Crisis intervention Interpersonal skills training for lay volunteers

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CRISIS INTERVENTION: INTERPERSONAL SKILLS TRAINING FOR LAY VOLUNTEERS

A Project Presented to the Faculty of California State College San Bernardino

In Partial Fulfillment of the Requirements for the Degree Master of Arts in Psychology

By Gary J. Ladoceour December 1977
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FOR LAY VOLUNTEERS

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By
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December 1977

Approved by:

Chairperson

Date

November 17, 1977
This study reviewed the theoretical background of crisis intervention services and training and outlined a therapeutic model based upon interpersonal skills training as a more effective orientation for this service than current training programs. This study implemented the interpersonal skills model exclusively in the training of 20 volunteers. The results confirmed the hypothesis that interpersonal skills training would result in a significant increase in trainees' use of verbal reflecting as a primary therapeutic response mode at the completion of training.
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INTRODUCTION

Although there may be some debate over why our mental health needs are growing, it is apparent that they are indeed growing and that evolving mental health programs require new sources of manpower and more efficient use of present resources (Albee, 1970). This paper dealt with one aspect of broadening services to reach greater numbers of people in psychological distress. The paper focused on telephone crisis intervention services manned by non-professionals on an around-the-clock basis; examined current trends in brief psychotherapy; argued that an interpersonal skills model for therapeutic intervention was more effective than currently utilized models; and proposed a training program which uses the interpersonal skills model for training non-professional crisis intervention workers. The major premise of this paper was that the interpersonal skills training model produces positive changes in trainees' attitudes and that these changes will be reflected in more helpful types of response modes that trainees will use as counselors responding to clients' calls for help.
The Traditional Crisis Intervention Model: A Psychoanalytically-Oriented Approach

A direction that has shown promise in recent years for more effective use of professionals has been short-term crisis intervention programs. These programs are designed to deal with sudden, acute, and specific problems which arise for an individual and interfere with his ability to live his life effectively. Jacobson (1974), in a review of the programs and techniques now in operation, pointed to the advantages of such a treatment system. In the foreground is the focusing on the particular problem while disregarding other psychological processes, and allowing for a time-limited course of treatment not to exceed six weeks. This service is available on a 24 hour basis, open to all people regardless of circumstances and without the need for appointments, psychological evaluations, or consultation. The goals, then, are narrowly defined; and this is in itself a progressive step towards more effective meeting of human needs.

However, most of these facilities have a psychoanalytically derived theory of crisis as a basis for treatment. The psychoanalytic mode presents at least two problems which deserve mention. The first is in the analytic
orientation itself which relies upon interpretation and psychodynamic insight. The validity and value of this approach has yet to be demonstrated empirically; yet even in this innovative framework of crisis intervention, it is the preferred mode of treatment. Ballak and Small (1965), in outlining the basic theoretical propositions for brief psychotherapy in their Trouble Shooting Clinic, stated categorically that the fundamental concepts of Freud's structure formed the basis for their treatment program. The value of insight as a "curative" factor is diminished when the means of communicating the insight through interpretation are considered. Interpretation, in this context, means having the therapist attempt to explain why the client behaves or feels in a particular way at a given time and always implies causation. Helner and Jessell (1974), in an investigation of the effects of interpretation in counseling, found that with their subjects interpretation tended to have an association with negative feelings by the clients. This study has numerous deficiencies (an all-male sample, simulated therapy sessions, and a reliance on a student population), but the general finding of negative feelings toward interpretation has implications which should not be overlooked in considering the merit of this technique when dealing with people in acute stress. This is especially so in the situation which is the focus of this paper—telephone
crisis intervention—where the establishing of rapport and communication with the client is essential to maintain the tenuous contact which could be so easily broken by simply hanging up the receiver.

The second aspect of using a psychoanalytic orientation concerns the training of clinical workers to use this traditional approach. The very nature of psychoanalytic concepts, precepts, and theory necessitates long and arduous training regimens. This heavy investment in time, money, and human resources must be carefully weighed. The training must be comprehensive and complete or it is nonexistent. There seems to be no middle ground for the training of lay personnel. Unfortunately, most lay training programs today still insist on injecting a smattering of psychoanalytic theory which only serves to confuse the issues for the trainee. In a very real sense, a little learning becomes dangerous.

Brief psychotherapy and crisis intervention are important and necessary movements toward alleviating shortages in the helping profession. It is heartening to see emphasis being placed on "sensitivity, warmth, and empathy" (Jacobson, 1974, p. 820) in this setting, but the disadvantages of the psychoanalytic mode of therapy which exist even in long-term treatment are magnified when applied to the acute distress of people in crisis.

As mentioned above, concern with the therapist's
ability to understand the inner experiences of his client is a welcome adjunct to any psychotherapeutic orientation, but until recent years it has been only that—an adjunct.

A New Model for Crisis Intervention: An Interpersonal Skills Approach

Building on Rogers' (1957) "necessary and sufficient" conditions for effective therapy, a school of therapy has developed which incorporates the conditions of empathy, positive regard, genuineness, and adds the dimensions of concreteness and self-exploration as core dimensions which will "elicit the greatest client process involvement and ultimately the greatest constructive change" (Carkhuff, 1967, p. 67). Carkhuff and Berenson (1967) described these core dimensions (or facilitative conditions) as being the conditions under which the therapist offers high levels of empathic understanding of the deeper as well as superficial feelings of the client and fully involves himself freely and nonexploitively in the relationship. He conveys genuine respect for the client's worth as a person and his rights as a free individual while at the same time concretely and specifically guiding the discussion to personal and relevant self-exploration. The goal is to provide the client with an honest, interpersonal experience by which he reaffirms his human worth. The client is seen as functioning at very low levels of these facilitating conditions, and this is seen as the result of a
succession of retarding relationships with other low-functioning individuals that have deprived the client of real human encounters (Carkhuff, 1967). The distorted relationships which have developed from these circumstances and are causing the client difficulties can be corrected by relationships with other "more knowing" persons who are able to offer human nourishment by expressing high levels of the facilitative functioning conditions. Thus, the model presents a therapist who functions at minimally high facilitative conditions who then becomes an agent of change as he engages in a relationship with a client functioning well below this level. The client is able to re-establish the perspective and communicative skills which will alleviate his distorted frame of reference and situational distress. This is, of course, an interactional process; and it is felt by these authors (Carkhuff & Berenson, 1967) that the therapist-offered conditions have the potential for either contributing significantly to the progress of the client by providing high levels of the core conditions or adding to the dysfunctioning of the client by presenting low level and retarding conditions.

The interpersonal skills model serves as the basis for the counseling approach advocated in this present study. This model also represents a rather radical departure from more traditional psychotherapeutic approaches and has resulted in an outpouring of research aimed at validating
the model. The results from these studies have implications for advancing the model as a standard for crisis intervention.

An early study by Truax (1963) reviewed the findings of a five-year research program and examined the relationship between high levels of Accurate Empathy, Unconditional Positive Regard and Self-Congruence of the therapists and the improvement or deterioration of clients. Using 384 tape-recorded samples of psychotherapy, randomly selected and coded, from four patients who had showed clear improvement and four patients who showed deterioration after six months of therapy, Truax analyzed each of the conditions separately. He found that clients who had been rated as having received high levels of the conditions improved significantly ($p < .01$) over those clients judged as receiving low levels of these conditions. An analysis of all three conditions combined using matched controls receiving no therapy with cases receiving at least minimally high conditions, and a group receiving low conditions, showed that controls and high level offered conditions produced positive gains; but that the cases receiving low levels of these conditions showed negative personality change. The implication is that not only are the facilitative conditions therapeutic, but the lack of them may retard progress and even induce a deterioration in the client's functioning. This early study indicates only
that these conditions were present and not that they were responsible for therapeutic change. The study was also post hoc and as such cannot answer the question of who in the relationship was responsible for the conditions offered (perhaps the therapist was following the client's lead) or what influence other interactional patterns might have had.

The matter of who in the relationship is responsible becomes of prime importance if the model is to have any validity at all. If it is the therapist who offers the conditions and controls the environment of the therapy session and if high levels of these conditions produce positive change in clients, then the problem of specifying what specific variables are responsible for effective therapy is nearly solved. Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, and Stone (1966) focused on this aspect in a study using 40 outpatients who were randomly assigned to four different therapists. The authors hypothesized that different therapists offered different levels of facilitative conditions, and thus there should be significant differences in the levels of conditions present in the relationships if they were therapist-offered, and none if clients elicited these facilitative conditions. The clients were also randomly assigned to two screening interviewers, each interviewer seeing half of each therapist's clients. It was assumed that if
conditions were therapist-offered, they should produce significant differences in this screening setting as well.

Four experienced raters then rated taped segments randomly selected from both the screening interview and the therapy interviews on the conditions of empathy, understanding, and non-possessive warmth. Means of each level were then calculated and subjected to analysis of variance. The results showed significant differences in the levels of facilitative conditions in both the screening interviews and in the therapy sessions on the rating scales of Accurate Empathy and Genuineness. Truax et al. (1966) felt that this strongly suggested that the therapist determines the level for these two conditions.

Further evidence also points to the therapist as the controlling factor of what level the interactions are going to occur on in therapy sessions. Truax and Carkhuff (1967) attempted to find the "something more" aspect of the therapist-offered stimulus complex by manipulating the level of core dimensions within the therapeutic session. They found that lowering the levels of empathy and positive regard during the middle 20 minutes of the session resulted in a corresponding drop in intrapersonal exploration by the client. The implication is that the therapist has a direct effect on self-exploration by the client, and that the depth of self-exploration can be varied experimentally in therapy with
predictable consequences. Holder, Carkhuff, and Berenson (1967) and Piaget, Berenson, and Carkhuff (1967) used similar manipulations but with clients rated on varying levels of interpersonal functioning and found that while high functioning clients tended to continue functioning at high levels regardless of the conditions offered, low functioning clients tended to deteriorate as the session proceeded. These findings are meaningful if it is kept in mind that clients seeking therapeutic assistance are usually functioning at minimal levels of interpersonal relating and communicating and that it is the offering of the therapist of higher levels which allows the client to increase his own level of interpersonal and intrapersonal functioning.

In a study to further validate the interpersonal skills model, and reasoning that effective change should generalize from the treatment situation to other interpersonal experiences of the client, Pagell, Carkhuff, and Berenson (1967) used eight outpatients randomly assigned to eight different counselors. The clients were cast in counselor roles prior to their initial session and after six months of treatment. Levels of functioning from pre-treatment and post-treatment sessions were rated and compared. Raters were from four different sources for each subject: experts, clients of the patients, the patients themselves, and the therapists assigned to the
patients. Pearson product moment correlation coefficients for rate-rerate and interrater reliabilities ranged from $r = .82$ to $r = .98$ with most falling in the high $r = .80's$ and low $r = .90's$. The results were in the predicted direction that those clients of therapists functioning at above the minimally facilitative conditions (an average of level 3 on all conditions as measured on a five-point scale; see Carkhuff & Berenson, 1967) would show the greatest gain. Only two of the therapists were functioning at or above this level, and their clients demonstrated the greatest amount of constructive change on measures of interpersonal functioning dimensions (empathy, respect, genuineness, concreteness, and self-disclosure) and gross behavioral functioning, while only one of the other six showed constructive change; and the other five showed no change at all. Empathy was the dimension most frequently yielding significant difference.

A criticism which may be leveled at these cited studies and the multitude of others conducted is that experimenter bias may be accounting for many of the positive results. In an experiment to evaluate the effectiveness of therapist-offered conditions of high level functioning in group psychotherapy, Truax, Carkhuff, and Kodman (1965) found that the study gave only moderate support to the generality of levels of empathy and unconditional positive regard; and the data showed a
negative correlation with high levels of self-congruence and genuineness and client progress. These findings are the opposite of those found in individual psychotherapy, and Truax et al. (1966) offered some explanations of how this could have occurred. Most importantly, though, this study which used the same methodology, rating scales, raters and similar measures of outcome and yet had contrary results seems to dispute the experimenter bias and shows that there does exist a change-inducing element in this approach.

Another criticism often expressed concerns the question of whether the facilitating conditions in this model are separate entities or whether the measures of their existence are merely tapping a single resource. Hefele, Collingwood, and Drasgow (1970) factor-analyzed the intercorrelations among the "core dimensions" and found that people functioning at high levels in one area correspondingly function at high levels in other areas. This study utilized 27 psychology graduate students who responded to the Counseling Stimulation Inventory (CSI). The CSI is comprised of 16 client statements of problem areas in four different contexts. Subjects were rated for global level of functioning on the basis of their responses by trained raters. Reliability for rater-rater was $r = .93$, and interrater reliability was $r = .86$. The data indicated that a single factor accounted for 79% of the variance in
correlations among the responses to the CSI. The authors felt that this cross-validated the earlier study by Muehlberg, Pierce, and Drasgow (1969) who contended that one factor accounted for 89% (not "81%" as reported by Hefele et al., 1970) of all variance. In this study data were analyzed "among variables" involving all the interacting conditions of the core dimensions. The study used three male counselors selected on the basis of their success treatment ratio and other outcome criteria, and the facilitative conditions of each of the therapists were rated by two highly trained researchers listening to ten 3-minute excerpts taken from each therapist in a single interview. In addition to a single source of variance, the ratings of therapists were found to be rank-ordered with their success-treatment ratios. Thus, if only one factor is accounting for most of the variance, the therapists high on one dimension will be high on all dimensions; and the converse is also true. The implication is that regardless of that one source, it is generalizable to therapist-offered conditions, and it does correlate with success outcomes. Future studies should certainly be conducted to determine this important major element underlying the core dimensions. However, whether we are dealing with a multi-dimensional set of factors or only one factor, the content of the interpersonal relationship remains and appears to be a contributing factor in the therapeutic
session. It might be noted that in addition to low correlation scores of global ratings (Bozarth & Krauft, 1972), other studies (e.g., Truax et al., 1965; Truax et al., 1966) show differing correlations between scores on different conditions, suggesting that the dimensions are separate entities.

Whether we measure successful psychotherapy by viewing it from a process point of view or from quantifiable outcome measures is a problem area which must also be looked at in connection with interpersonal skills research. It would appear at first glance that researchers have concentrated on the in-interview interaction between therapist and client, relying on pre-testing and post-testing to judge the effectiveness of the therapy and thus giving the appearance of a process study. Whether in fact this is true depends upon the defined limits specified in the design of the study. If client change during the therapy session is the dependent variable being measured rather than a long-term and fundamental change in behavior, then these studies are outcome studies. Further, as Kiesler (1971) notes, the process-outcome dichotomy has served to obscure the legitimacy of patient process change within the therapy session as being a valid outcome measure and that these process movements can be serious evaluations of the effects of psychotherapy.

Two other points must be considered in the discussion
of the process-outcome issue. First, Carkhuff (1966) and Berenson (Carkhuff & Berenson, 1967) present this model of interpersonal skills as only one important aspect of psychotherapy and not as a replacement for other theoretical orientations. Indeed, the entire model is multidimensional in that it incorporates the interpersonal dimensions as a core and has appropriate preferred modes of traditional treatment as secondary but essential dimensions. In-depth self-exploration by the client is sufficient only to a degree, and from that point the therapist must combine more traditional methods to effect client change. The selection of these secondary dimensions is dependent upon client function, nature of the problem, and socioeconomic aspects as well as other client and therapist related variables; but throughout the process the central core of interpersonal dimensions must play an integral part.

This second point concerns the nature of this study which had as its goal the exploration of the initial treatment of acute crisis by lay personnel. By its very nature, intervention in crisis must have severely limited outcomes. These criteria include preventing the accomplishment of suicide, relieving immediate and intense anxiety, and establishing a level of rapport and trust sufficient to induce the client to seek professional help. Thus, such intervention can be viewed as complete within itself. Of
course, if looked at in a broader context from the initial intervention, through long-term therapy, and to eventual resolution of the problem, then crisis intervention is part of a process. The reference point of this study is the narrower focus on the outcome of the initial intervention.

In line with this point of view, perhaps the most important studies reviewed are those which deal with manipulation of the facilitative conditions within the therapy session (e.g., Holder, Carkhuff, & Berenson, 1967; Piaget, Berenson, & Carkhuff, 1967). These studies show that therapists functioning at high levels of interpersonal skills (empathy, understanding, acceptance, etc.) contribute significantly to the self-exploration by clients who are functioning at low levels of these conditions during the therapy session. This point must be stressed when discussing the contact that lay volunteers have in telephone crisis intervention. It is, in effect, a one shot, easily client-terminated, therapy session in which the goal is to involve the client in sufficient self-exploration in order to gain some measure of order and an internal sense of self-worth which will ideally lead to professional counseling interviews. A great many of these calling clients are convinced of their own worthlessness and that they either have no value to the world or that the world is so chaotic that they are beyond controlling even their small portion of it. It is imperative that
within the brief few minutes a helper has with these clients, the helper at least effect a movement towards reestablishing the caller's self-worth, dignity, and a sense of control.

In short, this is an interpersonal skills model of psychotherapy that stresses empathy, genuineness, concreteness, self-disclosure, and other related variables as being facilitative conditions which, when offered at high levels by the therapist in a therapeutic relationship with a client, will be essential ingredients for constructive change and gain in the client. The early stages of therapy focus primarily on these conditions as a way of producing an interactional process on a moment-to-moment, fully sharing basis, which will elicit and reinforce the client's self-exploration.

The interaction process described above is what Gendlin (1970) saw as a communication dimension which enables the therapist to focus on the "felt meanings" of the client's expressions. By definition, this is communication which "refers inwardly to a mass of feelings, perceptions, intentions, judgments, wishes, etc." (Gendlin, 1970, p. 138) as expressed in the explicit verbalized statements by the client as he attempts to symbolize his implicit experiencing of feelings. The therapist's task is to respond to those felt meanings in such a way that the client's experiential process is carried forward. Each utterance of the client is responded to with reference to
the verbalized feelings expressed—the responses reflect back to the client that the implicit meaning of his experiencing has been perceived. The interacting with another in this way allows the client to symbolize more clearly what had previously been only vague and implicitly felt. There is a subtle shift in content; more implicit felt meanings emerge; and the flow of experiencing is reconstituted.

Rice (1965) defined "reflective responding" as a response category that is inner directed (e.g., "You feel that this is exciting") as opposed to outer directed (e.g., "Those people at the welfare office really are uncooperative"), and characterized as containing fresh and connotative words, phrases or sentences, rather than ordinary and stale words. Goodman and Dooley (1975) defined reflection as a response to the client's internal frame of reference and a means of communicating accurate empathy.

Thus, the interpersonal skills model presents the point of view that the therapist's empathic, genuine, positive, and concrete attitudes toward the client are essential ingredients in effecting client change; and Gendlin (1970) specified that the reflection mode of responding is necessary for communicating such conditions within the counseling relationship. This paper suggests that the two are inseparable: Therapists cannot "reflectively respond" without the core attitudes
espoused by Carkhuff, and the core attitudes are meaningless unless they are effectively communicated to the client. Further, this study hypothesized that a change in helper attitudes toward greater empathy, genuineness, and positive regard for the helpee will result in a change in helper verbalizations toward more reflective responding to helpee expressions.

**Crisis Intervention Training Programs**

The issue now becomes one of determining if lay workers can be trained to become constructive change agents and how best to implement such training. Carkhuff (1966) charged that for the most part counseling and therapy training programs concentrated on personalities and techniques rather than on the interpersonal facilitative conditions which he felt are essential for client benefit. Besides deficiencies in assessing the outcome of such programs and a reliance on process variables such as student grades for predicting the future skills of therapists, Carkhuff contended that the complexities involved in present programs result in an over-intellectualized training experience and an actual decrease in interpersonal skills. He felt that the primary conditions of therapy are conditions that minimally trained, non-professional people can provide and argued for short training programs that stress the development of these interpersonal skills.
As a move away from this traditionally didactic approach to training, Truax, Carkhuff, and Douds (1964) outlined a model which integrates the didactics of training with an experiential base. The rationale was that good counseling could be assured only if the counselor were effectively living. As such, the ultimate goal of training must be to work towards allowing the trainee to become a whole person—self-actualized, so to speak. Trainers, of course, must give educative shape to the trainees' future methods of dealing with clients. Unfortunately, a purely didactic approach often fails to offer a model for the interpersonal atmosphere that the crisis intervention trainees are expected to create for clients. To implement an integrative approach, lectures must be combined with the core dimensions of empathy, positive regard, congruence, etc., in order to foster self-exploration and self-growth in the trainees. For example, clinical definitions of these conditions are taught, while at the same time the trainer presents himself as a model which can be used for imitation and comparison by the trainees. The approach also utilizes tape-recorded samples of counseling to concretize the trainees' awareness of specific problems and conflicts that they may encounter. The taped interviews would provide the trainees with "on the one hand . . . vicarious experiential learning and on the other . . . didactically provided positive and negative feedback" (Carkhuff et al.,
Training in recognizing and discriminating facilitative conditions from tape-recordings is followed by role-playing and ultimately with actual client contact carefully supervised and critiqued. Training thus becomes an analogue of the therapeutic setting into which the trainees will be cast.

Two identical training programs utilizing this approach were conducted for a group of graduate psychology students and a lay volunteer group by Carkhuff and Truax (1965a) and an evaluation of the results concluded that in a relatively short time trainees can be taught to function at levels of therapy nearly commensurate with those of experienced professionals. The levels of functioning of these groups were compared to levels of functioning of the professionals; and although a hierarchy was evidenced (professionals being highest, students next, and lay personnel last), there was no significant difference on any of the dimensions with the exception of self-congruence. The significant difference on this dimension might be accounted for by the fact that experience may have allowed the professional to enter more freely and completely into the therapeutic experience.

In another study designed specifically to determine the effectiveness of this training model with lay personnel, Carkhuff and Truax (1965b) trained volunteer hospital workers exclusively in the therapist-offered conditions of
empathy, positive regard, and genuineness. The study was also an attempt to resolve the question of whether these conditions could be offered advantageously only by a therapist with a thorough knowledge of underlying dynamics and psychopathology. Since the trainees were not instructed in any of these areas, it was felt that the data would give some indication of the necessity for in-depth psychological processes training for short-term therapy. Clients for these trained volunteers were 80 hospitalized mental patients seen in groups of 10 by each volunteer. A control group of 70 patients was used for comparison. Outcome criteria were based on hospital discharge rates and ward behavior as assessed by nurses and ward attendants. The results showed that of the 80 treated patients, 11 were discharged after two or more months of treatment as compared to only six of the 70 control patients. Significant improvements were found on all indexes of ward behavior for the treated group compared to the control group. It is noted that these positive changes were in the opposite direction of expectancy as expressed by the nurses and ward attendants and thus helps dispel the criticism that a "halo effect" is creating spurious positive findings in these studies. This study demonstrates that short-term therapy can be effective using an integrated didactic-experiential training program for lay volunteers, and that for this type training a focus on particular theoretical orientations
is unnecessary.

Although these studies are impressive, other investigators have raised questions on some important issues concerning the conceptualization of the model. Ivey (1971), for example, pointed out that the model fails to adequately define the core dimensions in behaviorally observable terms and that these abstract concepts must be operationally quantified. It is his contention that communicating the facilitative conditions of empathy, warmth, genuineness, etc., is a skill which can be defined, described, and taught to trainees. Ivey's Microcounseling training, although seemingly mechanical, does not differ significantly from the proposition of Carkhuff and others that the important ingredient in the training course is the interpersonal relationship established between trainer and trainee. The emphasis in Microcounseling training is also placed upon the experiential aspect of the training. Role-playing, modeling, feedback, and analogue counseling are all important and crucial parts of the training program. A major contribution of this paradigm is that it does express exactly the behaviors associated with communicating the conditions of empathy, genuineness, warmth, and other interpersonal variables.

Interestingly, in an experiment designed to evaluate Microcounseling as an effective training tool by Moreland, Ivey, and Phillips (1973), it was shown that of all the
dependent variables tested (attending behavior, paraphrasing, open-ended questions, reflective responding and summarizing), only attending behavior and reflective responding were significantly increased by trainees in Microcounseling over trainees in the control group.

Another issue concerns the effect of trainer personality on the outcomes of training programs where the emphasis is primarily on the interpersonal relationship of trainee-trainer. Given that conducting training in a therapeutic environment has a strong effect on trainee self-exploration and provides the experience of being responded to with empathy, warmth, and genuineness, what would be the effect of blocking on trainer personality variables? The question implies that trainer personality rather than specific training methods or techniques influences outcomes. Dooley (1975) addressed the question in a study which employed only audiotaped instructions as a tool to teach reflective responding to an experimental group of trainees. The study was designed to test the hypotheses that there is a relationship between a response mode and counselor effectiveness, and that brief, automated audiotape training methods can effect change in verbal responses. The results indicated support for both premises. Peer ratings and trained raters' ratings showed a positive correlation between reflective responses and empathy/acceptance by the trainees trained in reflective responding,
and an increase in reflective responding by those trainees. Although statistically significant, these two findings are somewhat misleading in that "reflective usage accounted for only a small portion of the variance in the empathy and acceptance measures" (Dooley, 1975, p. 540) when the data were subjected to a 2 x 2 analysis of variance; and the increase in reflection usage may have been due to increases in usage by trainees already preferring that mode of responding, in which case the training was not instilling a new skill but rather eliciting an existing response behavior.

An important point posited by Dooley is that mere reflective responding is not sufficient for interpersonal effectiveness. Further, an implied a priori principle of this present paper was that teaching the mechanics of reflective responding will not produce more effective counselors. Given this, it would seem to follow that trainer personality is indeed an important component of training, just as therapist personality is an important aspect of psychotherapy. The issue is complex and research results are inconclusive and contradictory (see Meltzoff & Kornreich, 1970, pp. 306-311). However, to suggest that personality should be ignored in either training or therapy is to suggest that the therapeutic importance of being human is irrelevant. The alternative to ignoring the personality factor is to exercise more selectivity in our choices of
trainers and therapists.

Methodologically, Dooley's study was also an important test of the use of an assessment procedure based on Goodman's (1972) Group Assessment of Interpersonal Traits (GAIT). Much of the criticism of the Carkhuff model of training centers on the measurement of trainee change from pre-training conditions to post-training conditions. The rating scales developed by Carkhuff (1969) presented several relevant difficulties. Gormally and Hill (1974), for example, pointed to the lack of objective and quantified response categories which necessitates the requirement for training raters extensively in the use of the scales. This is a serious consideration for community mental health programs with limited budgets, manpower, and time. Others (O'Hare, 1976) described the scales as subjective and with poor operational and behavioral definition. GAIT attempts to overcome this criticism by separating a flow of communications into discrete units of verbal interactions. It utilizes the sentence as a category unit and defines a particular response in terms of the process or mode of communication (e.g., asking questions, giving advice) rather than the topic or content of the communication (e.g., family relationships, complexes). The criteria to be met for classification of the units include, among others, that the units be easily identifiable by a lay population; that they need not require extensive
psychological background to be understood, but that they incorporate most of the categories generally employed by psychotherapeutic communications; and that the number of categories be small enough to accommodate both training and research applications. The result is six categories of interaction: advisement, question, silence, interpretation, reflection, and disclosure. These categories define typical verbal or grammatical patterns and, as such, are mutually exclusive. The categories can be further refined to take into account intent or inference. Additionally, this system makes it possible to collapse the matrix across categories. The present study was designed to compare responses categorized only as reflective or nonreflective.

**Hypothesis**

The background research for this paper examined the advantages of using a didactic-experiential interpersonal skills model for training lay volunteers to be suicide and crisis intervention workers. The hypothesis was that trainees who received this training would select significantly more reflective responses on a post-training test than on a pre-training test.
METHOD

Subjects

Subjects for this study were 20 volunteers responding to newspaper advertisements, flyers, and radio announcements by a local community mental health organization calling for "people interested in helping people" to apply for unpaid positions and training as telephone crisis intervention workers. Prior to training, all applicants were screened with questionnaires and personal interviews by the professional staff of the sponsoring agency to eliminate those trainees most obviously unable to benefit from the training. The criteria for this selection process were established by the agency and included such dimensions as the presence of emotional and psychological stability, an absence of prurient interests, a willingness to work as a volunteer for a minimum of 12 months, and a sincere desire to be of service to others.

The Training Program

The orientation of this study was towards developing a brief, effective training program for non-professional suicide and crisis intervention workers. The trial variable was a didactic-experiential training program which taught interpersonal skills for communicating the conditions
of empathy, genuineness, positive regard, and self-congruence. These are conditions regarded as essential not only as a preferred counseling mode but also as an environment in which trainees are taught to be counselors.

Didactically, this training program used clinical and theoretical descriptions of the conditions of empathy, genuineness, etc., to present the background and the rationale for their use. Basic interviewing skills were taught using a modification of the techniques developed by Ivey (1971). Trainees were presented audio-taped excerpts of re-enactments of actual and analog therapy sessions to illustrate the various points made in lectures. They were also required to respond as counselors to audio-taped client utterances in order to focus and sharpen their ability to communicate in terms of the client's here-and-now feelings. Guest lecturers gave brief training in the use of administrative forms, referral services and resources, and intra-agency policies.

These didactic aspects were presented within a framework offering the same facilitative conditions that the model purports to teach. The trainees were provided with the opportunity for self-exploration through the group process experience and the advantage of observing the trainer for modeling. Role-playing, verbal responding to audio-tapes, and dyadic and triadic analog counseling sessions constituted the major portion of the training.
Critiques by both the trainer and the trainees themselves provided immediate feedback on the effectiveness of the trainee's individual level of interpersonal functioning.

This training model differed from the more traditional model in both the experiential emphasis placed on the training and in the perspective with which the client-counselor relationship is viewed. For example, during the early phases of training, trainees in this program were taught the value of communicating an empathic understanding of the client's frame of reference and then allowed to experience being both the recipient of the communication and the conveyor of such communication. Traditional training usually would have concentrated on teaching the trainee to obtain demographic data from the client in order to form an evaluation of the client's situational needs.

**Dependent Variable**

The dependent variable measured in this study was the verbal responding of trainees. Specifically, verbalizations were categorized as either reflective or non-reflective. A reflective response is defined as a response by the trainee which focuses on the inner feelings underlying statements by a client. Nonreflective responses are responses by trainees which label, advise, question, or otherwise focus on events and situations outside the client's immediate feeling experiences.
Response mode preference by the trainees was used as a measure of the outcome of this study. The rationale was that interpersonal skills training would result in an increased preference for reflective responding by trainees at the completion of training. Response mode preference was measured by the use of eight audio-taped excerpts of analog counseling sessions (see the Appendix). Each excerpt contained a client statement followed by four possible counselor responses. Two of the responses were nonreflective (e.g., "Tell me, what's your concept of a good marriage"), and two were reflective (e.g., "Life's not worth struggling for anymore, not even with me"). Trainees were asked to indicate their preferences by marking a written handout of the responses. Only the counselor responses were presented in written form; the client statements were given by audio-tape.

Trainees were thus scored from 0 to 8 on reflective preference, and changes in this score were measured from pre-training conditions to post-training conditions.

Procedure

The test was administered at the beginning of the first training session. Trainees were given brief instructions in how to complete the test and informed only that the test was not a part of the screening process. The trainees were told that their scores would not in any way
affect their progress through the training program. At the end of the training the test was administered once more with brief reminders of how to complete it. Trainees then were given an explanation of the purpose of the test, the rationale behind it, and were offered an opportunity to withdraw their written responses from the sample if they so desired. All trainees elected to remain in the sample.
RESULTS

The data were analyzed using a t test for related samples (one-tailed). A significant difference was found between pre- and posttest measures, $t (19) = 5.25$, $p < .005$. Subjects gave more reflective responses on the posttest (mean score 5.8) than on the pretest (mean score 3.8). Therefore, the experimental hypothesis was supported.
Table 1
Comparison of Pretest and Posttest Scores

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<th>Pre-training Score</th>
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\[ \bar{X} = 3.8 \quad \bar{X} = 5.65 \]

\[ t = 5.25^* \]

\[ *p < .005. \]
DISCUSSION

This study tested the effects of an interpersonal skills training program on the response repertoires of lay volunteer mental health workers. As hypothesized, it was found that the training increased the trainees' preferences for reflective responding. Several assumptions may be advanced about the data from this study.

The outcome measures may indicate that the didactic-experiential approach to the learning situation accounts for the trainees choosing a reflective response mode. The training focused on the therapeutic importance of interpersonal relationships and presented the view that those relationships are an experiential process in which the counselor acts as a constructive agent of change for the client. The training itself was presented as an experientially based learning process. Trainees were offered the opportunity for self-exploration and experimentation in an atmosphere of freedom and safety. The training context provided them with the means for working through their own feelings, for reassessing values and attitudes, and for moving towards openness and willingness to engage in a truly meaningful interaction. The assumption is that self-exploration is related to positive attitudinal change.
The contention of this paper was that only by changing trainees' attitudes would it be possible to change their preferences for types of verbal responses.

On a less philosophical level, the experiential aspect of the training program also offered the trainees the opportunity to practice and explore the techniques, theories, and knowledge which were didactically presented. In the process of exercising counseling skills, the neophyte counselors may have come to recognize that they must enter into the frame of reference of their clients in order to have a more empathic understanding of them. The most efficient way to do this is by accurately reflecting back to the client the literal statements made, and also the perceived feelings underlying the statements. Thus, the trainee must add functionally facilitative words and phrases to his verbal inventory; and, consequently, shift towards more reflective responding.

Trainees may also have modeled the trainer so it should be expected that post-training scores would be slightly elevated for this reason alone. This apparently extraneous and confounding variable does not invalidate the outcome results because one of the major goals of the training was to induce the response mode without actually teaching it as a mechanical response.

In summary, this paper suggests that the counselor must be more than an information gatherer, a soothsayer,
or a machine programmed to give platitudinous advice. The training program offered the trainees the opportunity to explore their own levels of interpersonal functioning, to experience the process of changing to a higher level of interpersonal functioning, and to acquire the skills needed to serve the client as constructive agents for positive movement.

The findings from this study indicate that an interpersonal skills training model results in an increase in empathic verbal behavior by trainees. If it is accepted that this is an effective mode for short-term crisis therapy, then this training program has a unique contribution to make in mental health agencies utilizing lay personnel. It provides effective training in minimal time with a limited output of manpower. Additionally, some of the nettlesome problems associated with the interpersonal skills training model (see Gormally & Hill, 1974) were overcome by the use of a collapsed GAIT (Goodman, 1972) rating scale matrix. As explained earlier, this eliminated the need for expensive and time-consuming training of raters and vastly reduced the subjectivity of previously used rating scales (e.g., Carkhuff, 1969). In terms of either future research or internal self-evaluations of training programs, this is a valuable method of measurement.
Implications for Future Research

There are several areas worthy of future studies. The first would be an experimentally designed study to compare outcomes between trainees receiving interpersonal skills training and more traditional training. One variable which should be investigated in this type of study is comparison of trainee retention for the course of training and also the retention rate for trainees once they become counselors. Turnover rates among volunteers are a serious consideration for the helping agencies which rely heavily upon them. On the surface, it appears that a training program geared not only to preparing workers for counseling others but also providing the trainee with a personal growth experience would add an incentive to remain involved.

In line with this, follow-up studies should also be conducted to determine whether the skills learned during training were diminished or retained. It is possible that using the skills has a spiral effect and that counselors become more fluent in interpersonal relating; or that the opposite is true, that usage declines as the training period recedes into the past. If the latter case is so, then the need obviously is for inservice training to regenerate these skills.

An effort should also be made to replicate the earlier studies (as summarized by Carkhuff & Berenson, 1967; Meltzoff & Kornreich, 1970) showing generally positive
therapeutic outcomes from an interpersonal skills mode of psychotherapy. This present study was predicated on these positive results, but it may be kept in mind that those other studies involved face-to-face contact with the client. Counselors in telephone crisis intervention lose this element, and the therapeutic effectiveness of using this proposed mode of therapy should be evaluated. This could be done in several ways. Counselor reports on client's progress and client self-reports should be among the criteria. Reports could also be obtained from significant others in the client's life. A final criterion involves a fundamental goal of telephone crisis intervention: the willingness by the client to seek out and obtain longer-term, professional psychotherapy at the conclusion of the brief telephone counseling session. Follow-up reports from clients and the agencies they are referred to would provide an assessment of this vital aspect. Results from a study such as this would add immeasurably to the literature of the search for answering the call for help from those who are out of hope.
APPENDIX

PRE-TRAINING AND POST-TRAINING QUESTIONNAIRE

Note: Client expressions were administered by audio-tape only.

Key to scoring of helper responses:  R = reflective response
N/R = non-reflective response

1. Client expression:

I love my children and my husband and I like doing most household things. They get boring at times but on the whole I think it can be a very rewarding thing at times. I don't miss working, going to the office every day. Most women complain of being just a housewife and just a mother. But, then, again, I wonder if there is more for me. Others say there has to be. I really don't know.

Helper response:

(N/R) a. Hmmm. Who are these other people?
(R) b. So you find yourself raising a lot of questions about yourself--educationally, vocationally.
(N/R) c. Why are you dominated by what others see for you? If you are comfortable and enjoy being a housewife, then continue in this job. The role of mother, homemaker can be a full-time, self-satisfying job.
(R) d. While others raise these questions, these questions are real for you. You don't know if you can find more fulfillment than you have.
2. Client expression:

He's ridiculous! Everything has to be done when he wants to do it, the way he wants it done. It's as if nobody else exists. It's everything he wants to do. There is a range of things I have to do—not just be a housewife and take care of the kids. Oh, no, I have to do his typing for him, errands for him. If I don't do it right away, I'm stupid—I'm not a good wife or something stupid like that. I have an identity of my own, and I'm not going to have it wrapped up in him. It makes me—it infuriates me! I want to punch him right in the mouth. What am I going to do? Who does he think he is anyway?

Helper response:

(R) a. It really angers you when you realize in how many ways he has taken advantage of you.

(N/R) b. Tell me, what is your concept of a good marriage?

(N/R) c. Your husband makes you feel inferior in your own eyes. You feel incompetent. In many ways you make him sound like a very cruel and destructive man.

(R) d. It makes you furious when you think of the onesidedness of this relationship. He imposes upon you everywhere, particularly in your own struggle for your own identity. And you don't know where this relationship is going.

3. Client expression:

I finally found somebody I can really get along with. There is no pretentiousness about them at all. They are real and they understand me. I can be myself with them. I don't have to worry about what I say and that they might take me wrong because I do sometimes say things that don't come out the way I want them to. I don't have to worry that they are going to criticize me. They are just marvelous people! I just can't wait to be with them! For once I actually enjoy going out and interacting. I didn't think I could ever find people like this again. I can really be myself. It's such a wonderful feeling not to have people criticizing you for everything you say that doesn't agree with them. They are warm and understanding, and I just love them! It's just marvelous!
Helper response:

(R) a. Sounds like you found someone who really matters to you.

(N/R) b. Why do these kind of people accept you?

(R) c. That's a real good feeling to have someone to trust and share with. "Finally, I can be myself."

(N/R) d. Now that you have found these people who enjoy you and whom you enjoy, spend your time with these people. Forget about the other types who make you anxious. Spend your time with the people who can understand and be warm with you.

4. Client expression:

I get so mad at my boss . . . everytime I try . . . to come up with some new ideas he knocks me down. Oh . . . sometimes I could . . . I just don't know what I would do.

Helper response:

(N/R) a. I don't know . . . sometimes there are bound to be conflicts between bosses and workers.

(N/R) b. Sounds like you probably get mad at a lot of people.

(N/R) c. Have you tried taking this problem to a higher supervisor?

(R) d. Boy! You could really let him have it! You could just cut loose on him!

5. Client expression:

(No response, sounds of sighing, throat-clearing, and moving around)

Helper response:

(R) a. You can't really say all that you feel at this moment.

(N/R) b. A penny for your thoughts.

(N/R) c. Are you nervous? Maybe we haven't made the progress we hoped to make, so far.

(R) d. You just don't know what to say right now.
6. Client expression:

I'm so overwhelmed. I can't say whether I can make it--now or ever. I don't even know if it's worth saying anymore, to anyone.

Helper response:

(N/R) a. Have you ever considered that many people feel this way?
(R) b. You're really feeling like it's just too much to handle.
(N/R) c. It sounds like you're in a deep state of depression.
(R) d. Life's not worth struggling for anymore, not even with me.

7. Client expression:

I'm so thrilled to have found a listener like you. I didn't know any existed. You seem to understand me so well. It's just great! I feel like I'm coming alive again. I've not felt this way in a long time.

Helper response:

(N/R) a. Gratitude is a natural emotion.
(N/R) b. This is quite nice but remember, unless extreme caution is exercised, you may find yourself moving in the other direction.
(R) c. That's a good feeling.
(R) d. Hey, I'm as thrilled to hear you talk this way as you are! I'm pleased that I have been helpful. I do think that we still have some work to do yet, though.

8. Client expression:

Damn these people! Who do they think they are? I just can't stand interacting with them anymore. Just a bunch of phonies. They leave me so frustrated. They make me so uptight. I get angry at myself. I don't even want to be bothered with them anymore. I just wish I could be honest with them and tell them all to go to hell! But I guess I just can't do it.
Helper response:

(R) a. They really make you very angry. You wish you could handle them more effectively than you do.

(R) b. Damn, they make you furious! But it's just not them. It's with yourself, too, because you don't act on how you feel.

(N/R) c. Why do you feel these people are phony? What do they say to you?

(N/R) d. Maybe society itself is at fault here—making you feel inadequate, giving you this negative view of yourself, leading you to be unable to successfully interact with others.
REFERENCES
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