are commonly employed in the process of counseling and psychotherapeutic intervention.

Watch. Effective counselors and psychotherapists learn to observe eye contact, affect, and body language of the client (Lee & Hallberg, 1982). Counselors look at, sense or observe (for counselors with visual impairments) skin flush, muscle tone and rigidity, areas of tightness in the face or other areas, subtle movements, posture, breathing, hand and arm placement, crossed legs, and eye movement. Counselors watch carefully for nervousness or relaxation and, especially, the congruence of the client as they speak. The counselor begins to match postural manifestations, facial expression, and breathing rate. This is a simple and effective method of building rapport with the client and necessarily the first step toward building a trusting relationship as expeditiously as possible (Wake, 2010). It is also a simple way to gather information about the person, sometimes within the first seconds or minutes of interaction.

Eye movement has been linked to variances in personality. Matsumoto, Shibata, Seiji, Mori, and Shioe (2010) examined eye movement in comparison with personality variables as measured by the Revised NEO-PI developed by Costa and McCrae. The Five-Factor NEO-PI-R measures five personality variables: neuroticism, extraversion, openness, agreeability and conscientiousness. Through path analysis that examined physiological responses such as where the eye stops on an image, how long the eye remains fixated on an object, speed of eye movement, and number of blinks, and relating certain of these types of eye movements, that there may be a connection between eye movement and aspects of personality. Eye movement may also give a clue as to the processing modality of the client (Bandler & Grinder, 1981).

In a similar vein, eye motion can be illustrated through Eye Movement Desensitization and Reprocessing (EMDR). EMDR has been established empirically and has been linked to neurological processes via neuroimaging in the anterior cingulate cortex of the brain (Chemtob, Tolin, van der Kolk & Pitman, 2000; Kaye, 2007; Shapiro, 2001). Through her research, Shapiro (2001) noted that when processing disturbing thoughts, eyes tended to move rapidly. Additional insight has linked eye movement during EMDR to dream state REM, rapid eye movement (Kuiken, Chudleigh & Racher, 2010).

Hear. Listening, according to Nichols (2010) is crucial to successful relationships, describing active listening as a powerful force in our lives. Listening, according to Nichols, has two purposes; taking in information and bearing witness to another's experience. Competent counselors listen carefully to the language, phraseology, and verbal expression of the client (Wachtel, 2011). The first words out of the client's mouth can be among the most important (Savickas, 1991). Integral to the Microskills Hierarchy, several stages of the process fall within the Basic Listening Sequence (Ivey, et al., 2012; Ivey, et al., 2010). Asking open ended questions, client observation skills, encouraging, paraphrasing and summarization, and reflection of

feeling, sometimes reflecting feeling with associated meaning, fall with this section of the Hierarchy. In addition, basic attending skills involve vocal qualities and verbal tracking skills.

Tone of voice, volume, speech rate, and timbre are heard. Hearing or interpreting what the client is really saying (or perhaps not saying) is also a key to this second area of counseling skill. Listening for key words, repeating patterns and separating the significant from the trivial is part of this process and is also necessarily the next component, following *watching* the client closely. Listening (or for hearing impaired or hearing limited counselors, interpreting), like watching, can help the counselor build rapport and demonstrates genuineness toward the client. Listening for key words may also give indication of thought access modality; When words like “see" or “look" occur in the client’s vernacular, the client may be in a visual frame of reference, whereas words like “hear" or “listen" may place the client in the auditory mode. I “feel" not only places the person in the kinesthetic mode, but also indicates access to a deeper more meaningful “feeling" point of reference (Bandler & Grinder, 1982; Ivey, et al., 2010). If these words match what the counselor observes, mental access mode may be verified, or at the very least, offer a clue as to the client process. Matching the client in these channels and mirroring the volume, timbre, rate of speech, and tone of voice also help to build rapport more quickly and easily, while helping to guide the counselor into good communication skills necessary for attending to the client. It is incumbent upon the counselor to follow the lead of the client, using the same modes of access, at least at this early stage of interaction (Bandler & Grinder, 1982). By doing so, rapport may be increased between counselor and client or between the message sender and receiver (Lakens & Stel, 2011).

Verbal tracking is described by Ivey, et al. (2010) as engaging what they referred to as the, “…full elaboration of the narrative” (p. 74). Listening carefully requires verbal tracking in order to increase rapport and to gain a clearer understanding of the client narrative as presented and at the same time, paying close attention to what is not being said. During the process, the counselor may revise or refine perceptions, reexamine irrational beliefs within the client story, and go through changes in the process of counseling based on a clearer perception of the cultural aspects of the client/patient (Scharf, 2012). This skill necessarily precedes the next steps in the WHAT Model, because having a clear and stable understanding of the client’s perspective can help the process evolve. Jumping to any conclusion without a clear understanding of the problem is counterproductive. Paraphrasing Ivey, et al. (2010), listen first, listen last and listen always.

Attend. Attending skills are important counseling microskills and are basic to the communication process (Ivey, D’Andrea & Ivey, 2012; Ivey, et al., 2010). Attending skills precede the fourth and last element of the WHAT Model, transcending beyond issues and problems. Because the client story is a main concern for counselors, paying close attention to the story becomes a salient function. Following *watching* and *hearing*, the counselor then attends to each unique and diverse client in a culturally appropriate manner that is specific to the individualistic nature of each unique person. Use of minimal encouragers, attending summaries, feedback, reflection of feeling and meaning,

questions, careful use of confrontation, and other such techniques bring the client and counselor even closer, building trust and rapport in the working alliance, demonstrating positive regard and empathy (Rogers & Farson, 1957; Rogers, 1992), and helping to draw out the significant thought, affect and emotion of the client.

The therapeutic alliance is considered to be an important goal in counseling interaction. The tenor of that alliance and the climate of the relationship, according to Wachtel (2011), is powerfully shaped by reciprocal interchanges of the words and phrases used in that process. The subtle nuances that are observed during the communication interchange, albeit not well understood, form a substantial contribution to the interchange that ensues during the process of counseling. Ivey, et al. (2012) noted that counseling students are trained to use various counseling theories in an effort to better understand how clients construct meaning in their lives. Virtually all counseling theories assume a significant contact between client and counselor. The increased quality of the dialog and working alliance are achieved by striving to gain a better understanding of the client's worldview. Communication skills are fundamental to all counseling theories (Ivey, et al., 2012). In the process of psychotherapy, words are the primary medium. What is said by the client and, conversely, what the counselor says to the client are salient to the outcome of the experience and understanding the communication process is described as substantial (Wachtel, 2011). The process of therapeutic communication is reciprocal. Attending to the client and to the process of communication that transpires between client and counselor are important skills that are outlined in the microskills hierarchy (Ivey, et al., 2012), of which a large part can be factored into the therapeutic counseling communication process itself.

As we continue to better understand neural networks and their relationship to human behavior, the consideration that listening skills and empathy may be linked to neuronal plasticity adds evidence to the importance of effective listening and attending skills. The process of watching, listening, and attending, what Ivey, et al., (2012) referred to as the basic listening sequence, are noted as vital in the communication of empathy, one of the necessary and sufficient conditions commonly associated with counseling outcomes and therapeutic change (Rogers, 1992). In addition, as mentioned earlier, Ivey and Ivey (2010) posited the Three v's + B, concept. Visuals, Vocals, Verbals, and Body Language, which comprise four components essential in gaining trust and building rapport with clients.

Transcend. Finally, the counselor assists the client in taking action, whatever form that may take, or at least helping the client in determining the client's intent to set goals or take action, mental or physical. The term, "transcend," means to go beyond - beyond limitations, to rise above, or to exceed. According to the Oxford English Dictionary (2017), to transcend is to go beyond or rise above, or to be greater than. With the counselor as catalyst, the client moves beyond limitations, at his or her own pace, from an external to an internal frame of reference, an internal locus of control (Rotter, 1954), to transacting adult to adult (Berne, 1964) or moving through developmental stages in which one may be "stuck" (Erikson, 1968; Wilber, 2000). Movement toward a more actualizing state of being (Maslow, 1968; Rogers, 1992) may be viewed as

transcendent. Goals are set (Glasser, 1965; Wubbolding & Brickell, 2017) by the client, with assistance from (but not by) the counselor, for the purpose of transcending (e.g., rising above, reaching toward movement, seeking a state of homeostasis, taking an integral view of reality (Wilber, 2000), or breaking through barriers, countering ambivalence, etc., rather than remaining stuck or imbalanced in state. Behaviors, awareness, or cognitions that run counter to the best interest of the client create a conflict. Interruptions in awareness (Perls, 1969) are identified and dealt with through psychodrama, hot seats, role play, homework and many other such Gestalt experiments. Irrational thoughts are noted and disputed (Ellis & Harper, 1961). Bibliotherapies (Miller, 1991) are suggested and instructions are relayed. Storytelling, narratives, and early childhood memories are investigated in search of 'miracles' and solutions (Ansbacher & Ansbacher, 1956; De Shazer & Berg, 1992; Corey, 2012; White, 1995). Dreams are interpreted, fears are desensitized (Beck & Emery, 1985), repressed memories are psychoanalyzed, and events hidden from consciousness are hypnotically uncovered. Situations of ambivalence and reluctance to move in the direction toward which the client intends to move are addressed through Motivational Interviewing (Miller & Rollnick, 2012).

Deep process therapies such as mindfulness are increasing in popularity and are included as called for by the client's needs (Stauffer & Perhsson, 2012). Transpersonal theory, although thought to be controversial in recent past, is gaining recognition in the literature. Grof (2008) extended the concept of self-actualization to the transcendent capacity of the individual. Recreation, art, dance, or music therapies can also be utilized as counseling techniques, as can animal or hippotherapy. Treatment approaches are considered in the client's best interest and with minimal countertransference. Techniques and styles match the particular needs of the client, not the counselor, just as medications are best prescribed to the specific needs of the patient, not to those of the physician**.**

The WHAT Model

With an emphasis on therapeutic communication, The WHAT Model, by its very nature, tends toward transcendence as well as integration of theory and practice. The four areas of the model may be used to alert the counseling student or the experienced counselor to the need to remain focused on the client, by: (a) maintaining eye contact; (b) observing the physical and nonverbal aspects of the client; (c) listening carefully, attending to the client as an individual; and (d) acting as a catalyst in the process of transcending above and beyond the issues and barriers that may be holding the individual back from attaining and achieving what the client desires from the interaction, and help in the process of moving past the ambivalence that often accompanies that process (Miller & Rollnick, 2012). *WHAT* does the client want? *WHAT* do I do first? *WHAT* do I do next? *WHAT do I do now?* In order to address these questions, to aid in the process of teaching counseling, and to assist in the process of counseling, and particularly through the integration of theories and techniques, the WHAT model was preliminarily analyzed.

Method

Population/Sample Selection

In order to address the needs of counseling and psychotherapy students and to provide a simple model to follow in the process of counseling, the WHAT Model was taught to voluntary groups of students taking a pre-practicum course in counseling techniques. A pre-post-test design was used using the Brief Counseling Self-Confidence Scale (BCSCS; See addendum) to determine if an increase in pre-practicum student self-confidence was noted after being trained on the WHAT Model. Results were computed through statistical analysis in an effort to empirically derive support for the use of the model.

Upon approval by the university IRB, students enrolled in a master's level pre-practicum counseling techniques course in a medium sized university in the central United States were recruited and informed of the study. Consent forms were distributed and students were duly informed of their voluntary participation and right to not participate. No outside funding was used in this study. All participants did so voluntarily and results remained anonymous as no identifying information was collected during the study.

Instrumentation

To test one aspect of the efficacy and usefulness of the model, a brief questionnaire was designed to address counselor self-confidence. The specifically designed instrument, which was titled, the Brief Counselor Self-Confidence Scale (BCSCS), consisted of 20 items. A Cronbach's alpha (N = 42) resulted in an alpha level of .90 (see table 1).

Table 1.
Cronbach's Alpha

Reliability Statistics

Cronbach's Alpha	N of Items
.904	20

Analysis

In order to examine the efficacy of the WHAT Model, counseling students in a counseling techniques central US university were first given the BCSCS to determine a baseline of counselor self-confidence prior to learning about the WHAT Model. After completing the pre-test BCSCS, students were exposed to the model and provided with approximately one hour of training on the four elements of the model. Upon completion of the 1-hour teaching and demonstration delivered by an experienced counselor educator, the post-test was administered.

A paired samples *t*-test was computed in SPSS (v. 21) to determine if a significant difference between groups could be found.

Results

Results of a pre- post-test design using a paired samples *t*-test ($N = 21$) indicated a significant difference ($t = 5.65$, $p < .001$) between pre- and post-intervention groups (see table 2).

Table 2.
Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pair1	3.2262	21	.43232	.09434
	Pair2	3.7500	21	.40311	.08797

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Dev	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pair1 - Pair2	-.52381	.42504	.09275	-.71728	-.33034	-5.648	20	.000

An effect size in the medium range ($\eta^2 = .61$) was found between groups. Statistical analysis following administration of the BCSCS resulted in a significant difference between pre- and post-intervention groups with a meaningful effect size supporting promise in the WHAT Model as a tool that might help individuals in gaining confidence in following a therapeutic basic cycle of communication.

Discussion

Although a significant difference in scores was noted, maturation effects and confounding variables could have contributed to the variation in the *t*-test results of the WHAT Model intervention. Confounding variables such as maturation and pre-post-test practice interference might have had an effect. However, based on the research design, intended to serve as a preliminary analysis, a convenience sample was utilized in this study. A randomized control group compared to a test group would be recommended as a future or follow-up study.

Conclusion

Consideration of eclecticism (Shostrum, 1976) or, from a different perspective, the integration of theories (Corey, 2012), a creative synthesis in the theory, process and practice of psychotherapy, may suit the WHAT Model. Adapting the counseling system to the client enhances the practice of counseling. Ericksonian techniques of first getting on the client's appropriate developmental level (Lankton & Lankton, 1983; Wake, 2010) is an effective technique for building rapport rapidly with the client, resulting in a greater

perception of a trusting and safe environment. Matching the posture, mood, and attitude of the client and simply listening for key words and repeating patterns captures the essence of whole individuality. Considering the whole person involves a positive asset search of past fortune in love, work, and play (Adler, 1917; Savickas, 1993), or put another way, love, work, fun, and freedom (Glasser, 1965). Watching and listening to the client are essential steps toward building rapport, and necessarily, building a therapeutic relationship between client and counselor or therapist.

Results of a paired samples *t*-test conducted by the authors of this study for the purpose of comparing the means between groups tested showed significant differences between groups. The Brief Counselor Self-Confidence Scale, which was designed to collect the data, resulted in an acceptable level of reliability although more research is needed in better norming the BCSCS. Although a more robust design would help to reduce threats to reliability and validity, the results of this preliminary analysis were promising. Students, based on a previous qualitative study, overwhelmingly found the model to be useful (Szirony & Boden, 2009).

Many counseling theories and techniques of practical applications involve in some fashion the four steps posited by the WHAT Model; Watch, Hear, Attend, and Transcend. The results of this study illustrated the WHAT Model appeared to provide a method of alleviating some stress, increasing confidence, and improving counseling outcomes for new or experienced counselors although further examination and robust empirical testing of the model is needed. Furthermore, additional empirically oriented research is suggested in assessing the attitudes of counselors presented with this technique and in the pre- and post-test assessment of a counselor training group versus a control group. Nonetheless, application of the model may be helpful in teaching counseling skills, application of counseling, and in a wider variety of general communication settings where therapeutic processes are of value in eliciting change. The WHAT Model may have implications beyond that of counseling and psychotherapy. The fields of education, marketing, law, nursing and medicine might also find benefit in the process of improved interpersonal communication.

References

Adler, A. (1917). *The neurotic constitution: Outlines of a comparative individualistic psychology and psychotherapy*. New York: Moffatt, Yard, & Co.

Ansbacher, H. L., & Ansbacher, R. R. (1956). *The individual psychology of Alfred Adler*. New York: Basic Books.

Bandler, R., & Grinder, J. (1982). *The structure of magic: A book about language and therapy.* Palo Alto, CA: Science and Behavior Books.

Beck, A., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

Berne, E. (1964). *Games people play: The psychology of relationships*. New York: Grove Press.

Bodie, G. D., Vickery, A. J., Cannava, K., & Jones, S. M. (2015). The role of "active listening" in informal helping conversations: Impact on perceptions of listener helpfulness, sensitivity, and supportiveness and discloser emotional improvement. *Western Journal of Communication, 79*(2), 151-173. https://experts.umn.edu/en/publications/the-role-of-active-listening-in-informal-helping-conversations-im

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-267.

Borden, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L.S. Greenberg (Eds.), *The working alliance* (pp. 13-37). New York: Wiley.

Gross, D. R., & Capuzzi, D. (2011). Helping relationships: From core dimensions to brief approaches. In D. Capuzzi & D. R. Gross (Eds.), *Counseling and psychotherapy: Theories and interventions* (5th ed.) (pp. 3-28). Hoboken, NJ: John Wiley & Sons.

Capuzzi, D., Stauffer, M. D., & Gross, D. R. (2016). The helping relationship: From core dimensions to brief and integrative possibilities. In D. Capuzzi & M. D. Stauffer (Eds.), *Counseling and Psychotherapy: Theories and Interventions* (6th ed.) (pp. 3 – 72). Alexandria, VA: American Counseling Association.

Capuzzi, D., & Stauffer, M. D. (2012). *Career counseling: Foundations, perspectives and applications* (2nd ed.). New York: Routledge.

Cautin, R. L., & Lilienfeld, S. O. (2015). *Encyclopedia of clinical psychology*. Malden, MA: John Wiley and Sons.

Chemtob, C. M., Tolin, D. F., van der Kolk, B. A., & Pitman, R. K. (2000). Eye movement desensitization and reprocessing. In E. B. Foa & T. M. Keane (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 333– 335). New York: Guilford Press.

Corey, G. (2012). *Theory and practice of counseling and psychotherapy* (9th ed.). Belmont, CA: Brooks/Cole.

Corsini, R. J., & Wedding, D. (2014). *Current Psychotherapies* (10th ed.). Belmond, CA: Thompson Brooks Cole.

Crits-Christoph, P., Gibbons, M. B. C., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research, 16*(3), 268-281. http://psycnet.apa.org/record/2006-07980-002

Duncan, B. L., & Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy.* Washington, DC, American Psychological Association.

De Shazer, S., & Berg, I. K. (1992). Doing therapy: A post-structural re-vision. *Journal of Marital & Family Therapy, 18*(1), 71-81. doi: 10.1111/j.1752-0606.1992.tb00916.x

Ellis, A., & Harper, R. A. (1961). *A guide to rational living,* Englewood Cliffs, NJ: Prentice-Hall.

Erikson, E. (1968). *Identity, youth and crisis.* New York: Norton.

Foley, G. N., & Gentile, J. P. (2010). Nonverbal communication in psychotherapy. *Psychiatry, 7*(6), 38-44. https://www.ncbi.nlm.nih.gov/pubmed/20622944

Glasser, W. (1965). *Reality therapy: A new approach to psychiatry*. New York: Harper & Row.

Grof, S. (2008). A brief history of transpersonal psychology. *International Journal of Transpersonal Studies, 27*(2008), 27-54.

Guerrero, L. K., & Floyd, K. (2006). *Nonverbal communication in close relationships.* Mahwah, NJ: Lawrence Erlbaum.

Hargie, O. (2011). *Skilled interpersonal communication: Research, theory and practice* (5th ed.). New York: Routledge.

Holland, J. L. (1985). *Making vocational choices.* Englewood Cliffs, NJ: Prentice-Hall.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. https://www.ncbi.nlm.nih.gov/pubmed/21401269

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2010). *Essentials of intentional interviewing: Counseling in a multicultural world*. Belmont, CA: Brooks-Cole.

Ivey, A. E., D'Andrea, M. J., & Ivey, M. B., (2012). *Theories of counseling and psychotherapy: A multicultural perspective* (7th ed.). Thousand Oaks, CA: Sage.

Ingram, S., & Robson, M. (2015). Therapeutic skills. In Pattison, S., Robson, M., & Beynon, A. (Eds.), *The handbook of counselling children & young people* (pp. 183-195). Thousand Oaks, CA: Sage.

Kaye, B. (2007). Reversing reciprocal suppression in the anterior cingulate cortex: A hypothetical model to explain EMDR effectiveness. *Journal of EMDR Practice and Research, 1*(2), 88-99. doi:10.1891/1933-3196.1.2.88

Knox, R., & Cooper, M. (2015). *The therapeutic relationship in counselling and psychotherapy.* Thousand Oaks, CA: Sage.

Kuiken, D., Chudleigh, M., & Racher, D. (2010). Bilateral eye movements, attentional flexibility and metaphor comprehension: The substrate of REM dreaming? *Dreaming, 20*(4), 227-247. doi: 10.1037/a0020841

Kottler, J. A. (1991). *The compleat therapist.* San Francisco: Jossey-Bass.

Lakens, D., & Stel, M. (2011). If they move in sync, they must feel in sync: Movement synchrony leads to attributions of rapport and entitativity. *Social Cognition, 29*(1), 1–14. http://guilfordjournals.com/doi/abs/10.1521/soco.2011.29.1.1

Lankton, S. R., & Lankton, C. H. (1983). *The answer within: A clinical framework of Ericksonian Hypnotherapy.* New York: Brunner/Mazel.

Lee, D. Y., & Hallberg, E. T. (1982). Nonverbal behaviors of “good" and “poor" counselors. *Journal of Counseling Psychology, 24*(4), 414-417. http://psycnet.apa.org/record/1982-33395-001

Maslow, A. H. (1968). *Toward a Psychology of Being* (2nd. ed.). New York: Van Nostrand.

Matsumoto, K., Shibata, S., Seiji, S., Mori, C., & Shioe, K. (2010). Factors influencing the processing of visual information from non-verbal communications. *Psychiatry & Clinical Neurosciences, 64*(3), 299-308. doi:10.1111/j.1440-1819.2010.02077.x

Miller, J. B. (1991). *Toward a new psychology of women* (2nd ed.). Boston, MA: Beacon.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

Nichols, M. P. (2009). *The lost art of listening: How learning to listen can improve relationships* (2nd ed.). New York: Guilford.

Perls, F. S. (1969). *Gestalt therapy verbatim*, Palo Alto, CA: Real People Press.

Perls, F., Hefferline, R., & Goodman, P. (1994). *Gestalt therapy: Excitement and growth in the human personality*, Highland, NY: Gestalt Journal Press.

Prever, M. (2015). The therapeutic alliance and counseling process. In S. Pattison, M. Robson, & A. Beynon (Eds.), *The handbook of counselling children & young people* (pp. 170-182). Thousand Oaks, CA: Sage.

Rogers, C. R. (1951). *Client-centered therapy.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person: A therapist’s view of psychotherapy*. New York: Houghton Mifflin.

Rogers, C. R. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 60*(6), 827-832. https://www.ncbi.nlm.nih.gov/pubmed/22122245

Rogers, C. R., & Farson, R. E. (1957). *Active listening*, Chicago, IL: Industrial Relations Center of the University of Chicago.

Rotter, J. B. (1954). S*ocial learning and clinical psychology.* Englewood Cliffs, NJ: Prentice-Hall.

Shostrom, E. (1976). *Actualizing therapy: Foundations for a scientific ethic.* San Diego: Edits.

Savickas, M. L. (1991). The meaning of work and love: Career issues and interventions. *Career Development Quarterly, 39*(4), 315-324. http://onlinelibrary.wiley.com/doi/10.1002/j.2161-0045.1991.tb00299.x/abstract

Scharf, R. S. (2012). *Theories of psychotherapy & counseling: Concepts and cases* (5th ed.). Belmont, CA: Brooks/Cole.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford Press.

Sommers-Flanagan, J. (2015). Evidence-based relationship practice: Enhancing counselor competence. *Journal of Mental Health Counseling, 37*(2), 95-108. http://amhcajournal.org/doi/abs/10.17744/mehc.37.2.g13472044600588r?code=amhc-site

Stauffer, M. D., & Pehrsson, D. E. (2012). Mindfulness competencies for counselors and psychotherapists. *Journal of Mental Health Counseling, 34*(3), 227-239. https://doi.org/10.17744/mehc.34.3.208547m4p2010308

Szirony, G. M., & Boden, C. J. (2009). WHAT model in a graduate adult education setting: Improving communication and peer learning. *The International Forum of Teaching and Studies, 5*(1), 5-13. http://scholarspress.us/journals/IFST/journal_previous_issues.php

Thayer, L. (2003). Communication: Sine qua non of the behavioral sciences. In R.W. Budd & B.D. Ruben (Eds.), *Interdisciplinary approaches to human communication* (2nd ed., pp. 7-31). New Brunswick, NJ: Transaction.

Transcend (2017). In *Cambridge English dictionary online* (7th ed.). Retrieved from http://dictionary.cambridge.org/us/dictionary/english/transcend

Vacc, M. A., & Loesch, L. C. (1994). *A professional orientation to counseling.* Muncie, IN: Accelerated Development.

Truax, C. B., & Carkhuff, R. (2008). *Toward effective counseling and psychotherapy: Training and practice.* Piscataway, NJ: Transaction.

Tudor, K., & Worrall, M. (1994). Congruence reconsidered. *British Journal of Guidance & Counselling, 22*(2), 197-206. http://www.tandfonline.com/doi/abs/10.1080/03069889408260314

Wachtel, P. (2011). *Therapeutic communication: Knowing what to say when* (2nd ed.). New York: Guilford.

West, R., & Turner, L. H. (2010). *Understanding interpersonal communication: Making choices in changing times.* Boston, MA: Wadsworth Cengage.

White, M. (1995). *Re-authoring lives,* Adelaide, South Australia, Dulwich Centre Publications.

Wilber, K. (2000). *A theory of everything*. Boston: Shambhala.

Wubbolding, R., & Brickell, J. (2017). *Counselling with reality therapy* (2nd Ed.). New York: Routledge.

***Counseling: WHAT* Matters**

A simple guide to therapeutic communication...

WHAT is a simple acronym that may help you as a counselor through those stressful initial counseling sessions. At any time during the process, recall the word, **WHAT**, meaning Watch, Hear, Attend and Transcend, the process followed in sequence in most successful counseling endeavors. Take a deep breath, relax and remember, **WHAT"** to do!

Watch the eyes of your client. Watch their body posture, their lean, movements, and affect. Subtly match their posture.

Hear your client's words and intonations. Hear what they are saying and not saying. Listen for real meaning and feeling words. Subtly, match their tone, rate of speech. Separate the significant from the trivial in what your client is saying. Does what you ***Hear*** match what you ***Watch***?

Attend Attend to your client with attending skills: verbal and nonverbal minimal encouragers, summaries, reflection of feeling and meaning, ask one question at a time. Find patterns in your clients' thoughts and behaviours. Carefully challenge contradictions in what you hear or in word/affect incongruence using open-ended questions and reflection.

Transcend through unconditional positive regard, cognitive restructuring, homework, imagery, or whatever technique or techniques, guided by theory, that work best for your unique, diverse client. Act as a catalyst in assisting your clients in reaching goals that work for them. Help your clients ***Transcend*** beyond barriers, limitations, and restrictive aspects. Use reframing, help move from an external to an internal frame of reference, an internal locus of control, to transacting adult to adult, or moving through developmental stages of growth. Find the Gestalt. Help your clients identify irrational thoughts and self-destructive behaviours. Avoid using words like must, always and never, should and ought, and avoid giving advice. Refer when necessary.

Addendum

Brief Counseling Self-Confidence Scale

Answer the following items on a 1-5 scale:
1=strongly disagree 2=agree 3= not sure or neutral 4=agree 5 strongly agree

1. I am fairly confident in my ability to communicate clearly with a client ____.
2. If I am not sure of what to say or do in a counseling session, I feel comfortable in knowing that I can figure it out ____.
3. I am pretty good at interpreting client issues ____.
4. I am confident about my ability to respond appropriately to clients ____.
5. I am confident that I can express myself clearly and succinctly ____.
6. I know how to pick up subtle expressions and nonverbal emotions ____.
7. The presenting problem is easily distinguishable from the real problem ____.
8. I can understand and respond to culturally diverse clients ____.
9. I am confident in my use of reflecting skills, summarization, and clarification ____.
10. I am confident about my ability to respond appropriately to my clients regardless of their background ____.
11. I am comfortable with my ability to relax at the onset of the counseling session and throughout ____.
12. I can easily determine the difference between feeling and meaning ____.
13. I am fairly confident about the flow of the counseling session and what to do next ____.
14. I know when and when not to give advice ____.
15. I'm usually very good at active listening - listening to what is said and what is not being said ____.
16. I know how to start and when to end a counseling session and exactly what to do in-between ____.
17. If I get stuck in a counseling session, I know just what to do ____.
18. I am confident in my knowledge of counseling methods, theories and techniques ____.
19. I am confident in my ability to integrate appropriate counseling techniques into the counseling session as needed ____.
20. I am confident in my ability to integrate appropriate counseling theory into the counseling session as needed ____.

Total ____