AN

EVALUATION OF THREE TRAINING PROGRAMS FOR

VOLUNTEER CRISIS INTERVENTION TELEPHONE COUNSELORS

by

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ABSTRACT

The effects and effectiveness of three different training programs for volunteer crisis intervention telephone counselors were examined. Three groups of 12 trainees and an equal sized group of prospective volunteers who did not go through training were the subjects. All four groups were administered the same measures over equivalent time periods. Measures included pre- and post-training measurements of local resource knowledge and ability to discriminate facilitative conditions for client change. Standardized, role-played crisis intervention calls were audiotaped and rated for both Technical Effectiveness and Empathic Understanding in Interpersonal Processes. An additional contribution of this study was the development of a parallel form of the Ability to Discriminate Facilitative Conditions measure. The four groups were not initially equivalent on pre-training measures and these differences were taken into account using an analysis of co-variance procedure. Differential effects and effectiveness of the three training programs were discussed and recommendations were made to the participating crisis centres.

DEDICATION

I would like to dedicate this thesis to my good friend Robbie Russnaik, who helped me survive my first four years of graduate school. His untimely and unexpected death was an extremely sad event for myself and many others at Simon Fraser University.

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I. Chapter 1: Introduction

The extensive use of volunteer nonprofessional helpers in the direct delivery of modern mental health services has been one of the major contributions of the community psychology movement in general, and crisis intervention in particular (Rappaport 1977, Zax and Spector 1974, and McGee 1974). In one of the most comprehensive reviews of the emerging fields of community psychology and community mental health, Rappaport (1977, Page 15) contends that the re-introduction of nonprofessionals to social welfare jobs has been of central importance. Zax and Spector (1974) point to shortages of professional manpower as one of the main factors involved in opening up helping roles to nonprofessionals in both volunteer and salaried positions. Emory Cowens, a recent recipient of the American Psychological Associations' Distinguished Contribution Award for Division 27, sums up some of the earlier research data in this area (in Iscoe and Spielberger ,1970, Page 103):

> It is already clear primarily through Albee's work
> (1959, 1963, and 1967) that the mental health fields are
> grossly lacking in qualified personnel ...
> extrapolations based on estimates of future demand and
> future training potential indicate that the present
> unhappy situation will become more acute with time.

McGee (1974) has written a comprehensive history of the field of crisis intervention as well as aiding in the development of the field. McGee and his students and co-workers have conducted a large number of evaluation studies and measurement development research in this area (McGee, Richard, and Bercun 1973, Knickerbocker and McGee 1973, Fowler and McGee 1973, McGee and Jennings 1973, Knickerbocker 1972, and Ansel 1972). These studies will all be discussed in detail in later sections of this thesis. McGee (1974) argued that crisis intervention centers could not operate on a 24-hour basis without utilizing nonprofessional volunteers as their primary staff resource. Norman Farberow (in McGee's 1974 introduction on page viii) reports that over eighty percent of the approximately two hundred crisis centers then operating in the U.S.A. were using volunteer nonprofessionals as their major staff resource. This finding was replicated by Fisher (1973, Page 46) who surveyed 192 crisis centers on a National Institute of Mental Health study and found that the overwelming majority of centers (86%) used and relied upon volunteers to deliver their helping services. McGee, Richard, and Bercun (1973) found that the two conditions necessary to ensure efficient service by crisis centers were 24 hour a day direct access by telephone and the use of volunteer crisis counselors as the primary staff resource.

1.1 Nonprofessionals as Effective Helpers

Early studies which demonstrated the potential
effectiveness cf nonprofessionals in other mental health roles
(Rioch, Elks, Flint, Newman, Sibler, and Udansky 1963; Carkhuff
and Truax 1965, Poser 1966, Sobey 1970, and Siegal 1973) were
crucial to the rapid deployment of nonprofessionals in the
direct service function of crisis intervention by telephone.
Rioch et al. (1963) demonstated that housewives could be trained
to effectively conduct individual psychotherapy. The housewives
used were college graduates who received training from Rioch and
her associates. Carkhuff and Truax (1965) provided further
evidence that demonstated the effectiveness of nonprofessionals
when they found that lay therapists could lead group therapy for
hospitalized mental patients and obtain results comparable to
professionals doing the same task with similar patients. Poser
(1966) used eleven young untrained women undergraduates to lead
group therapy for psychiatric inpatients. Psychological test
change scores served as the dependent variables. The untrained
lay therapists were compared to fifteen professionals (7
psychiatrists, 6 psychiatric social workers, and 2 occupational
therapists). Poser (1966, Page 283) reports;

> By comparison to an untreated control group the lay
> therapists achieved slightly better results than
> psychiatrists and social workers doing therapy with
> similar patients.

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In summarizing the subsequent flurry of research that followed Poser's controversial finding, Rappaport (1977, Page 380) reports that Poser's finding have been replicated and extended. For example, Rappaport, Chinsky, and Cowen (1971) who studied 320 chronic patients who were given therapy by college student volunteers and showed significant gains.

Sobey (1970) saw the entry of nonprofessionals into the mental health field as a revolution. She studied over ten thousand nonprofessionals in one hundred ane eighty-five National Institute of Mental Health programs. Sobey (1970) concluded that nonprofessionals were not only taking the place of professionals in old jobs but were also being trained to provide new services in innovative ways. One such new role was in the area of crisis intervention by telephone, 24 hours a day, a job that professionals would not take in some cases (McGee 1974). Sobey (1970, Page 159) provided this summary:

> Nonprofessionals helped projects substantially in serving more people offering new services, and providing the project staff with new viewpoints in regard to the project population.

Siegal (1973) in a review of research on the effectiveness of mental health volunteers concluded that their effectiveness has been repeatedly demonstrated. Karlsruker (1974) in a slightly later literature review for the same journal was slightly less enthusiastic about the demonstated effectiveness of volunteer nonprofessionals in the mental health system.

Karlsruker (1974) concluded that the effectiveness of volunteer nonprofessionals has been clearly demonstrated with psychiatric inpatients but the evidence for their effectiveness with other groups such as adolescents is mixed.

Durlak (1979) in a survey of 42 studies concluded that paraprofessionals achieve clinical outcomes equal to or better than professional therapists. Durlak goes on to add that there is a lack of knowledge about the underlying dynamics of paraprofessionals' effectiveness. Nevertheless, he feels that the evidence is conclusive and is based on sound methodological results.

When the effectiveness of volunteer nonprofessionals in the area of crisis intervention is directly examined the evidence supports the contention made by McGee (1974) that trained volunteers are at least as effective as professionals, if not more so (Knickerbocker and McGee 1973) at crisis intervention tasks. This study and other related research will be examined in detail in a subsequent section.

Nonprofessionals have filled a needed role in community psychology programs such as crisis intervention by telephone. This movement has not grown without some difficulties however. Zax and Spector (1974) surveyed the literature on the use of nonprofessional helpers and uncovered a number of possible problems that may arise when using nonprofessional helpers. Zax and Spector (1974) report that sometimes professional helpers

will have a negative reaction to the use of nonprofessionals in direct service helping roles. Most modern crisis centers utilize professionals in consultant capacities and thereby alleviate this problem.

Zax and Spector (1974) felt that nonprofessionals' helping role may alter their pattern of interactions within their community which may lead to to loss of closeness to the client population, a factor that is believed to be at least partially responsible for the effectiveness of nonprofessional helpers. However in crisis intervention volunteer helpers usually do one four-hour shift per week, a time commitment of sufficient brevity so as to not radically affect their community interaction patterns.

Zax and Spector (1974) also discussed fears voiced by professionals that nonprofessionals might not respect confidentiality enough and that nonprofessionals might project their own problems on clients. Nonprofessional helpers are not immune to these possible problems but comprehensive selection and training can minimize these possible difficulties as with professional helpers. Supervision by experienced nonprofessinal helpers can be useful in dealing with these issues.

The final possible difficulty in the use of nonprofessionals discussed by Zax and Spector (1974) is the fact that nonprofessionals may "burn-out" when they don't perceive rapid improvement in their clients. "Burn-out" in the area of

crisis intervention by telephone has been examined by Driol (1978). She reported that approximately half of a group of crisis intervention workers will have become inactive prior to the end of their year's commitment. The reasons given for the inactivity included moving out of the area, personal life change, "too busy at school" or job, and also perceived ineffectiveness.

"Burn-out" of crisis intervention volunteers in particular and nonprofessional helpers in general, is an important phenomenon that can be dealt with. Marcia (1977) suggested that support in the form of supervision and chances for upward mobility in the helping professions may reduce the number of burn-outs. Marcia (1977) also recommended an ongoing support group for the nonprofessional helpers which would be led by a professional consultant. These recommendations have not been directly examined in the field of crisis intervention but Driol's (1978) results provide partial support. She found volunteers who were still active at the end of their one year commitment, responded more positively to questions regarding their training program and relations with crisis centre trainers and other salaried staff than did "burn-outs". She suggested that this is one of a number of complex factors involved in crisis intervention "burn-out".

A final caution in the use of nonprofessionals in helping roles is given by Durlak (1979). After concluding that

non-professional helpers have had their effectiveness repeatedly demonstrated, he cautioned that the process by which nonprofessionals help is not well enough understood and much more research is necessary.

1.2 Special Problems in the Evaluation of Nonprofessionals in Crisis Intervention

The evaluation of the effectiveness of crisis intervention workers and crisis intervention programs poses special problems due to the nature of the service and the characteristics of the client population (Bleach 1973, Spector and Claiborne 1973, and Lester 1973). Spector and Claiborne (1973, Page 107) report that there are special dangers and risks in studying a program which relies on confidentiality of client information for credibility. Lester (1973) sees the anonymity of clients as one of the unique features of crisis intervention by telephone and views this innovation as a central aspect of the crisis intervention model, one that allows it to reach a much larger client population than traditional helping services. He warns that evaluators of this type of service must be aware of the importance of this anonymity and design research accordingly. Bleach (1973 , Page 109) echoes these sentiments and sums up the issue well;

> Research on the effectiveness of these services poses special problems, all centering around the issue of how the most informative, well controlled research can be

done with the least disruption of the crisis service.

1.3 Rationale for this Study

It has been suggested in this brief introduction that
volunteer nonprofessionals have been of central importance in
the recent development of the fields of community mental health
and community psychology. This importance is especially evident
in services which offer crisis intervention by telephone, where
specially trained nonprofessionals are the primary staff
resource. Rappaport (1977) has outlined much of this development
and suggests that there is an important role that psychology
graduate students can play in this development. Rappaport feels
that graduate students in the role of program evaluators can
provide important data and scientific rigor in program
evauluation research. As France (1975) maintains , and as the
author believes, it is the responsibilty of the centers who
offer themselves to the public as potential helping agencies, to
select and train the workers who offer service in their name.
Crisis intervention centres draw their volunteer workers from
the general population of the area they service. McGee (1974)
and others have found that not all volunteer applicants make
effective crisis intervention workers; the intervention may be
for better or worse as with psychotherapy. The criteria that
have been used and proposed in the selection of crisis

intervention volunters will be discussed in detail in a later section of this thesis. Briefly, volunteer applicants who are not accepted are typically those who are judged by crisis centre staff as being too judgmental, unreliable (cannot commit themselves to regular shifts), too unstable psychologically, or are characterized by other drawbacks. Unsuitable helpers may have a detrimental influence upon clients. Of those volunteer applicants who are accepted into training, a furthur group will select themselves out, and others will be asked to discontinue by trainers during the experiential aspects of training.

The concerns voiced earlier by Zax and Spector (1974) about non-professional helpers require that crisis intervention volunteers be specially prepared for their arduous and often thankless task with specialized training programs. Training can include components such as non-judgmental listening practice, information on local resources, determination of the seriousness of suicide calls, and other aspects.

Little disagreement exists between a wide range of sources on the contention that crisis intervention workers require special training due to the unique features of the service (Delworth et al. 1972, Berman 1973, Lester and Brockopp 1973, Bleach and Claiborne 1974, Genther 1974, McGee 1974, France 1975 and many others). Bleach and Claiborne (1974) and others have demonstrated a positive relationship between performance variables and training. Fisher (1973) reported that somewhere

between 15 and 20 hours of pre-service training is the norm for crisis intervention workers. The training literature is not in agreement however, on how much or what type of training is best.

Dixon and Burns (1975) surveyed seven articles on crisis intervention training and found little or no agreement on what type or what length of training is most effective. This is an extremely important finding and it represents one of the major motivations for the current study. The literature on training will be discussed in detail in a later section of this thesis. Berman (1973, Page 95) provides a good summative statement on the recent history of non-professional training:

> In the rush to train the new manpower the professional community has behaved much like a client in crisis, i.e., by falling back on old, well tried, but presently inapplicable modes of coping and adaptation.

The contributions that this study hopes to make are multiple. First, the current study hopes to provide a well-controlled examination of the effects of different amounts and types of crisis intervention training on a variety of performance criteria, both written and behavioral. Secondly, this study hopes to contribute to the development of crisis intervention by developing parallel forms of a measure that can be used either as a selection instument (Delworth, Rudow, and Taub 1972) or as a pre/post measure of training effectiveness (Morgan and King 1975). Third, the current study hopes to provide research expertise and resources which are not usually

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available to non-profit community services currently functioning in the community mental health area. As Rappaport (1977) contends, these centers can benefit in terms of increased program effectiveness through the use of evaluation research. And finally, this study also assesses the crisis telephone worker in his/her role as referral agent. The effectiveness of this role has not been adequately assessed previously (France 1975 and Auerbach and Kellermann 1977).

Following is a discussion of the previously published literature on the history of crisis intervention, overall evaluations of crisis intervention's effect on the community and clients, research on selection and training of crisis telephone workers, important measurement development research, and the results of some pilot research conducted by the author.

II. Chapter 2: Literature Review

2.1 The Modern History of Crisis Intervention and Suicide
Prevention

In 1958, the modern history of institutionalized crisis
intervention and suicide prevention began with the opening of
the first suicide prevention centre in Los Angeles. The funding
for the Los Angeles Suicide Prevention Center (L.A.S.P.C.) came
from a National Institute of Mental Health five year grant
(McGee 1974). There are now approximately 200 crisis centres
operating in the United States and an additional 80 crisis
centres operating in Canada (Brockopp 1973, Fisher 1973, McGee
1974, and Powicke, Mair and Kremer 1976). New studies of crisis
intervention and suicide prevention were launched, as many other
areas in psychology are launched, by an accidental discovery by
some observant psychologists. Norman Farberow and Edward
Shneidman accidentally discovered several hundred suicide notes
in the Los Angeles coroner's office. According to McGee (1974)
they then analyzed these notes in terms of thinking process
involved and they became convinced that they could prevent some
of these suicides. These conclusions lead to their National

Institute of Mental Health grant application and the birth of the L.A.S.P.C.

The original focus of the centre was almost entirely on suicide prevention and the actual saving of lives. This somewhat narrow focus has broadened tremendously in the face of client demands, and suicide calls now represent only a small percentage of total calls (Delworth, Taub, and Rudow 1972; and McGee 1974). The range of presenting problems that crisis telephone workers dealt with included loneliness, marital problems, family problems, drunk callers, abusive callers, suicide attempts and threats of suicide, and chronic (repeat) callers. Brockopp (1973) discusses special treatment modes for special types of calls. Driol (1978) found differences in self-reported effectiveness for crisis workers dealing with different types of calls.

In discussions of the development of crisis intervention theory Lindemann (1944) and Caplan (1964) are cited as pioneer theoreticians by both Shneidman (1973) and Rappaport (1977). Lindemann studied the survivors of the famous "Coconut Grove" night club fire in Chicago. He detailed methods for helping deal with these people in crisis and also developed a four stage theory of response to crisis. Crises can be either accidental or developmental periods of high stress that upset psychological equilibrium and push coping stategies to and beyond their limits of effectiveness. The treatment approach suggested involved

support from empathic and warm outsiders that supplements personal resources. Intervention at this point may avoid exacerbation of the problem. Caplan viewed crisis intervention as a level of prevention. Intervention at crisis time may prevent an individual from later, costly institutionalization or even death by suicide. In discussing crisis intervention theory Shneidman (1973) feels that there are two main dimensions to a crisis that must be assessed. These dimensions are intensity of the crisis and the time of life in which the crisis is occurring. Shneidman contends that crisis intervention is not the time for complex psychological interpretations and that a crisis worker does not therefore, need the same level of training that is required to do psychotherapy effectively.

Crisis intervention as practiced in most centers, is a one-shot, anonymous interaction between persons who are experiencing themselves in crisis and a volunteer helper who is armed with only a desire to help and minimal training (Fisher 1973 reports that between 10-20 hours is usual). The services offered by crisis centers are usually on a 24-hour basis and are as accessible as a telephone. These services could not achieve this level of accessibility without volunteer non-professionals (Fisher 1973, Farberow 1974; McGee, Richard and Bercun 1973 and Powicke, Mair and Kremer 1976). Farberow (1974) reports that 80% of the crisis centers in the United States use volunteers as their primary staff pool. McGee, Richard, and Bercun (1973)

concluded that the only way to ensure direct service to people in crisis was to use volunteer workers and to operate a 24 hour direct telephone service. Fisher (1973) surveyed 192 suicide prevention and crisis intervention centers and reported that 86% utilize and rely on volunteers in some capacity.

2.2 Current Status of the Field of Crisis Intervention

The fields of crisis intervention and suicide prevention have undergone tremendous expansion since the days of their modest beginning less than twenty-five years ago. The National Institute of Mental Health in the United States now has a permanent subsection called the National Institute of Suicidology which publishes the Bulletin of Suicidology. Brockopp and his co-workers have established the Erie County Suicide Prevention and Crisis Intervention Service, which publishes a journal titled Crisis Intervention (Brockopp 1973). R.K. McGee and his co-workers and doctoral students at the University of Florida have contributed significantly in measurement development for evaluation research, have produced a number of doctoral dissertations on various aspects of crisis intervention theory and practice (Knickerbocker 1972, Ansel 1972 and others), and have established the Crisis Worker Data Bank in Gainesville, Florida (McGee 1974). Delworth, Taub, and Rudow (1972) at Colorado State University have provided an instrument for the selection of crisis telephone workers and have also

developed a training program specifically designed for crisis
phone workers. In Canada, the crisis centers now have a National
Directory (Powicke, Mair, and Kremer 1976) and their
representatives meet regularily at local, regional, national,
and international conferences (i.e. Resnik and Hawthorne 1971).

2.3 Overall Evaluations of Crisis Intervention and Suicide Prevention Services

As mentioned earlier, Rappaport (1977) contends that the
psychologist can aid in the development of community psychology
programs by providing consultation in the areas of program
evaluation, planning, and change. In evaluating the impact of
community psychology programs that offer crisis intervention
services researchers have used many different dependent
variables as the criteria of success. Studies of the overall
effectiveness of crisis intervention services have utilized such
wide ranging criteria as: subjectively-rated evaluations
provided anonymously by former clients (Slem and Cotler 1973,
King 1977); ratings made by non-anonymous clients (Slaikeu
1979); rate of re-use of the service by former clients (Apsler
and Hoople 1976); the client showing or not-showing at a
subsequently scheduled face-to-face counseling session (Walfish,
Tapp, Tulkin, Slaikeu, and Russell 1975 and others);
subjectively rated interviews made with suicidal clients one

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month after making a call to a crisis centre (McKenna, Nelson, Chatterson, Koperno and Brown 1975); level of facilitative conditions for therapuetic change (Carkhuff 1969) and others offered by crisis workers to simulated calls (Knickenbocker 1972, Knickerbocker and McGee 1973, Bleach and Claiborne 1974, Genther 1974, Carothers and Inslee 1975, Jamieson and Johnson 1975, Libow and Doty 1976, and Kalafat, Boroto, and France 1979); and workers' perfcrmance as measured by two different rating scales that rate the technical aspects of crisis worker performance (Fowler and McGee 1973, Morgan and King 1975 and Hart and King 1979).

Slem and Cotler (1973) and also King (1977) used ratings of effectiveness by former crisis centre clients as a criterion of overall crisis centre performance. This method of data collection is extremely inefficient due to the fact that most clients of crisis centers are anonymous. Subjects were obtained by sending out a large number of questionaires to potential crisis centre clients obtained from random sampling of the population. King (1977) sent out three thousand questionaires and recieved only sixty-six replies. This figure represents only a 2.2% reply rate for all subjects to which the questionaire was mailed. The percentage of subjects who were former crisis centre users was not known. Sixty-seven percent of male Ss rated the crisis centre as at least somewhat helpful. Eighty percent of female Ss gave favorable ratings of the effectiveness of the

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crisis centers' performance.

In a follow-up study of non-anonymous former crisis centre clients Slaikeu (1973) found that 80% of callers rated the call as a four or a five on a five-point helpfulness scale. Slaikeu also reported that forty-three percent of the callers attributed positive change in the problem to the call. Slaikeu's study does not suffer from the wasted experimental efforts of King (1977). Ratings of crisis centre performance by non-anonymous former callers are much more efficiently obtained. However most crisis centers, (including the three that are the subject of this study), utilize a method of crisis intervention in which most callers remain anonymous. It has been argued earlier that the anonymity of clients is a crucial factor in crisis intervention and that changes in this factor may lead to reduced use by some members of the potential target population (Lester 1973 and McGee 1974).

The rate of re-use of crisis centre services was utilized as an effectiveness criterion by Apsler and Hoople (1976). This is also an inadequate performance criterion as the re-use of a crisis centre by a caller may not always be viewed as positive by crisis centers. For example, Brockopp (1973) discusses the phenomenom of the "chronic caller", this type of caller is very resistant to change and makes repeated, inappropriate use of the hotline, presenting the same difficulties over and over. With limited phone lines and limited numbers of available phone

volunteers these chronic callers tie up services that others could use more appropriately with more acute problems. Chronic callers seriously confound using the re-use rate as an effectiveness measure. Furthermore, Driol (1978, Page 66) in a survey of crisis centre volunteers in the Greater Vancouver area, reports that the majority of volunteers rated themselves ineffective with chronic or repeat callers.

K. A. Slaikeu and colleages have completed a series of studies which have used the dichotomous variable of attendance or non-attendance at a subsequently scheduled face-to-face counseling session as a criterion of crisis centre effectiveness (Walfish, Tapp, Tulkin, Slaikeu, and Russell 1975; Russell, Slaikeu, Tapp, Tulkin, and Walfish 1978; and Slaikeu 1979). These studies were conducted at crisis centers which make a point of obtaining identifying information from clients and which also employ face-to-face counseling services as well as telephone crisis intervention. Slaikeu (1979) found that calls on which more silence occured were more likely to be "no shows". Russell et al. (1978) found that the technical-effectiveness rating of worker performance developed by Fowler and McGee (1973) was positively related to "shows", while Walfish et al. (1975) concluded that specific crisis worker behaviors such as focusing on the problem early in the call were positively related to this criterion of subsequent appointment attendance.

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McKenna, Nelson, Chatterson, Koperno, and Brown (1975)
interviewed eighteen suicidal callers 28 days after they had
called a crisis centre with a suicide call. McKenna et al.
defined a suicide call as a call in which the client talked
about present suicidal feelings, and threatened or attempted
some self-destructive act. The authors defined acute and chronic
on the basis of length of time that the subjects had been
presenting suicidal ideation. For the acute suicide callers
(n=3) the majority of their responses indicated that they had
improved. For the chronic suicide callers (n=15) McKenna et al.
(1975) report that sixty percent were still suicidal at
follow-up. This study employed a very small sample size and the
criteria of improvement were poorly defined. Based on this small
sample and these subjective interviews McKenna et al. (1975)
concluded that crisis centre techniques are more effective with
acute suicidal callers.

The most widely used criterion of effectiveness of crisis
centre performance is ratings of facilitative conditions for
therapeutic change offered by crisis phone workers to real or
simulated calls. The ratings of "facilitative conditions" are
based on the theory of psychotherapy developed by Rogers (1957),
Carkhuff (1969), and many others. Rogers (1957, Page 95) defined
conditions for therapeutic personality change that he felt must
be provided by the therapist in order for positive client change
to occur. These conditions included accurate empathic

understanding on the part of the therapist which is communicated to the client in a genuine and empathic manner. Carkhuff and associates (1969) have developed a series of rating scales on which the client/therapist interactions can be reliably rated for such criteria as empathy and facilitative genuineness on the part of the therapist. Carkhuff (1969) has developed an instrument for the selection of prospective helpers based on the ability to discriminate the presence or absence of these facilitative conditions in helper responses to clients' problems. A similar instrument specifically designed for use in the selection of crisis centre prospective helpers has been developed by Delworth, Taub, and Rudow (1972). Mickelson and Stevic (1971) rated couselors using earlier versions of Carkhuff's rating scales for empathy, warmth, and facilitative genuineness (from Truax and Carkhuff 1967) and found that information-seeking behavior was significantly higher ($p > .01$) for clients of counselors who achieved high scores. Gormally and Hill (1974) have provided guidelines for research on Carkhuff's model including recommendations that researchers use a comparable control group and use more than just one dependent variable. Gormally and Hill (1974) surveyed studies that have used these rating scales and they report inter-rater reliabilities that range from .68 to .94, which they find acceptable. A brief summary of studies that have used performance criteria developed from the Rogers and Carkhuff

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model follows.

Knickerbocker (1972) found that trained non-professional crisis intervention telephone workers offered significantly more total facilitative conditions for change than did professionals dealing with the same client population. The total facilitative conditions measure was a combination of rating scores of empathy, warmth, and genuineness. Knickerbocker and McGee (1973) provide a comprehensive discussion of Knickerbocker's findings. The rating scales used were those developed by Truax and Carkhuff (1967) and another similar scale developed by Lister (1970). On both sets of scales Knickerbocker found that non-professional crisis intervention workers were offering levels of facilitative conditions at the midpoint of the scales, levels judged by the authors as minimally necessary for client change to occur.

Bleach and Claiborne (1974) also used the scales developed by Truax and Carkhuff (1967). They found that the centers they studied offered generally low levels of facilitative conditions for client change. One important result obtained by Bleach and Claiborne (1974) was the finding that the centre which offered the most comprehensive and systematic selection and training programs also offered the highest levels of facilitative conditions. Genther (1974) called ten crisis centers in New England and had a confederate role-play to the crisis centre worker without the workers' knowledge that the call was not a

real crisis. Genther manipulated the callers' levels of
self-exploration and found two interesting results. First, all
of the crisis centers called offered low levels of facilitative
conditions. He used Carkhuff's (1969) scales and got an overall
average rating of 1.35 on a scale of five. This is a level that
Carkhuff (1969) would rate as not helpful to the client. The
other interesting result was that the lowest functioning helpers
were more affected by the experimenter's manipulation of helpee
self-exploration. The helpers who were rated as higher on
faciltative conditions were less affected by the experimenter's
artificial manipulations of the clients' levels of
self-exploration. They appeared to be more inner directed.
Several problems detract from the external validity of Genther's
(1974) study. He used only one call to each centre and so did
not get an accurate sampling of variability between crisis phone
workers within a center. Genther's calls were rated live so
replication of his results is impossible. And finally, by
structuring in advance the level of client self-exploration he
placed demand characteristics on the crisis centre workers that
were very powerful.

Carothers and Inslee (1974) called twenty-one crisis
centers and role-played a standardized call which they
audiotaped. The crisis centre workers who were called were not
informed that the call was a role-play and not a real crisis.
The taped calls were then rated using Carkhuff's (1969) rating

scale of Empathic Understanding. The average level of empathic understanding offered by the twenty-one centers was 1.95 on a one-to-five scale. This is a level of empathic understanding that Carkhuff judges to be minimally facilitative for positive client change. The range of mean levels of empathic understanding offered were 1.02 to 3.10. When level of empathic understanding was related to length of call it was found that a significant positive relationship exists. Carothers and Inslee (1974) conclude that the levels of empathic understanding offered by the crisis centre workers were low but still somewhat helpful. They also concluded that this minimal level of empathic understanding was important because it was avaliable to a much larger client population that almost any other helping service.

There is one primary difficulty with the method employed by Carothers and Inslee (1974). Crisis centers have only limited phone lines and volunteers available and this method ties up the service thereby creating a disruption in service. At most crisis centers there are often only one crisis worker "on duty" at a time and while the lone worker is handling a role-played call, he or she might be missing a suicide caller who is getting a busy signal. Local crisis centres receive an average of approximately 50 calls per day with very little time between calls. Furthur ethical issues are also raised by their method. The crisis workers were not told that they were a subject in this study prior to their participation. If the crisis phone

worker was told to expect a role-played call as part of a research study, this might seriously affect the workers performance thereby again causing a disruption to the service. As mentioned earlier, Bleach (1973) cautioned that service disruption must be avoided when doing evaluation research in the area of crisis intervention by telephone.

Jamieson and Johnson (1975) used a written measure of empathy developed by Hogan (1969) and found that trained male volunteer crisis intervention workers were significantly more empathic than male untrained undergraduates, male professional therapists, and trained female paid crisis phone workers. There were no significant differences between any of the groups of female subjects, a finding that the authors do not attempt to explain.

Libow and Doty (1976) used psychology undergraduates as subjects in an attempt to compare empathic with advice-giving styles of crisis intervention by telephone. Subjects played the role of the client and interacted with two of the experimenters' confederates, one of whom used an empathic style while the other used an advice-giving style. Subjects were then asked to rate the role-played calls for helpfulness and helper likability. Libow and Doty (1976) report that the subjects preferred the advice-giving style. Based on their findings they concluded that crisis phone workers should be trained more in a directive, advice-giving style. However, two major criticisms of this study

detract from the generalizability of Lidow and Doty's (1976)
results and the validity of their conclusions. Libow and Doty
did not use actual crisis intervention workers as the helpers in
their study. The helpers were advanced psychology undergraduates
trained by the authors. The other major criticism is of their
use of psychology undergraduate students as the "clients".
Psychology undergraduate students do not accurately represent
the population of potential crisis phone line users. Therefore
the subjects evaluations of the helpfulness of the call and
their preference for the helper's style may not be safely
generalized to the population of crisis centre callers. This
preference for advice-giving helpers is not the same as the
information-seeking behavoir discussed by Mikelson and Stevic
(1971). Information and advice are not necessarily the same
thing.

Kalafat, Borota, and France (1979) related crisis
volunteers' experience at the task of crisis intervention by
telephone to an empathy scale and also the Technical
Effectiveness scale developed by Fowler and McGee (1973). They
found that performance on both these variables improved with
training and experience. This parallels findings with
nonprofessional helpers in areas other than crisis intervention
summarized by Carkhuff (1969).

The Technical Effectiveness Scale developed by Fowler and
McGee (1973) for crisis telephone workers has been the second

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most widely used type of measure in evaluation studies in this area. The scale consists of a checklist of nine behavioral items of crisis telephone worker effectiveness. These items have specific behaviorally-anchored scoring criteria which make ratings highly reliable. The authors report that Kendall co-efficients of concordance for three raters ranged from .904 to .992 . McGee (1974) comments that this rating scale is so reliable that it can be used by one rater if need be. The items in this scale address very specific crisis phone worker behaviors which included defining the problem, determining if the caller is suicidal or not, and determining if the caller has any social support system or not. This scale is shown in Appendix A.

Morgan and King (1975) developed a similar scale also based on specific crisis worker behaviors judged necessary for successful crisis intervention to occur. It is a twelve-item scale that has lower reported reliability than the Technical Effectiveness Scale developed by Fowler and McGee (1973). Morgan and King found that this measure was positively related to a helper's ability to discriminate facilitative conditions for client change as measured by the Crisis Center Discrmination Index (C.C.D.I.) developed by Delworth, Taub, and Rudow (1972). As previously mentioned, this instrument is based closely on a similar scale developed by Carkhuff (1969). The C.C.D.I. was specifically designed as a selection instrument for crisis

intervention workers. Volunteer applicants whose discrimination ability did not reach a certain level were judged as not likely to profit from training and so were not accepted into training. This decision by Delworth et al. (1972) was based on findings summarized by Carkhuff (1969) who found that prior ability to discriminate facilitative conditions for therapuetic change was highly predictive of ability to take advantage of training and later ability to communicate facilitative conditions such as empathy. Morgan and King (1975) found that the Crisis Center Discrimination Index could be used to predict post-training performance scores on their Technical Effectiveness Scale. Based on these findings Morgan and King (1975) recommend using the C.C.D.I. as a selection instrument and also a pre- and post-measure of training effectiveness.

Hart and King (1979) did not evaluate a functioning crisis centre training program but trained helpers for three two-hour sessions and then used the Technical Effectiveness Scale developed by Morgan and King (1975) to rate role-plays obtained before and after a training program. The role-plays were simulated crisis phone calls which were audiotaped. The authors found that training significantly improved technical effectiveness scores. As the training is less than the average amount reported by Fisher (1973), actual crisis intervention training may affect T.E.S. scores to a different degree.

One last criterion of crisis centre effectiveness merits discussion at this point. It has been argued by Rogers (1957), Carkhuff (1969), and Ivey (1970) and others involved in the business of selecting and training new helpers, that direct advice from the helper is usually not helpful to clients. In contrast Libow and Doty's (1976) study had concluded that helpees preferred a directive, advice giving style of helping, but their study suffers from serious difficulties that detract from the generalizability of the findings. Mikelson and Stevic (1971) found that clients of highly facilitative counselors engaged in information-seeking behaviors which is not the same as desiring advice. Knowles (1979) examined the amount of advice given to clients in thirty taped and simulated crisis intervention calls. The subjects were crisis intervention volunteers from a British Columbia crisis center. The author found that an astounding 70% of all helper responses consisted of kinds of advice. This figure approached 90% for calls dealing with the caller's perceived loneliness. Knowles (1979) concluded that the training and supervision of these crisis intervention workers needs to concentrate more on the training of other helper responses such as reflection. Knowles findings are compatible with some of the results of training evaluations that will be discussed in the appropriate section.

In summary, many widely varied criteria of effectiveness have been used in the evaluation of crisis intervention

services. The preceding section discussed difficulties in using criteria such as rate of re-use of the services, non-anonymous clients' ratings of the service, and subsequent attendance at face-to-face counseling sessions. The most widely used and most appropriate effectiveness criteria are based on ratings of crisis telephone counselors' behaviors in the areas of facilitative conditions for therapeutic change (Carkhuff 1969) and technical effectiveness (Fowler and McGee 1973, Morgan and King 1975).

2.4 Review Studies

Two major review studies have been published to date in the area of crisis intervention by telephone (France 1975, Auerbach and Kilmann 1977). France surveyed one hundred articles on the performance of workers in the field of crisis intervention by telephone. He found that crisis intervention workers have attempted to perform three main roles in the delivery of helping services to the community. These roles are: first, the role of a caring individual whose goal is to express warm, empathic concern to the caller; second, as a referral agent to other community resources who through a knowledge of local resources is able to match caller need to a specialized resource such as birth control information or rental aid; and third, as a behavior change agent who changes individual behaviors of

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clients in crisis. Individual behaviors that might be the target of change in crisis intervention include coping strategies and amount or type of social contacts. France concluded that there is ample evidence that crisis intervention workers are fulfilling the first role adequately, however there was no conclusive evidence that crisis intervention workers are operating effectively as referral sources or as behavior change agents. He stressed that the performance of telephone crisis intervention workers is by far the most important area for evaluation, rather than studies of caller or volunteer demographics. He also argued that crisis centers should be held responsible in determining the level of effectiveness of their workers. France suggested that simulated calls provide a good vehicle for this investigation. However, he cautioned evaluators about the dangers of disrupting the service. These dangers exist especially in the areas of anonymity of callers and crisis intervention volunteers' anxiety over being evaluated.

Auerbach and Kilmann (1977) conducted a slightly more recent literature review and came to some very different conclusions regarding the field of crisis intervention by telephone. They took a much wider look at the field than did France, who examined worker performance exclusively. Auerbach and Kilmann (1977) concluded that the field of crisis intervention was poorly organized and not well integrated. The authors felt that concise crisis intervention theory was lacking

and that the techniques of crisis intervention that were being practiced were many and extremely varied. When Auerbach and Kilmann (1977) examined the previous literature on Fowler and McGee's (1973) Technical Effectiveness Scale, they found it to be extremely reliable but they questioned the relationship of the scale to client change variables. Auerbach and Kilmann (1977) concluded that much more research is necessary in the area of validation of measures.

Auerbach and Kilmann (1977) were also very pessimistic about the clinical effectiveness criteria that have been utilized in many studies, such as empathy and facilitative genuineness . However, they concluded somewhat more hopefully:

> Both of the primary measures used, technical
> effectiveness and clinical effectiveness, can be
> reliably rated (clinical effectiveness to a lesser
> degree) from taped calls following brief rater training
> periods(Auerbach and Kilmann 1977, Page 1197).

Auerbach and Kilmann (1977) called for more research relating both technical effectiveness and clinical effectiveness to client outcome variables but they do not provide any suggestions about which other measures should be used while this research is being done. They do stress that the referral agent role also needs to be assessed directly in some manner but again provide no suggestions for a measure in this area. Hesse (1976) stressed the importance of the crisis intervention worker as referral agent and concluded that workers are not being well trained for this role.

Auerbach and Kilmann (1977) concluded their literature review with special emphasis on the need for evaluation research on crisis intervention services and agree with France's (1975) conclusion that the evaluation of training programs can lead to improved programming and more effective crisis phone workers.

In summarizing the key issues discussed in these two review studies, both of these studies point to the need for more research and understanding of both the process of crisis intervention and the selection and training of prospective helpers. Both France (1975) and Auerbach and Killmann (1977) agree that the performance of crisis intervention workers needs regular evaluation especially in the yet-unexamined role of referral agent.

2.5 Selection of Helpers for Crisis Intervention by Telephone

Crisis centres are primarily staffed by volunteer nonprofessionals who receive no material compensation for their efforts (Fisher 1973, McGee 1974). As in other areas of nonprofessional helping (Carkhuff 1969), crisis intervention volunteers are screened before being allowed to offer themselves as helpers to the community. There is widespread agreement that prospective crisis intervention counselors should be screened before beginning service (Delworth et al. 1972, Brockopp 1973, Ansel 1973, McGee 1974, Engs 1974, Tanley 1974, Morgan and King

1975, D'Augelli, Danish, and Hauer 1976; Gray, Nida, and Coonfield 1976; Evans 1976, and Hart and King 1979). While all these authors agree that selection should occur, they disagree strongly concerning which criteria for selection are most suitable and on which aspects of the selection process are the most important.

Carkhuff (1969) argued that because an intended helping interaction can have either positive or negative consequences for the client, prospective helpers should be carefully screened before being allowed access to clients. He developed several instruments to assess trainee helpers' levels of functioning in areas that he believed to be crucial to the helping process. These measures assess helpers' abilities to discriminate and communicate facilitative conditions for client change. Much research has been conducted on this model and a large amount of it is summarized by Carkhuff (1969). Gormally and Hill (1974) provided guidelines for research on this model. Lindquist and Rappaport (1973) have argued that the Group Assessment of Interpersonal Traits (G.A.I.T.) developed by Goodman (1965) is more efficient than the Carkhuff method. The G.A.I.T. brings all prospective helpers together in a face-to-face group exercise where they rate each others' interpersonal traits. This method involves a situation producing high levels of anxiety. Prospective crisis intervention volunteers might possibly be negatively affected by this method and so lead to the disruption

in service that Bleach (1973) warned evaluators against. The crisis centre selection process needs to evaluated as currently functioning before such an intrusive innovation can be safely introduced. Delworth et al. (1972) agreed strongly with Carkhuff's rationale. The authors aided in the development of the Roadhouse Crisis Center at Colorado State University. They were faced directly with the selection of both volunteers and paid crisis intervention staff at their crisis centre. They argued that effective selection was extremely important because it served the functions of screening prospective volunteers whose personal problems might interfere with their effectiveness in the role of helper and also of selecting those prospective helpers who had the most potential. Delworth, Taub and Rudow (1972) also agreed strongly with Carkhuff's (1969) contention that the best index of how helpers will perform after training is the helpers' current level of functioning. Delworth et al. developed the Crisis Center Discrimination Index (C.C.D.I.) as a selection instrument for crisis intervention counselors. The authors reported that students scored the same on both the C.C.D.I. and Carkhuff's Discrimination Index but the student subjects preferred the C.C.D.I. as the excerpts in the C.C.D.I. are more representative of problems faced by a university population.

Morgan and King (1975) administered the C.C.D.I. to volunteer crisis intervention applicants before training. After

training the crisis intervention trainees role-played a crisis
call which they rated with their Telephone Counselor
Effectiveness Scale (T.C.E.S.). Morgan and King (1975) found a
significant relationship between pre-training scores on the
C.C.D.I. and post-training scores on the T.C.E.S. The authors
concluded that the C.C.D.I. was a valid selection instrument.
Scores are calculated from a total of deviations from experts'
ratings of each of the four possible responses to sixteen
excerpts. Subjects make 64 ratings in all. Morgan and King
reported that Delworth et al. (1972) recommended a cutoff score
of 70-75 for selection. This cutoff score means that a subject
is making an mean error of 1.1 on a 1-5 helpfulness scale.
Morgan and King (1975) also suggested that pre- and
post-training administrations of the C.C.D.I. might make a good
criterion for the evaluation of training programs.

Brockopp (1973) argued that the selection criteria for
crisis intervention counselors should be broadly defined. He
felt that self-selection was a very important part of the
selection process. Brockopp reported that during the course of
training and the first few months of service, many crisis
intervention volunteers would find out that they were not
personally suited to the task. Brockopp (1973) listed several
reasons for which a volunteer might be asked to resign. These
reasons included poor performance, non-willingness to be
supervised, deviant atitudes, inability to make schedule shifts,

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violaticns of confidentiality of client information, and a
refusal to commit enough time to the crisis centre.

Ansel (1972) correlated crisis centre volunteer performance
with demographic characteristics. The author collected data on
variables which included age, marital status, previous suicidal
ideation, and amount of experience with suicidal friends or
relatives. The performance variables included the Technical
Effectiveness Scale developed by Fowler and McGee (1973). Ansel
(1972) found that volunteers who had been through marriage and
child-rearing were more likely to keep a long commitment to the
crisis centre. Ansel also found that there were no significant
relationships between the personality characteristics measured
and performance variables. Ansel concluded that monitoring of
new crisis intervention counselors' performance and continued
supervision would be more effective than 'a priori screening
based on demographic or personality variables.

McGee (1974) examined the screening process for volunteer
applicants at a Gainesville, Florida crisis centre. His total
sample began with 404 applicants who requested an application
form. One hundred and ninety-five (48.3%) of these applicants
eventually began service as crisis intervention telephone
counselors. The selection process consisted of seven steps with
the largest amount of screening-out of applicants occurring at
the interview stage (23.7%). McGee concluded that most of the
screening takes place early in the selection process and he

viewed this as a positive result because the selection process selected out most unsuitable applicants prior to their exposure to the crisis centre operation and confidential material. McGee (1974) also pointed out that valuable trainer time is saved by an efficient screening process. McGee seems to have assumed that that selection ends when service starts. This is not the case as Driol's (1978) study of "burn-out" so aptly indicated. The key components of McGee's (1974) selection process were the personal interview of applicants, psychological testing (which included the California Psychological Inventory), and the processes of experiencing training and obtaining feedback on trainees' performance.

Engs (1974) used the C.P.I. in a study of the characteristics of successful crisis intervention applicants. Engs found that that successful applicants scored higher on the Flexibility subscale and recommended this as a selection criterion. She also utilized the Kilander-Leach Health Knowledge Test and found uniformly low scores; because of this she recommended furthur training in this area for crisis intervention counselors.

Tanley (1974) determined crisis intervention counselors' type on the Whitehorn-Betz A-B therapist variable and related it to performance with two types of calls. The volunteers were divided into groups who then listened to simulated calls of a schizoid-type and a intropunitive-neurotic-type. Tanley (1974)

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rated these simulated calls with scales developed by Truax and Carkhuff (1967) that measure facilitative conditions for client change. Tanley concluded that A-type therapists are more effective with the schizoid callers and B-type therapists are more effective with the other kind of caller. He recommended that crisis centres utilize the A-B therapist variable as a selection instrument.

D'Augelli, Danish and Hauer (1976) rated simulated crisis intervention calls with the Helper Verbal Response System. This rating system consists of a series of frequency tabulations of categories of helper responses which include open and closed questions, and continuing and leading responses. D'Augelli et al. (1976) found that beginning helpers asked twice as many closed versus open questions and made more leading than continuing responses. They viewed these results as negative and recommended that their rating scale be used as a selection instrument. D'Augelli et al. (1976) also recommended that training be used to reverse these trends.

Gray, Nida and Coonfield (1976) developed a 60-item performance test for crisis intervention counselors. This test is very similar in design to Carkhuff's (1969) Discrimination Index. It has 15 client problems with four alternative helper responses that subjects were asked to rate for helpfulness to the client. Gray et al. (1976) gave this test to three groups of subjects. The groups consisted of undergraduates in a

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communications class, graduate students in counseling and crisis
intervention telephone counselors. The purpose of their study
was to validate their selection instrument by administering it
to established groups. Gray et al. found that crisis
intervention counselors scored significantly higher than both of
the other groups of subjects; graduate students in counseling
also scored significantly higher than the undergraduate group.
The authors recommended that their scale be used as a selection
device for prospective crisis intervention volunteers.

Evans (1976) administered the M.M.P.I. to 56 applicants at
an Ontario crisis centre. Evans used number of shifts completed
over a three month period as a measure of crisis centre
conscientiousness. He divided subjects who completed training
into two groups, those that did less than two shifts per month
on the average, and those that did more than two shifts per
month on the average. A discriminant anaysis of the M.M.P.I.
data failed to show any significant differences between the two
groups so Evans developed an empirical scale based on selected
M.M.P.I. items that did discriminate between the two groups. He
called this scale the Hotline Perseverence Scale. Using this
scale Evans was able to successfully classify 90% of one group
and 96% of the other.

Hart and King (1979) examined the interaction between
selection and training. The authors divided subjects into four
groups: two groups were selected on the basis of high Telephone

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Counselor Effectiveness Scale scores and two were randomly selected. One T.C.E.S. group and one randomly selected group were given 3 2-hour training sessions and the other two groups were given no training. They found a three-way interaction between training, selection and test. The authors also reported that training significantly improved T.C.E.S. scores.

The research that has been discussed in the previous section clearly illustrated the lack of agreement in the area of selection of crisis intervention telephone counselors. Many widely variable criteria were suggested as selection variables. The lack of agreement on selection procedures is mirrored when the literature on the training of crisis intervention counselors is examined. This discussion continues in the next section.

2.6 Training of Crisis Intervention Counselors

There is widespread agreement with the contention that crisis intervention telephone counselors require specialized training to prepare them for their difficult task (Delworth et al. 1972, Brockopp 1973, Fisher 1973, McGee 1974, Margolis, Edwards, Schier and Cramer 1975, Dixon and Burns 1975, and many others). However Dixon and Burns (1975) reported that there exists no systematic agreement on the issue of what is the most effective training model for crisis intervention telephone counselors. Delworth et al. (1972) provided a training program

and recommended that trainers be functioning at higher levels on measures of facilitative conditions for therapeutic change than trainees. The authors agreed with Carkhuff (1969) who demonstrated that trainees' levels of functioning on measures of facilitative conditions converge on those of the trainers', either up or down.

Brockopp (1973) also provided a training program model complete with role-play recommendations and instructions for dealing with special types of callers. The author recommended eight 2 1/2 to 3 hour training sessions. Brockopp also recommended an additional six hours of monitoring of experienced crisis intervention counselors as they handled real calls.

Fisher (1973) in a survey of crisis centres in the United States reported that workers usually received between fifteen and twenty hours of pre-service training. She reported that the content of this training varied widely from centre to centre, and that debate existed on the relative merits of didactic and experiential training components.

McGee (1974) recommended a heavy emphasis on experiential components of training. He contended that didactic presentations of facts and the reading of experimental articles were not as effective as role-played helping interactions and exercises that were designed to develop interpersonal sensitivity and personal awareness. McGee also recommended that measures of both clinical and technical effectiveness be used in the evaluation of

training programs.

Margolis, Edwards, Schier and Cramer (1975) provided yet
another description of a training program that they recommended.
Their description emphasized the development of sensitivity and
self-knowledge on the part of the prospective crisis
intervention counselors. They recommended components of training
that included practice in active listening techniques and
knowledge of local resources, placing particular emphasis on
preparing crisis intervention volunteers to be referral agents.
Active listening practice includes role-played practice in
specific helper behaviors such as reflection, continuing
responses and minimal encouragers such as "Hmmm" and "Go on".
France (1975), Hesse (1976) and Auerbach and Killmann (1977)
also recommended that the performance of crisis intervention
counselors in the role of referral agent be specifically trained
for and evaluated. The degree to which a crisis intervention
counselor is able to provide an appropriate referral can be
viewed to be a function of his/her preparedness for the task and
an evaluation criterion of training programs.

As previously mentioned, Bleach and Claiborne (1974)
reported that the crisis centres that were functioning at the
highest levels on measures of facilitative conditions for
positive client change, were those that had the most systematic
and well defined training programs. Also Driol (1978) reported
that crisis intervention counselor "burn-outs" were less

satisfied with the training and preperations they received prior to beginning crisis intervention counseling by telephone than active volunteers.

Other interesting findings on the topic of training included Morgan and Kings' (1975) finding that training significantly increased scores on ratings of technical effectiveness made on role-played calls. Gray, Nida, and Coonfield (1976) found that trained crisis intervention counselors scored higher on a counseling performance measure than graduate students in counseling. Evans, Uhlemann and Hearn (1978) compared sensitivity training for crisis intervention counselors to both microcounseling training (Ivey 1970) and no training. They used measures of facilitative conditions for client change as their dependent variables and they found that both trained groups scored significantly higher than the no-training group. Evans et al. (1978) also found that the microcounseling training group scored significantly higher than the sensitivity training group. Microcounseling training consisted of highly structured experiential exercises that concentrated on very specific counselor behaviors. The sensitivity training consisted on relatively less structured exercises designed to increase the prospective counselors' self-exploration and self-awareness.

Hart and King (1979) reported that training significantly increased ratings of role-played calls that were rated using the

Telephone Counselor Effectiveness Scale. And also, Doyle,

Foreman and Wales (1977) reported that supervision after

training was related to greater client satisfaction with the

therapeutic interaction that they had with crisis intervention

counselors.

In summary, no single training regime is universally

accepted in the area of crisis intervention counseling by

telephone. Different sources do tend to agree that training is

most effective when it consists of experiential components that

include role-played practice by the trainees. Measures of

facilitative conditions for client change and technical

effectiveness have been widely used and recommended as criteria

of training effectiveness. The performance of the crisis

intervention counselor in the role of referral agent has not

been adequately assessed to date and training in this area has

not been evaluated.

The following section presents a discussion of the local

crisis centres that participated in this study and a discussion

of some pilot research conducted at these centres by the author

of this thesis.

2.7 The Local Situation and Some Pilot Research

There are currently four crisis centres operating in the Greater Vancouver area. Three of these four crisis centres participated in the current study and also in some pilot research that was carried out by the author. The fourth centre suffered from a disruption in service due to funding difficulties during the time encompassed by the study and did not participate. The three participating centres were Chimo Crisis Centre in Richmond, Lifeline in Coquitlam, and Vancouver Crisis Centre. As in other locales discussed by McGee (1974), these three crisis centres use volunteers as their primary staff resource. Powicke, Mair and Kremer (1976) have provided a detailed description of each of these centres. Briefly, Chimo Crisis Centre has approximately 50 volunteers who are drawn from a mainly suburban city. Lifeline usually has between 40 and 60 volunteer crisis intervention counselors who reside in the surrounding communities of Burnaby, Coquitlam, New Westminster, Port Moody and Port Coquitlam. Students attending Simon Fraser University make up a significant proportion of Lifeline's volunteer population. Vancouver Crisis Centre has between 90 and 100 volunteers residing mainly in Vancouver and on the North shore area. V.C.C. draws volunteers from both the University of British Columbia and local community colleges.

Some of the demographic characteristics of volunteer crisis intervention counselors at these three crisis centres were examined as part of a research study conducted by the author as part of a two graduate courses in program evaluation taught by Ronald Roesch (Ph.D.) in 1977-78. At Chimo the average age of volunteer applicants was 32.2 years, seventy-two percent were female, 33 % had previous helping experience of some type, and most had heard that the crisis centre needed volunteers through advertisements in the media. Chimo volunteers had the least amount of knowledge about local resources prior to the start of training. At Chimo Crisis Centre volunteer crisis intervention telephone counselors are selected on the basis of the results of a highly structured, two-hour interview with crisis centre staff. Telephone counselors receive 18 hours of pre-service training over the course of a three week period.

At Lifeline the average age of volunteers was 31.9 years, 83% were female and approximately 45% had previous helping experience of some type. Volunteers were drawn mostly from the friends and aquaintances of active volunteer crisis intervention counselors, through advertisements at Simon Fraser University and local community colleges, and through the Burnaby Volunteer Bureau and S.H.A.R.E. society, a local helping agency. Lifeline volunteers had higher initial knowledge of local resources than the volunteer applicants at Chimo. Volunteer crisis intervention counselors at Lifeline had the lowest mean errors on ability to

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discriminate facilitative conditions for therapeutic client change (Carkhuff 1969, Delworth et al. 1972). Volunteers are selected using a thirty- to sixty-minute interview by salaried crisis centre staff. They received approximately 24 hours of pre-service training that included a heavy emphasis on aquisition of knowledge about local community resources.

At Vancouver Crisis Centre the mean age of volunteer applicants was 28.0 years. Fifty-seven percent were female and approximately sixty-seven percent had previous helping experience of some type. Volunteers were drawn from the Vancouver and North Shore areas through friends of active volunteers and through advertisements in the media and at local colleges and universities. V.C.C. volunteer applicants had the highest pre-training knowledge of local resources and they had significantly more previous helping experience. Volunteer applicants attend a two-hour orientation meeting that consists of a slide and tape presentation followed by a question-and-answer period with crisis centre staff. After this meeting volunteer applicants that are still interested, sign up for interviews with crisis centre staff. The interview lasts from 30 to 60 minutes. Training at V.C.C. lasts approximately 30 hours and includes a heavy emphasis on self-exploration and role-playing. The trainee crisis intervention counselors are required to monitor experienced counselors. They are then monitored for at least one more four-hour shift before being

signed-up for regular non-monitored shifts.

The selection process carried out by these three local crisis centres reflects the lack of standardization in the selection literature. Powicke, Mair and Kremer (1976) provided a detailed description of this process. The effects of this selection process were examined in the pilot research conducted by the author. At Chimo Crisis Centre 18 volunteer applicants were interviewed for two hours each. All of these applicants were selected into training. Twelve of these eighteen volunteers selected themselves out or were asked to discontinue during the course of training. At Chimo the volunteer co-ordinator spent approximately 36 hours on interviewing and selected out none of the volunteer applicants. The greatest amount of screening was done by the volunteers themselves later during the course of training.

At Lifeline, 12 of 12 applicants were interviewed and accepted into training. During the course of training three volunteer applicants were screened-out, two by themselves; one applicant was informed by the trainers that s/he was not suitable.

At Vancouver Crisis Centre 30 volunteer applicants attended the two-hour volunteer orientation meeting. 11 of these applicants did not request an interview. In a time-based cost/benefit analysis, V.C.C.'s two-hour orientation cost two hours of staff time but saved 11 one-hour interviews for a net

time saving of 9 hours of crisis centre staff time. Applicants who did not seek an interview were expecting to commit less time than volunteer applicants who signed-up for interviews. Their expected length of commitment was less than the four hours per week over one year that is required by the crisis centre. This screened-out group was also significantly younger than the other 19 subjects. Of the 19 volunteer applicants that requested interviews, 6 screened themselves out during the course of training, 1 was rejected at the interview and 1 was asked to discontinue during training. Eleven of the total of thirty volunteer applicants finished training and began service as volunteer crisis intervention telephone counselors.

In summary, at the three local crisis centres almost all of the selection that occurs is self-selection. Only a few volunteer applicants are rejected by the crisis centres. Most simply quit on their own, usually during training, when they find out that they are not personally suited to the role of telephone crisis intervention counselor. The sole efficient phase of the selection process is V.C.C.'s effective use of the two-hour orientation to screen-out volunteer applicants who do not feel that they can commit themselves to the required amount of time.

At Lifeline, pre- and post-training measures of trainees' knowledge of local community resources and ability to discriminate facilitative conditions for therapeutic change were

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available for nine trainees. Training at Lifeline significantly
increased Local Resource Knowledge (L.R.K.) ($\underline{t}$ 8 =11.24, p$\leqslant$01)
and decreased errors on discrimination of facilitative
conditions for client change ($\underline{t}$ 8 = 3.81, p$\leqslant$.01). These
preliminary results appeared to be positive but no comparison
group was available, and the use of repeated measures of the
same scale may account for some of the improvements in
performance on these measures. Parallel forms of the measure of
ability to discriminate facilitative conditions was seen as
desirable.

The training programs at each of these three local crisis
centres show a similar lack of standardization. The effects and
effectiveness of these different training programs are the
subject of this current thesis.

2.8 Conclusions of the Literature Review

Based on a review of the literature on crisis intervention
counseling by telephone the author decided to examine the effect
and effectiveness of training programs for these counselors at
three local crisis centres. France (1975) argued convincingly
that this area is of extreme importance. Crisis centres should
be held responsible for the level of service they offer and the
major way of controlling this is to provide effective training
that is regularly evaluated. The local situation reflects the

findings of Dixon and Burns (1975) who found little or no agreement on the questions of what type and amount of training is best. And also, the role of the crisis telephone counselor as referral agent is directly examined as recommended by Auerbach and Killmann (1977).

The following section presents the hypotheses, method, and procedures used in the current study.

III. Chapter 3: Method

3.1 Aims and Hypotheses of the Current Study

The main aims of the current study were the examination of
the effects and the evaluation of the effectiveness of three
different training programs for crisis intervention telephone
counselors. The three crisis centres offer different types and
amounts of pre-service training to their volunteer crisis
intervention counselors. A variety of written and behavioral
performance criteria was used to provide detailed feedback to
the centres. It is hoped that one result of this study will be
the standardization of the most effective training for crisis
intervention telephone counselors at the three crisis centres.
The following hypotheses were advanced based on the review of
the training literature.

Hypothesis 1: Vancouver Crisis Centres training program will
improve performance measure scores significantly more than the
other two centres in the areas of clinical and technical
effectiveness and also score higher on the post-training rating
measures.

Hypothesis 2: Lifeline's training program will improve scores on

local resource knowledge significantly more than the training
programs at the other two crisis centres.

Hypothesis 3: All three training programs will increase
performance variable scores significantly more than the
untrained comparison group and also score higher on
post-training performance ratings.

Hypothesis 4: Chimo crisis centre's trainees will perform
poorest on all performance criteria because of the brief and
compact nature of their training.

3.2 Training Programs

The three crisis centres that participated in this study
offer different amounts and types of pre-service training. At
Chimo Crisis Centre the volunteer trainees receive 18 hours of
pre-service training during a three-week period. Appendix B
contains an outline of this program. Chimo uses a series of
previously taped role-played crisis interventions that
illustrate specific types of calls. These taped calls are
discussed in detail throughout the course of the training
program. The trainees also do some role-playing. Group
discussion of procedure and examples are the major component of
training at Chimo. In general, the training program at Chimo is
highly time-intensive with two 3-hour sessions per week plus
home assignments on local resources and observation of

experienced counselors handling live calls. Chimo brings in one guest speaker who presents a seminar/discussion on the functions of the suicide prevention "Flying Squad". At the end of the three-week training period the trainees meet individually with the trainers to receive individual evaluations of their performance during training. Training groups at Chimo are led by the salaried volunteer co-ordinator with help from experienced volunteers.

At Lifeline Crisis Centre the trainees attend twelve 2-hour training sessions over the course of a six-week period. The training opens with an orientation and discussion period led by the Director. Lifeline brings in a number of outside speakers who give seminars on the topics of relationship counseling, alcohol abuse, suicide follow-up, drug use and abuse, and the volunteers' role in relation to the rest of the helping community. Trainees at Lifeline also receive didactically presented information on crisis centre policy and procedure. Role-plays by trainees are part of 8 of the 12 training sessions. Trainees are interviewed at the midpoint and again at the end of training to provide them with evaluative feedback on their performance. Lifeline also gives trainees a resource assignment in which they are required to use information services to expand their knowledge of local community resources. Each trainee is also required to call one agency to which they might refer clients. In this call the trainee role-plays a

client who is seeking help. The purpose of this assignment is to increase the prospective crisis intervention counselors' empathy for clients who are calling referral agencies. Training groups at Lifeline are led by the salaried volunteer co-ordinator with help from experienced volunteers. Appendix C contains an outline of Lifeline's training program.

The trainees at Vancouver Crisis Centre receive approximately 30 hours of pre-service training. The two-hour orientation of prospective volunteers has already dealt with most information-based questions so V.C.C. begins with an intensive, 8-hour training session. The first session is composed of awareness exercises, sensitivity training exercises, role-plays by trainers and trainees, and a detailed discussion and exercise on determining the severity of suicidal calls. This process uses video-taped examples and a guest speaker from the crisis centre's suicide prevention team. Subsequent training sessions takes place for 2 hours, twice per week. They heavily emphasize the use of role plays and exercises that are designed to increase trainees' self-exploration and self-awareness. Trainees recieve a large number of handouts on crisis centre operating procedures and crisis intervention theory. Trainees are also given specific instructions for dealing with child abuse calls. At the end of the training period trainees are required to monitor experienced crisis intervention counselors for at least one 2-hour shift. The monitored calls are discussed

in detail with trainers and the counselor who handled the call. Trainees are monitored for their first few calls or until the trainers determine that the trainee is ready to start working unsupervised shifts. Training groups at V.C.C. are led by pairs of experienced volunteer telephone counselors. Vancouver Crisis Centre did not provide an outline of their training program.

In summary, Chimo offered the least number of hours of pre-service training to their crisis intervention counselor trainees and their training is compacted into the shortest time period. Chimo made heavy use of previously prepared taped role-plays that dealt with specific types of common calls. Chimo's training program is the least experiential of the three programs. Lifeline offered more hours of training over a time period that is twice as long as the time period used at Chimo. The Lifeline training program is less heaviily structured than Chimo's. Lifeline brought in the greatest number of outside speakers who presented seminar/discussions on selected topics. Lifeline appeared to spend the most amount of effort in preparing their volunteers for the role of referral agent. Vancouver Crisis Centre provided the largest amount of training over a time period equal to Lifeline's. They placed the most emphasis on sensitivity and self-awareness aspects of training by including role-plays in every training session. Vancouver Crisis Centre also provided the most technical preparation for dealing with suicidal callers, and monitoring was a key part of

the training process. V.C.C.'s training program is the most
experiential of the three training programs.

3.3 The Experimental Design

The design of this study is primarily of the pre/post
non-equivalent comparison group type (Campbell and Stanley
1966). The sources of possible confounding variance that are
controlled by this type of design include history, maturation,
testing, selection, instrumentation and mortality of subjects.
In addition this type of design allows for causal inferences to
be made. Pre- and post-training measures of Local Resource
Knowledge and Ability to Discriminate Facilitative Conditions
for Client Change were collected from all subjects.

Role-played calls were obtained from all subjects only at
post-training . This part of the study represents a weaker,
static group comparison design. This type of design does not
control for sources of confounding variance in the areas of
selection bias, subject maturation and mortality. The choice of
the relatively weaker type of experimental design in favor of
lack of disruption in crisis centre operation reflects the
position recommended by Bleach (1973). The role-play procedure
was too intrusive to use prior to the crisis centres' selection
process: it might have led to a disruption in service by raising
the anxiety level of prospective volunteers to a point where

they decided not to continue.

3.4 Subjects

The subjects were 48 volunteer crisis intervention trainees at three different crisis centres in the greater Vancouver area. Twelve subjects were selected and trained at Chimo Crisis Centre in Richmond; their mean age was 37.8 years and 9 were female ard 3 were male. Twelve of the subjects were selected and trained at Lifeline Crisis Centre in Coquitlam; their mean age was 32.9 years. Eleven of the Lifeline Ss were female . Twelve subjects were selected and trained at Vancouver Crisis Centre; their mean age was 25.7 years and 9 were male. The comparison-group subjects were 12 prospective volunteers at Vancouver Crisis Centre who were waiting to go through a later training session or to start service at a later date. The mean age of the comparison group subjects was 28.1 years and the group consisted of 8 females and 4 males.

All of the subjects voluntarily participated in the study. They were paid $5.00 after the post-training data collection. The money for subject payments was provided by National research council (N.R.C.) subject funds made available through the Psychology Department at Simon Fraser University.

3.5 Measures

This study used measures of a) knowledge of selected local community resources and b) ability to discriminate facilitative conditions for client change, administered before and after training. In addition post-training role plays of a standardized crisis intervention call were rated for both c) empathy and d) technical effectiveness.

a) Local Resource Knowledge (LRK): Subjects were presented with a list of fifteen local community helping resources to which client referrals are often made. This list was compiled after consultations with directors and volunteer co-ordinators at each of the three crisis centres and included each of the crisis centres and also other agencies such as the Rentalsman, community care teams, mental health centres, Riverview Hospital and suicide follow-up teams. See Appendix D for this measure. Subjects were asked to give the location of the service and to describe the client population served by each. One point was credited for correctly locating an agency and one point was credited for correctly identifying the appropriate client population of the agency yielding a maximum possible score of 30. The range of obtained scores was 0 - 28. Only one form of this measure was used at both pre- and post-training data collection.

b) Ability to Discriminate Facilitative Conditions for Client

Change (ADFC): The ADFC measure was developed as part of this study. It consists of 16 excerpts of client problems that are followed by 4 possible helper responses. Subjects were asked to rate each of the 4 alternative responses using a 1 to 5 rating scale that is provided on each page. The rating of each alternative response is based upon the subject's opinion about how much facilatation of client change is contained in each response. Eight of these excerpts were borrowed from the Discrimination Index developed by Carkhuff (1969) and an additional eight of these excerpts were borrowed from the Crisis Centre Discrimination Index developed by Delworth, Rudow and Taub (1972). Each of these authors provided 16 excerpts; a subset of 8 excerpts was chosen from each of these authors based on their representativeness of the types of calls handled by crisis centres dealing with the general population. Carkhuff's (1969) excerpts were not specific to crisis centres and so some were unsuitable. Delworth et als.' (1972) excerpts were developed at a college crisis centre so some were not applicable to a general population.

Subjects were given 8 of these excerpts at pre-training and 8 others at post-training data collection. In order to control for the effects of repeated administrations of the same measure parallel forms of this measure were developed by the current author with the aid of one of his supervisors. Guildford (1954) defined parallel forms of a measure as having equal means, equal

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variances and high correlations between pairs of parallel forms. In order to develop parallel forms of the ADFC, the 16 excerpts were administered to 61 students in Psychology at Simon Fraser University. The data were analyzed with a program developed by R. Koopman (1979). This program compared all possible split-halfs of the 16 excerpts and chose the most appropriate parallel forms minimizing the mean square of form A minus form B differences for all subjects. This mean squared difference value was 3.79 and the Standard Error of Measurement for this sample equaled 2.61. The parallel forms chosen had $r(AB) = .909$, Mean A= 30.3, Mean B= 30.39, Mean A - Mean B = .09, and Variance A = 8.61, Variance B = 8.77. Form was included as a variable in the analysis of the current data for all Ss and was analyzed using a S.P.S.S. Breakdown procedure. Pre-training Form A scores had Mean = 35.5 and S.D. = 7.3. Pre-training Form B scores had Mean = 34.7 and S.D. = 6.7. Post-training Form A scores had Mean = 31.8 and S.D. = 5.6. Post-training Form B scores had Mean = 33.1 and S.D. = 7.6. Sequence A/B had a difference score of -2.4 and sequence B/A had a difference score of -2.9. This parallel form of the ADFC meets the definitional criteria proposed by Guildford (1954). See Appendices E and F for forms A and B of this measure. Approximately half (25 of 48 Ss) of the subjects were administered Form A at pre-training and Form B at post-training data collection. The other 23 subjects were administered the measures in reverse order. Further evidence

that demonstrates the success of the development of these parallel forms is the form A-B correlation for the no-training comparison group of r= .96. In summary, this type of measure has been shown to be reliable and the validity has been demonstated by studies cited by Carkhuff (1969) and Morgan and King (1975). In the current study the ADFC was related to both amount of previous helping experience and ratings of empathy of taped role-plays.

c) Ratings of Technical Effectiveness: Standardized, role-played crisis intervention calls were audio-taped and rated using the Technical Effectiveness Scale developed by Fowler and McGee (1973). This scale consists of a nine-point checklist of behaviorally-anchored items that are highly-reliably rated. The authors of the scale report a inter-rater reliability estimate .9 when the Kendall Co-efficient of Concordance was computed for three raters. In the current study two raters who rated eight role-played calls obtained a reliability estimate of .86 on the Spearman Correlation Co-efficient. Appendix A provides a copy of the T.E.S.

d) Ratings of Empathic Understanding in Interpersonal Processes: The audio-taped role-plays were also rated with this rating scale. This scale consists of a 1-5 ratings that are averaged over the entire length of the call. It was developed by Carkhuff (1969) and is closely based on a previous scale created by Truax and Carkhuff (1967). It is extremely widely used in counseling

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research. Gormally and Hill (1974) provided guidelines for research on this scale and model: they reported inter-rater reliability estimates that ranged from .68 to .94 . For the current study, the author and an advanced psychology undergraduate who received approximately 8 hours of training, served as the raters. Two raters, who rated 9 role-played crisis intervention calls, achieved an inter-rater reliability estimate of .88 on a Pearson correlation co-efficient. English and Jelenevsky (1971) reported reliability estimates obtained on audio, visual and audio-visual recorded helping interactions and found no significant differences between the three conditions. They reported that significant co-efficients of inter-rater reliability were obtained for all three rating conditions. Appendix G contains a copy of this rating scale.

Standardized Call for Audio-taped Role Plays :At the end of training for all experimental group subjects and after an equivalent period for comparison group subjects, subjects were asked to role-play the role of crisis intervention telephone counselor in an audio-taped role play. Williamson, Goldberg and Packard (1973) and France (1975) recommended using simulated taped calls to evaluate counselor performance. This method does not seriously disrupt crisis centre operation. The role of the client was played by an advanced psychology undergraduate, who was also an experienced crisis intervention counselor, for

two-thirds of the role plays. The author role-played the client in the remaining one-third of the taped calls. The author and the research assistant developed a standardized call which was based on a collection of information about a lonely and depressed caller. The client began each call similarly and revealed as much information as the helper elicited. Appendix H contains a detailed description of the characteristics of this standardized call. The type of call chosen represents one of the most common type of calls that crisis intervention counselors must deal with and is a type of call that telephone counselors usually do not find to be overly difficult (Brockopp 1973, Driol 1978).

3.6 Procedure

At Chimo Crisis Centre the pre-training measures of the LRK and ADFC were administered to subjects prior to their selection interview with the volunteer program co-ordinator. Twenty prospective volunteers filled out the pre-measures but only 12 of the volunteers completed training and became subjects in this study. Training lasted three weeks and the post-training data were collected at the crisis centre, four to six weeks after the pre-training measures were completed.

At Lifeline Crisis Centre 20 prospective volunteers completed the pre-training measures prior to their selection

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interview. Fourteen of these volunteer applicants completed training at Lifeline and only twelve of these became subjects in the current study (one refused to complete post-training measures and another was not available due to illness). Training lasted 6 weeks at Lifeline and post data was collected at the crisis centre within six to eight weeks of the pre-data collection.

At V.C.C. 36 prospective volunteers completed the pre-measures prior to the 2-hour orientation screening at Vancouver. Twelve of these prospective volunteers completed the next training session at V.C.C. and became subjects in this study. Of the remaining 24 volunteer applicants, 12 were contacted as part of the "No training" comparison group. Most of these subjects were either waiting to go through a subsequent training session or were planning to start their crisis centre service at a later time due to present commitments. These subjects also had their post data measures administered at Vancouver Crisis Centre. Post data were collected within seven to ten weeks of the pre data collection.

3.7 Data Analysis Procedures

Demographic variables of age, sex, residence and amount of previous helping experience were analyzed using Crosstabs and Breakdown procedures from the Statistical Package for the Social

Sciences (Nie, Hull, Jenkins, Steinbrenner and Bent 1975 and also Hull and Nie 1979). Tests of significance included chi squares for the crosstabs, and f tests on anovas for the breakdown procedures. The non-equivalence of pre-training scores on LRK and ADPC measures were determined with one-way anovas from the breakdown procedure. Subsequent analyses of post-training scores and post-training minus pre-training difference scores were analyzed using the BMDP 2V Analysis of Co-variance procedure using pre-scores as co-variates. Technical Effectiveness and Empathy ratings were analyzed with one-way anovas from the S.P.S.S. breakdown procedure. Comparisons of means obtained from significant anovas were made using the Scheffe' procedure. Comparisons of adjusted means obtained from the ancovas were made using Dunnett's comparison (Myers 1972). Correlations between variables were down using Pearson r and Tau C correlation co-efficients from S.P.S.S.

IV. Chapter 4: Results

4.1 Demographic Variables

Data on all subjects' age, sex, city of residence and
amount of previous helping experience were collected prior to
the start of training. The mean ages for each of the four groups
were analyzed with a a one-way analysis of variance (anova) from
the S.P.S.S. package. A significant difference was found between
groups (F (3,47)= 2.702, $p \leq .06$) on the age variable. Vancouver
Crisis Centre trainees were the youngest at mean age equals 25.7
years. Chimo Crisis Centre trainees were the oldest at mean age
37.8 years. Table I presents these results.

The proportions of male and female subjects in each group
were analyzed with an S.P.S.S. crosstabs procedure. A
significant difference in the proportions of female and male
subjects in each group was found (x^2, 3 = 12.66, $p \leq .006$). Chimo
Crisis Centre subjects were 75% female, Lifeline Ss were 91%
female, V.C.C. subjects were 25% female and the comparison group
subjects were 66.7% female.

City of residence was collected for all subjects to
determine if the crisis centres were drawing volunteers from

each others' areas. At Chimo, 11 of 12 subjects reported that they were residing in Richmond while the other subject reported a residence in the neigbouring community of Delta. At Lifeline, all 12 subjects reported living in the surounding communities of Burnaby, Coquitlam, Surrey, Port Coquitlam and Port Moody. Of the Vancouver Crisis Centre subjects, 10 reported residences in Vancouver while one each reported that they were residing in Burnaby and Coquitlam. Of the Vancouver based comparison group, 10 reported residences in Vancouver while 2 were living on the North Shore. In summary, only 2 of 48 subjects reported residences in areas serviced by a crisis centre other than the one they attended.

Subjects were asked to indicate the amount of previous helping experience on a 0-5 scale of ordered categories which ranged from 0= no experience to 5= more than 2 years previous helping experience. Helping experience was very broadly defined. It included any formal or semi-formal paid or volunteer experience in areas such as hospital volunteers, Big Brothers/Sisters, crisis intervention or companionship therapy with ex-mental hospital patients as well as other areas. A crosstabs by group performed on this data revealed no significant differences. Table II presents these results. Although not significant, Chimo subjects appeared to have less previous helping experience than the other three groups. 67% of Chimo subjects reported no previous helping experience as

compared to 27.8%, 11.1% and 16.7% at Lifeline, V.C.C. and in the comparison group, respectively.

4.2 Local Resource Knowledge

Mean scores on a fifteen-item measure of Local Resource Knowledge (LRK) were obtained at pre- and post-training data collection for each of the four groups. The four groups were significantly different on pre-training scores of the LRK (F (3,47) = 3.661, $p \leq .02$). Table III presents these results. Chimo trainees start training with significantly less knowledge of local resources. Post-training means on the LRK were also significantly different when the four groups were compared with a one-way anova (F (3,47) = 10.771, $p \leq .0001$). Table 3 presents these results and Figure 1 shows pre- and post-training change on the LRK for the four groups. Group means on the LRK were compared using the Scheffe paired comparison procedure with alpha set at .05. On the LRK pre-training scores, Vancouver Crisis Centre subjects had a significantly higher mean score than did Chimo trainee subjects. V.C.C. subjects were not significantly different from Lifeline or comparison group subjects on this measure, nor were Chimo subjects. On a post-training measure of the LRK all three groups of trained subjects had significantly higher means than the "no-training" comparison group.

Because of these intitial differences on pre-training scores on the LRK this data was furthur analyzed using a B.M.D.P. 2V Analysis of Co-variance procedure. Pre-training scores were included in this analysis as the co-variate. Table IV presents these results. All three training groups significantly increased LRK scores while the no-training comparison group did not change significantly. Pre-training scores were also a significant factor in this analysis. Dunnett's test of comparison of control group mean to experimental group means showed that each of the three trained groups of subjects scored significantly higher than the comparison group and that the three trained groups of subjects were not significantly different from each other. The 95% confidence interval for the smallest mean difference between a trained group and the no-training comparison group was 7.09 (+ or - 1.53) for V.C.C. versus the comparison group.

4.3 Ability to Discriminate Facilitative Conditions

Scores on the 32-item measure of ability to discriminate facilitative conditions for client change (ADFC) were obtained for all subjects. The total score represents a summation of all deviations from experts' ratings of the amount of facilitative conditions in each of four responses to eight clients' statements of their problems. Pre-training scores on the ADFC

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are presented in Table V. Apparent differences between the means of the four groups were not significant (F (3,47) = .922, p= .44) when a one-way anova was calculated. Post-training mean scores on the ADFC were also not significantly different between the four groups (F (3,47) = .952, p = .4238). Table V present these results and Figure 2 shows pre- and post-training change on the ADFC. However, when pre-training scores on the ADFC were included as a co-variate in a B.M.D.P. 2V ancova, both the means (F (1,47) = 10.06, $p \leqslant$ 003) and co-variate (F (1,47) = 18.38, $p \leqslant$ .0001) were highly significant. Adjusted means were contrasted with Dunnett's paired comparison test which revealed that none of the group means were significantly different from each other. Table VI presents these adjusted means.

4.4 Ratings of Technical Effectiveness

Audio-taped role-played crisis intervention calls were rated using the Fowler Technical Effectiveness Scale (Fowler and McGee 1973). Table VII presents the mean ratings for all four groups. Post-training differences in mean ratings of Technical Effectiveness approached but did not reach the .05 level of significance (F (3,47) = 2.348, $p \leqslant$ .09). Scheffe comparisons of group means with alpha set at .05 revealed no significant differences between the four groups.

4.5 Ratings of Empathy

Audio-taped role-plays were also rated using Carkhuff's
(1969) scale for the measurement of empathic understanding in
interpersonal processes. Ratings were summed and means were
calculated for the entire role-play. Table VIII presents these
results. A one-way anova revealed significant differences
between the means of the four groups (F (3,47) = 3.442, $p < .03$).
Scheffe paired comparisons with alpha set at .05 showed that
Vancouver Crisis Centre trained subjects scored significantly
higher than Chimo Crisis Centre trainees. There were no other
significant differnces between the group means.

4.6 Amount and Experientialness of Training

Number of hours of training was correlated with the
performance variables for the trained subjects only using a
Pearson Correlation co-efficient. Chimo trainees recieved 18
hours of training, Lifeline trainees received an average of 22.8
hours of training, and V.C.C. trainees received 30 hours of
training. Number of hours of training was significantly
correlated with LRK prescores (r = .44, $p < .005$), ratings of
post-training empathy (r = .48, $p < .001$), and post-training
ratings of technical effectiveness (r = .27, $p < .06$). ADFC
post-training scores were correlated -.25 with number of hours

of training ($p \leq .08$).

The three training programs were ordered on how experiential their training. Chimo was ranked as the least experiential, Lifeline was ranked second and V.C.C.'s training was ranked as the most experiential. This ordinal variable was correlated with performance variables using a Tau C statistic. Relative experience level of training was significantly correlated with LRK prescores (tau = .42, $p \leq .005$), empathy ratings (tau = .45, $p \leq .002$), and ratings of technical effectiveness (tau = .29, $p \leq .03$).

4.7 Relationships Between Variables for All Subjects

Age of subjects was significantly related to group ($F_{(3, 47)}$ = 2.702, $p \leq .06$).

Sex of subjects was analyzed in relation to all other variables using S.P.S.S. crosstabs and breakdown procedures. Sex was not significantly related to city of residence, age, pre and post scores on either the LRK or ADFC, or ratings of Technical Effectiveness and Empathy. Sex of subjects was marginally related to amount of previous helping experience (x^2 = 9.69, $p \leq .09$). Female subjects appeared to have more previous helping experience.

Amount of previous helping experience was significantly related to pretraining scores on the LRK (r= .29, $p \leq .02$),

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pre-training scores on the ADFC (r= -.29, p≤.02), and post-training LRK score (r= .25, p≤.04). Amount of previous helping experience was not significantly correlated with post-training ADFC scores or either of the rating scales. Amount of previous helping experience was correlated with the performance variables using a Tau C correlation co-efficient. It was significantly correlated with LRK prescores (Tau = .23, p≤ .03), ADFC prescores (Tau C = -.22, p≤.03), and LRK post-training scores (Tau = .20, p≤.04). Amount of previous helping experience was not significantly correlated with post-training perfromance ratings made on role-played crisis intervention calls.

The only other significant correlation between pre-training LRK scores and other variables was with LRK post-training scores (r= .51, p≤.001). LRK post=training scores were also highly correlated with number of hours of training received (r= .63, p≤ .001).

ADFC pre-training scores were significantly correlated with amount of previous helping experience as previously mentioned, and ADFC post-training scores (r= .53, p≤.001). ADFC post-training scores were also significantly correlated with empathy ratings (r= -.24, p≤.06).

Ratings of Technical Effectiveness were significantly correlated with number of hours of training (r= .27, p≤.04). Mean ratings of Empathy were significantly correlated with the

ADFC post training scores, as previously mentioned. They were also significantly correlated with number of hours of training ($r = .29$, $p \leq .03$).

The following section presents a discussion of these results in relation the hypotheses of the current study and related research literature. This final section also contains recommendations for the participating crisis centres regarding future training program strategies.

Table I

Mean Age of Group Members

Group	Mean Age	sd
Chimo	37.8	16.6
Lifeline	32.9	11.1
V.C.C.	25.7	5.9
Comparison	28.1	8.8

F (3,47) = 2.702, $p < .06$

Table II

Previous Helping Experience by Group

	Chimo	Lifeline	V.C.C.	Comparison
Amount				
None	8	5	2	3
Under 3 mo.	0	1	1	1
3-6 mo.	1	1	4	3
6-12 mo.	0	0	2	0
1-2 yrs.	1	2	2	3
2 yrs. or more	2	3	1	2

Table III

Local Resource Knowledge Scores Before and After Training

Group	Before Mean	sd	After Mean	sd
Chimo	4.4	4.7	15.9	5.4
Lifeline	8.7	4.5	18.8	5.0
V.C.C.	9.6	3.8	18.0	4.1
Comparison	6.9	3.4	9.2	3.7

$F_{(3,47)} = 3.661$, $p < .02$

Table IV

Analysis of Co-variance on Local resource Knowledge Postscores with Prescores as Co-variate

Source	ss	df	ms	F	p
Mean (A)	1179.4	1	1179.4	84.06	.0001
Centre (S/A)	585.4	3	195.1	13.91	.001
Co-variate	329.5	1	329.5	23.48	.0001
Error	603.4	43	14.03		

Table V

Ability tc Discriminate Facilitative Conditions Before and After

Training

Group	Before Mean	sd	After Mean	sd
Chimo	37.8	7.8	33.1	7.5
Lifeline	35.1	6.9	34.1	5.9
V.C.C.	34.1	5.8	29.8	6.0
Comparison	33.4	7.0	33.0	7.2

Table VI

Adjusted ADFC Post-training Group Means from the Analysis of

Co-variance

Group	Adjusted Mean
Chimo	31.7
Lifeline	34.1
V.C.C.	30.3
Comparison	33.9

Table VII

Technical Effectiveness Mean Group Ratings After Training

Group	Mean Rating	sd
Chimo	2.92	.8
Lifeline	3.50	1.1
V.C.C.	3.67	.8
Comparison	3.00	.6

Table VIII

Mean Empathy Ratings by Group After Training

Group	Mean Rating	sd
Chimo	1.86	.34
Lifeline	2.05	.27
V.C.C.	2.26	.34
Comparison	1.95	.34

F (3,47) = 3.442, p≤.025

Figure 1.

PRE- and POST-TRAINING LRK by GROUP
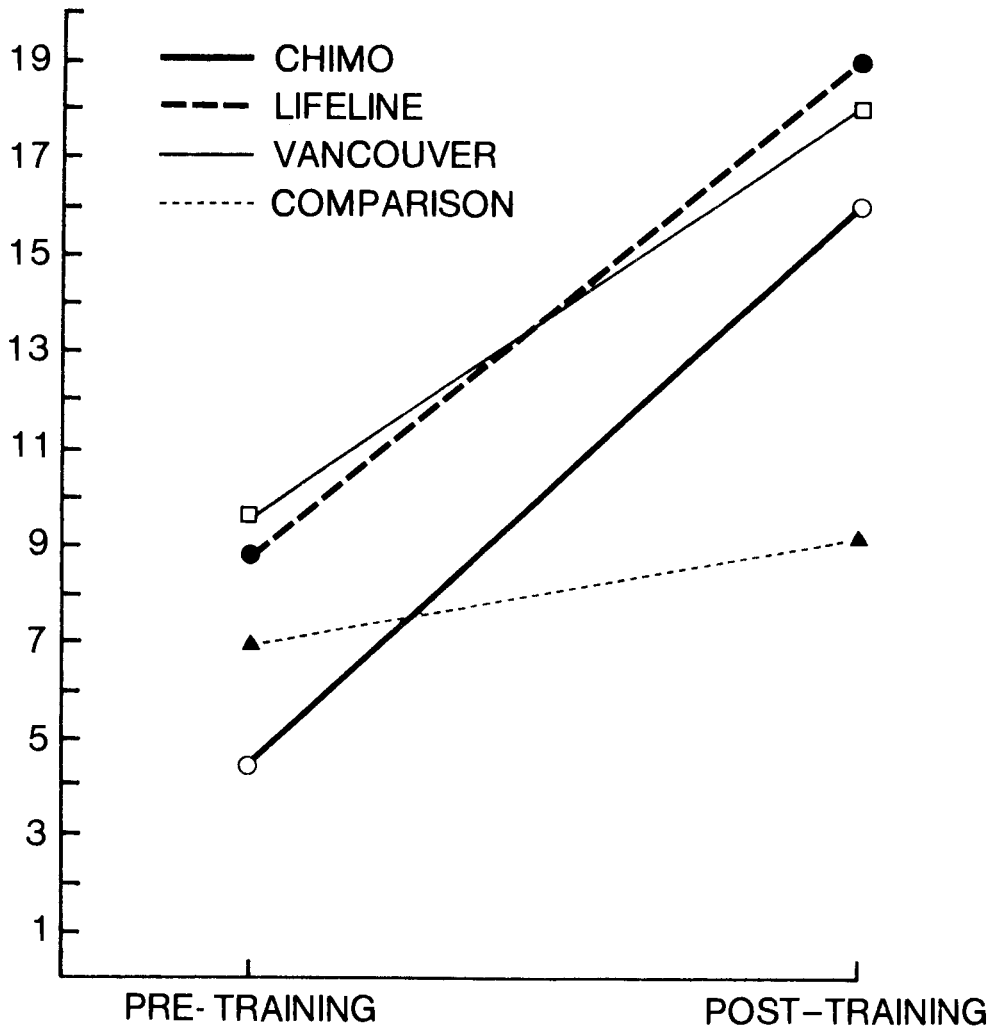
Figure 2.

PRE - and POST-TRAINING ADFC
by GROUP
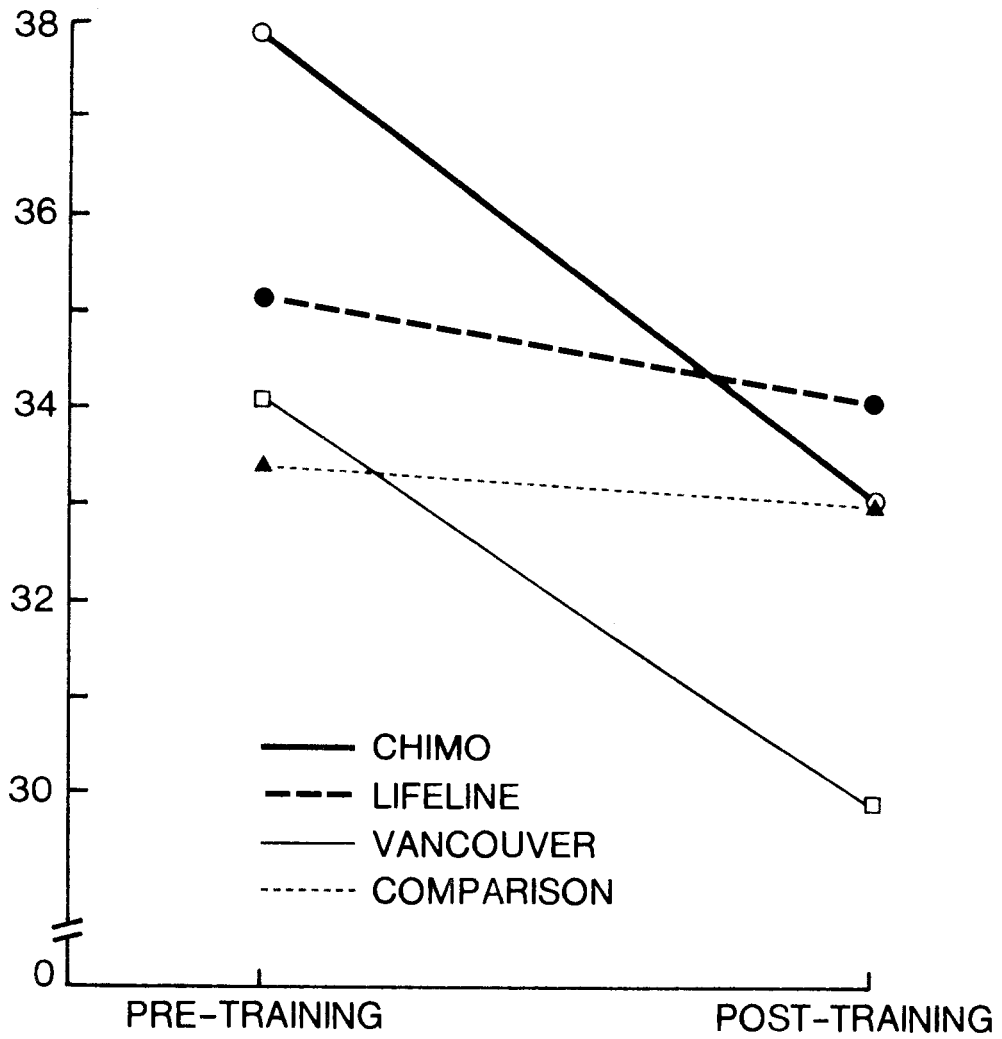
V. Chapter 5: Discussion

5.1 Summary of Main Results

This study was designed to examine the effects and effectiveness of three different training programs for crisis intervention telephone counselors.

Demographic Variables: There were demographic differences between the four groups of subjects. Vancouver Crisis Centre trainees were the youngest of the subjects. Chimo Crisis Centre trainees were the oldest and also had the least amount of previous helping experience. V.C.C. subjects were only 25% female while each of the other three groups were overwelmingly female in make-up.

Pre-training Differences: The groups were not equivalent on pre-training measures of Local Resource Knowledge (LRK) and Ability to Discriminate Facilitative Conditions for Client Change (ADFC). Chimo trainee subjects had the lowest amount of pre-training Local Resource Knowledge and the largest mean errors on Ability to Discriminate Facilitative Conditions.

Local Resource Knowledge: All three groups of trained subjects improved significantly on a post-training measure of L.R.K.,

while the "no-training" comparison group did not change. No single training group improved L.R.K. scores more than the other two trained groups of subjects.

Ability to Discriminate Facilitative Conditions: Two of the three trained groups showed positive non-significant change on the post-training A.D.F.C. measure. The "no-training" comparison group and one of the trained groups did not change over time on this measure of Ability to Discriminate Facilitative Conditions for Client Change.

Performance Ratings: Ratings of Technical Effectiveness on post-training role-played crisis intervention calls were not significantly different when the four groups were directly compared. The non-significant trend showed that one of the trained groups performed more poorly than the "no-training" comparison group which in turn scored lower than both of the other two groups of trained subjects. A significant difference was found between groups on the post-training ratings of Empathic Understanding in Interpersonal Processes. The order of performance for the four groups was the same as that found for the T.E.S. ratings, with V.C.C. best, Lifeline next, then the "no-training" comparison group, and finally the Chimo trainees.

5.2 Implications for the Hypotheses of this Study

Hypothesis 1 stated that V.C.C. training would improve performance more than the other two training programs on measures of clinical and technical effectiveness and also that V.C.C. trainees would perform better on the post-training only performance ratings. This hypothesis received partial support. V.C.C. trainees showed a positive but non-significant trend when they finished training with the lowest mean error scores on the ADFC measure. However, the pre/post-training difference score for V.C.C. (-4.34) was not greater than Chimo's trainees improvement (-4.46). Both Chimo's and V.C.C.'s trainees showed decreased errors on the ADFC measure while Lifeline trainees and the "no-training" comparison group did not change substantially. The lack of change on the ADFC by the comparison group is positive and reflects the success in the development of the parallel forms of the ADFC. The lack of post-training change for the Lifeline trainees on the ADFC measure may be the function of at least two factors. First, one Lifeline subject acheived the lowest (best) pre-training score on the ADFC (a score of 18.5, which means an average error of .6 per item, a level that Carkhuff 1969 reported for trained counselors). The impressively low pre-training score increased to 31.5 at the end of training. This decrease in apparent performance could have been the result of either regression to the mean of the farthest outlying score

or alternatively, this may be an example of a trainee's score converging on that of a more poorly functioning trainer, a phenomenon reported by Carkhuff (1969).

On the post-training role-plays, V.C.C. trainees had the highest mean scores on both Technical Effectiveness (Fowler and McGee 1973) and Empathic Understanding in Interpersonal Processes (Carkhuff 1969). Because no pre-training scores were available on these rating scales other sources of variance may be confounded with these results. However, from an evaluative perspective, V.C.C. trainees were the most prepared on these indexes of clinical and technical effectiveness of crisis intervention counselor performance at the end of training.

Hypothesis 2 stated that Lifeline training would improve trainees Knowledge of Local Resources significantly more than the other two training programs. This hypothesis was not supported by the data. When pre-training nonequivalence on the LRK was taken into account by a B.M.D.P. ancova procedure, the three training programs all improved LRK scores by approximately equal amounts. Chimo Crisis Centre trainees showed the greatest improvement in LRK score at +11.5 as compared to +10.1 for Lifeline, +8.4 for V.C.C. and +2.3 for the "no-training" comparison group. Adjusted means from the ancova procedure reinforced the finding that Chimo subjects started with the lowest pre-training LRK scores and improved the most.

Hypothesis 3 stated that all three training programs would improve performance measures significantly more than the "no-training" comparison group, and that the trained groups would score significantly higher on post-training performance ratings made on the role-played crisis intervention calls. This hypothesis received partial support from the data. Post-training group means on the LRK measure were significantly higher for all three groups of trained subjects when they were compared directly to the "no-training" comparison group. The comparison group did not change significantly over a time period equivalent to the lenghth of training. Training at all three of the crisis centres did prepare telephone counselors to fill the role of referral agent, at least partially.

As previously mentioned, only V.C.C. and Chimo trainees showed decreases in errors on the ADFC measure over the course of training however, these changes were positive but not significant. The Lifeline training program did not substantially affect this score, possibly for the reasons discussed earlier. The ADFC mean score did not change for the comparison group.

On the post-training rating of Technical Effectiveness both V.C.C. and Lifeline trainees scored higher than the untrained comparison group although these differences were not significant. Chimo trainees scored marginally lower than this untrained group of subjects. Possible explanations for these results fall in two main areas. First, the Chimo training

program had the least amount of practice of role-played crisis intervention skills. Second, Chimo trainees are the oldest and least experienced helping persons and performed more poorly on the pre-training measure of the ADFC, a type of measure which Morgan and King (1975) found was related to post-training technical effectiveness scores (albeit on a different Technical Effectiveness Scale than the one used here).

The post-training ratings of empathy showed significant results in the same pattern found on the T.E.S. ratings. Both V.C.C. and Lifeline trainees scored higher on the average than both the "no-training" comparison group and Chimo trainees. Role-play practice may be a factor here as well as the relatively heavier emphasis on self-exploration and self-awareness in the Lifeline and Vancouver Crisis Centre training programs.

Hypothesis 4 stated that Chimo Crisis Centre's trainees would perform at the poorest levels on all the performance variables because its training program was the shortest and was also too compact in time. As discussed earlier, this hypothesis received partial support, especially on the behavioral performance criteria. Chimo trainees performed similarly to untrained subjects on both rating scales and much more poorly than both other groups of trained subjects. However, the brief, highly compact nature of the Chimo training program did not appear to detract from the information aquisition that was

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required to improve LRK scores and it did improve ADFC scores (but only to the pre-training level of V.C.C.) The V.C.C. trainees subsequently improved to an even more effective level of performance on the Ability to Discriminate Facilitative Conditions for Client Change measure.

In discussing the relationship between amount of hours of training and experiential aspects of training and the performance variables there were several interesting findings. Number of hours of training was significantly correlated with both post-training performance ratings. The greater number of hours of training at V.C.C. appears to pay off on behavioral indexes of crisis intervention counselor performance. Post-training ADFC scores also tended to be lower (better) for the V.C.C. trainees although not quite at the .05 level of significance.

The relatively greater experiential aspects of the V.C.C. training program was also positively related to better performance on the post-training behavioral performance ratings.

In summary, more hours of training and more experiential training do relate significantly to behavioral measures of crisis intervention telephone counselor performance. This finding has implications for future training programs at crisis centres everywhere.

5.3 Implications for Future Crisis Centre Training Programs

On measures of Local Resource Knowledge all three training programs showed significant improvements in trainees' scores over the course of training. This is a positive evaluative finding. However, the mean LRK scores for all groups of trained subjects were only approximately 60% of the total possible score. No subject achieved a perfect score on the LRK and most subjects were not aware of the location and client population serviced by at least one-third of the fifteen local resources listed on the LRK. All three training programs have room for improvement in this area of training. In this evaluation of crisis intervention telephone counselors in the role of referral agent, their performance was adequate but not outstanding. It is recommended by the author in agreement with France (1975), Hesse (1976) and Auerbach and Killmann (1977), that the three training programs concentrate more effort in preparing their crisis intervention counselors for the role of referral agent.

On the ADFC measure only Vancouver Crisis Centre and Chimo trainees showed some improvement as a result of training however, this apparent improvement was not significant on a one-way anova. Each of the three crisis centres requires more emphasis on this type of training, especially Lifeline whose trainees showed little change and Chimo whose trainees start with a pre-training handicap on this measure. Carkhuff (1969)

and Delworth, Rudow and Taub (1972) suggested that the trainers' Ability to Discriminate Facilitative Conditions for Client Change be assessed prior to training and that trainers should be selected on the basis of low error scores. Carkhuff (1969) cited research that demonstated that trainees' ADFC scores converge on those of the trainers, either up or down. This may be a factor in the lack of significant improvements on the ADFC measure and in decreases in performance level for some of the subjects who had the lowest pre-training ADFC scores. Also, Chimo trainees had a non-significant trend towards higher pre-training error scores on the ADFC and as a result they require more and not less training in this area if initial differences are to be made-up by their training program.

On the Technical Effectiveness Rating Scale (Fowler and McGee 1973) none of the groups of crisis intervention trainees performed at a high level on the T.E.S. The highest mean for any group was 3.67 for V.C.C. trainees. If Chimo Crisis Centre both lengthens and spreads-out their training program they might make-up for these deficits. Inclusions of more trainee self-exploration and role-playing of crisis intervention calls could lead to improvement in this area. The T.E.S. is a nine-point checklist of appropriate telephone counselor behaviors. The highest score that was obtained by any subject was 5. Not one of the subjects made an effort to determine if the role-played caller was suicidal or how serious his suicidal

ideation was. All three training programs need to improve in this area.

On the ratings of Empathic Understanding in Interpersonal Processes (Carkhuff 1969) the Chimo trainees performed slightly more poorly than both other trained groups and also the "no-training" comparison group. As this variable is related to the ADFC the finding is similar, Chimo needs more not less training in this area. The highest mean Empathy rating was 2.26 on a 5-point scale for V.C.C. trainees. Carkhuff (1969) views this level as only minimally facilitative for client change. These findings replicate the findings of Genther (1974), Bleach and Claiborne (1974), Carothers and Inslee (1975) and others. All of these authors recommended more systematic training in this area. The finding that is of interest to the three participating crisis centres is that they might concentrate more specifically on training their telephone counselors in empathic listening skills, especially Chimo.

In summary, an evaluation of three training programs for crisis intervention telephone counselors revealed much room for improvement on a variety of performance criteria, both written and behavioral. Chimo Crisis Centre in particular was singled out as requiring longer, less compact training due to a pre-training deficit in volunteers' helping abilities. Both Lifeline and Vancouver Crisis Centre showed relatively better performance but they too require adjustments in their training

programs if they desire to have telephone crisis intervention counselors who are both highly effective referral agents and who are performing at high levels on measures of clinical and technical effectiveness.

5.4 Implications for Future Research

This study addressed the performance of crisis intervention telephone counselors in the role of referral agent for the first time. More research and measurement development is desirable in this area. Performance of trainees on both written and behavioral performance measures showed mixed results. The best trainees were performing at adequate but not outstanding levels of performance. Changes in the training programs designed to improve the performance of telephone counselors can be assessed with furthur evaluation research. Another desirable addition to this and future studies of crisis intervention training would be an additional data collection point, three to six months after the trainees had begun service as telephone counselors. In this type of design the relationship between training and experience could be assessed, possibly providing valuable evaluative feedback to the crisis centres. Another possible future study might link performance measures at the end of training with trainees' atitudes towards training, trainers and other variables.

In summary, this area is open to much more research which graduate students in psychology can provide as part of the development of the Community Psychology movement (Rappaport 1977). Crisis centres can benefit from research expertise and results but the nature and limits of their funding makes research dollars scarce or non-existent. Hopefully, the Applied-Clinical Psychology Programs at Simon Fraser University and other universities can help fill this gap.

Appendices

Appendix A: The Fowler Technical Effectiveness Scale

Items and Scoring Criteria

1. Can the caller be immediately re-contacted?
In order to answer this question affirmative the call must
contain enough information to enable the center to call or
contact the caller or to immediately go to the caller.
2. Did the volunteer ask or obtain specific information
regarding significant others?
A specific question dealing with the possibility of roommates,
parents, neighbours, friends or relatives must occur in order to
answer this question "yes". A general inquiry such as, "Do you
have someone to talk to?", will not be enough to qualify as a
"yes" answer.
3. Were specific problems identified?
A problem identified to which the center can respond, even if it
is not the focal problem, will qualify for a "yes" answer.
4. Did the volunteer communicate that s/he is willing to help?
This question may be answered on the basis of both affect and/or

content.

5. Did the volunteer develop a structured plan of action or help the caller to develop one?

A structured plan of action must lead to some action or event that will involve the caller in an observable behavior.

6. Did the caller agree to the action plan?

A definite committment must be obtained from the caller for this question to be answered "yes".

7. Was it determined whether or not this was a suicide case?

Specific inquiry from the worker mentioning "suicide" or "kill self" or spontaneous statement from the caller may be scored.

8. (a)Did the volunteer ask about a suicide plan? or (b)If the caller voluntarily disclosed the information did the volunteer inquire about furthur details?

Answer either (a) or (b) but not both.

9. Was it determined if the caller has made prior suicide attempts?

Specific inquiry must be made by the worker or a spontaneous statement by the caller may be scored.

Appendix B: Chimo Training Outline

Sessions: 1900 to 2200 Hours

Session #1: Orientation :Introduction, Handout of handbook,
Issue of interim ID cards, awareness exercise, tour of the
building, taped role play "Gloria", Group and individual role
plays, phone room procedures lecture and home assignments.

Session #2: Discussion on "domestic problems" and "drugs".
:Awareness exercises, taped role play "Nick Evans", individual
role plays, question period and home assignments.

Session #3: Discussion on "sexual problems", "loneliness and
depression" and "manipulation". Awareness exercises, taped role
play "Geno", qustion period and home assignments.

Session #4: Guest speaker from the suicide prevention "flying
squad". Awareness exercises, taped role play "Jack Dugan",
individual role plays, question and discussion period.

Session #5: Quiz, mini-drama, self-evaluation, taped role play
"Mary-Jo", issue of ID cards, return of handout, and
announcement of a social evening.

Session #6: Open question period, concluding remarks,
appointments for individual evaluations and a social gathering.

Appendix C: Lifeline Training Outline

Session #1: Orientation with the Director (1 Hour)

Session #2: Seminar and discussion on "relationships". Guest
Speaker. (2 hours)

Session #3: Lifeline rules and policy discussion. Introduction
to role playing. (2 hours)

Session #4: Seminar and discussion on "alcohol". Guest speaker.
(2 Hours)

Session #5: Communication and active listening discussion.
Role-plays on "alcohol". (2 hours)

Session #6: Role plays, question and answer period. (2 Hours)
Interviews with trainers.

Session #7: Phone room procedures, emergency procedures, and
resource assignments.

Session #8: Monitoring scheduled. Question and answer period.
Role-plays. (2 hours)

Session #9: Guest speaker presents seminar and discussion on
suicide attempt follow-up team (S.A.F.E.R.). (2 hours)

Session #10: Seminar and discussion on "drugs". Guest speaker.
(2 hours)

Session #11: Role plays on suicide and drugs. (2 hours)

Session #12: The role of the Lifeline volunteer in relation to other community agencies. Guest speaker presents seminar/discussion. (2 hours)

Appendix D: Local Resource Knowledge Measure

SECTION B

Write one sentence describing the client population and location of
each of the following community referral sources.

1. Chimo Crisis Center

2. Al-a-teen

3. Parents-in-crisis

4. Family Planning Association

5. Legal Aid

6. Lifeline

7. S.A.F.E.R. or S.O.S.

8. Community Care Teams

9. Canadian Mental Health Association   LRK score

10. Intersection

LRK Page 2

11. The Rentalsman

12. Riverview

13. Vancouver Crisis Center

14. Ministry of Human Resources

15. Post Partum Counseling

Appendix E: Ability to Discriminate Facilitative Conditions Measure; Form A

Section C

You will read about eight persons who are seeking help with a problem. These may not be formal clients but simply people who have sought the help of another person in a time of need. Following each excerpt by a person seeking help you will read four possible responses. These are initial responses that might be made early in the course of a helping relationship. Each of the four responses should be rated according to the continuum below. Rate each response independently of the others.

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimall aids the person i in deal-ing wit his problem.

Excerpt #1

Helpee; I would like your opinion, given this choice. I purchased a tab of acid from a friend of mine. He said it was very mild, a good one for someone who has never tripped before. I have always wanted to try LSD once--I have heard all about the controversies so I believe I know what I'm getting myself into. However, I would still like to hear what some other people have to say about it. I've made the transition to a freak almost, the acid is the last stage--so can you tell me what acid is all about?

Helper Responses; 1. Listen, I really think you should consider the physiological effects of acid. They can be detrimental to your psychological health.

2. Seems like a difficult choice to make. I can see how you might feel that it is part of becoming a freak.   _____

3. I hope that no one saw you purchase the tab.   _____

4. Being a freak is pretty important to you. But I sense some hesitancy or conflict in making your decision.   _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-	Partial re-	Minimally	Significantly	Optimall
ful in recog-	ognition of	helps the	helps the per-	aids the
nizing the	problem and/	person in	son in recog-	person i
problem;may	or feelings	recognizing	nizing the	in deal-
hinder com-	towards it.	the problem	problem and	ing wit
munication.		and his	dealing with	his
		feelings to-	it.	problem.
		wards it.		

Excerpt #4

Helpee: Your ad said you were interested in people's problems, so I'm gonna lay a heavy one on you. I've been dating this black chick for about three months now. There wouldn't be a problem excep that I'm white. I've been raised to see no difference between white and black and I beleive that I exhibit this point of view myself now as an adult The problem is with my chick who scmehow beleives that I should see a difference between us--she is always testing me to see if I have yet become a racial bigot. As though matters weren't bad enough, she is now pregnant; I believe that it is probably my kid, but there always exists the chance that it could be one of her black brother's. So, here is the problem. Now, what is the answer?

1. That's a rough one alright. Sounds like   _____
you're really rushed to make up your mind about how you feel
                    towards her.

2. Would it be a whole lot less hassle if she was white or if you
                    two were married?

3. You're right it's a tough one.I can see how you'd feel a conflic
within your feelings towards her, and now her pregnancy makes _
some kind of decision mandatory. Maybe pregnancy is some kind of
                    final test?

4. I can't answer it for you; all I can do is help you consider ___
                    the alternatives.

Rate each response using the following scale. Rate each response independently of the others.
  Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem; may hinder com-munication.	Partial re-ognition of problem and/ or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimall aids the person i in deal-ing wit his problem.

Excerpt #5

Helpee: What should I do ? My son is taking drugs, I just know he has to be. He has been acting very odd ever since his father and I got the divorce last month. It must be his father's doing. He would do anything to take my boy away from me and that father of his is always up to no good.

Helper Responses: 1. What indications do you have that your son is taking drugs, other than he has been acting strange ? How can you be sure that his father has something to do with it ? Could anything else, say your divorce and the seperation of the family, be making your son act strange ?

2. Sounds like you're pretty upset about two problems: first, your son and his recent behavior and second, your ex-husband's influence on your son. What specific examples indicate that your son is taking drugs?

3. It's really a disturbing feeling when you think that your son i doing something that might be harmful to him. It's doubly disturbing when you think that your ex-husband might be involved.

4. Divorce in a family sometimes causes all sorts of hassles. How long has it been since you and your husband were divorced ?

Rate each response using the following scale. Rate each response
independently of the others.
    Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-	Partial re-	Minimally	Signifigantly	Optimall
ful in recog-	ognition of	helps the	helps the per-	aids the
nizing the	problem and/	person in	son in recog-	person i
problem;may	or feelings	recognizing	nizing the	in deal-
hinder com-	towards it.	the problem	problem and	ing wit
munication.		and his	dealing with	his
		feelings to-	it.	problem.
		wards it.		

Excerpt#7

Helpee: I want to quit school; I'm tired of being broke and
having a rundown car and a crappy apartment. I want some of the
things that I feel that I deserve. Even when I graduate I won't
be able to get any better job than I can right now. I don't see
why I should waste another year. I do enjoy studying and learning
but I can't stand the constant hassle with money. I'm there on
financial aid so that if I quit I probably won't ever be able to
come back. I'm also tired of this place. I figure if I have to
            stay here one more year I'll never make it.

Helper Responses: 1. Is there any reason why you should have to
    finish school at that particular university ?   _____

2. Have you looked into any alternatives to being a poverty-stricke
    college student in any great detail ?   _____

3. I know what you mean. It's really a rotten situation to be in.   _

4. You've really got a lot on your mind. Could you tell me more
about where you stand in school or what the money hassle involves?

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt # A

Helpee: I don't know if I'm right or wrong in feeling the way that I do. But I find myself withdrawing from people. I don't seem to social ize and play their stupid little games any more. I get upset and come home depressed and have headaches. It all seems so superficial. There was a time when I used to get along with everybody. Everybody said, "Isn't she wondeful. She gets along with everybody. Everybody likes her." I used to think that was something to be really proud of, but that was who I was at that time. I had no depth. I was what the crowd wanted me to be--the particular group I was with.

Helper Responses:
1.You know you have changed a lot. There are a lot of things you want to do but no longer can.   _____

2. You are damned sure who you can't be any longer but you are not sure who you are. Still hesitant as to who you are yet.   _____

3. Who are these people that make you angry? Why don't you tell them where to get off? They can't control your existence. You have to be your own person.   _____

4. So you have a social problem involving interpersonal difficulties with others.   _____

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Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/ or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Signifigantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt # _6_

Helpee: I love my children and my husband and I like doing most house hold 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 th the office every day. Most women complain of being just a housewife and just a mother. Others say there has to be. I really don't know.

Helper Responses:
1. Hmm. Who are these other people ?   _____

2. So you find yourself raising a lot of questions about yourself---educationally, vocationally.   _____

3. 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. _____

4. While others raise these questions, these questions are real for you. You don't know if there is more out there for you. You don't know if you can find more fulfillment than you have.   _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Signifigantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt# _F__

Helpee:I get so frustrated and furious with my daughter. I just don't know what to do with her. She is bright and sensitive, but damn, she has some characteristics that make me so on edge. I can't handle it sometimes. She just--I feel myself getting more and more angry! She won't do what you tell her to do. She tests limits like mad. I scream and yell and lose control and think there is something wrong with me--I'm not an understanding mother or something. Damn! What potential! What she could do with what she has. There are times she dcesn't use what she's got. She gets by too cheaply. I just don't know what to do with her. Then she can be so nice and then, boy, she can be as onery as she can be. And then I scream and yell and I'm ready to slam her across the room. I don't like to feel this way. I don't know what to do with it.

Helper Responses:
1. So you find yourself screaming at your daughter more frequently during the last three months.   _____

2. Why don't you try giving your daughter some very precise limita-tions. Tell her what you expect from her and what you don't expect from her. No excuses.   _____

3. While she frustrates the hell out of you, what you are really asking is, "How can I help her? How can I help myself, particularily in relation to this kid?"   _____

4. While she makes you very angry, you really care what happens to her.   _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-. munication.	Partial re-ognition of problem and/ or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Signifigantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt# _H_

Helpee: Gee, I'm so disappointed. I thought we could get along to-gether and you could help me. We don't seem to be getting anywhere. You don't understand me. You don't know I'm here. I don't even think you care for me. You don't hear me when I talk. You seem to be some-where else. Your responses are independent of anything I have to say. I don't know where to turn. I'm just so--doggone it--I don't know what I'm going to do, but I know you can't help me. There is just no hope.

Helper Responses:
1. I have no reason to try and not help you. I have every reason to want to help you.   _____

2. Only when we establish mutual understanding and trust and only then can we proceed to work on your problem effectively.   _____

3. It's disappointing and disillusioning to think that you have made so little progress.   _____

4. I feel badly that you feel that way. I do want to help. I'm won-dering, "Is it me? Is it you, both of us?" Can we work something out?   _____

Appendix F: Ability to Discriminate Facilitative Conditions

Measure: Form B

Rate each response using the following scale. Rate each response
independently of the others.
Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-	Partial re-	Minimally	Signifigantly	Optimally
ful in recog-	ognition of	helps the	helps the per-	aids the
nizing the	problem and/	person in	son in recog-	person in
problem;may	or feelings	recognizing	nizing the	in deal-
hinder com-	towards it.	the problem	problem and	ing with
munication.		and his	dealing with	his
		feelings to-	it.	problem.
		wards it.		

Excerpt #2

Helpee: I have a problem. It's about this guy. You see, I'm gay
and I'm having this love quarrel. John, the name of my lover, is
more straight than gay. He has recently met this girl who is more
exciting than me--so he says anyway. If he continues seeing this
girl it will only mean heartbreak for me. I've never thought
about suicide before now, but everyday just brings more and more
confusion. People say I'm strange, and maybe everybody would be
just as happy if I happened to disappear.

Helper Responses: 1. Things are pretty confused right now, but
don't you think that you could find somebody else? Are you
perhaps taking this too seriously?   _____

2. Sounds like you're pretty depressed and confused; you feel very
alone and empty because you feel that your relationship with
someone that you love is very threatened, and possibly over.It _____
seems to mean the whole world to you. But, are you only living
because of John?

3. In any personal relationship there are problems. When these
arise it's good to talk about them to the person who is _____
involved. Have you talked to John about it ?

4. Wow, things are really going bad for you--you're feeling
pretty depressed and worthless. The loss or possible loss of
someone that you really care for can be shattering.   _____

8

Rate each response using the following scale. Rate each response independently of the others.
   Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt#3

Helpee: [scbbing], I've got a terrible problem and I need some answers really quick. If your fiance' was away, like going to another school, and you got pregnant by what you thought was a good friend, How would you tell your fiance' the situation? I mean I'm getting an abortion, so that's all taken care of, he doesn't ever need to know about it, or anything like that, but I feel that I've got a responsibility to tell him about the situation. I think he deserves to know about what went on and what a rat I am, but I don't know how to tell him. I just don't know!

Helper Responses:

1. Does your fiance' know the guy who got you pregnant ?   _____

2. If you really want it, go ahead and have the abortion and tell him about everything. That way, he won't have to worry about _____ that aspect. Then, you can proceed from there.

3. Wow, it sounds like you really are in a fix. If you feel like crying go ahead. Then you can tell me a little more about _____ the situation and we can see what to do from there. Maybe we can think of some alternatives together that would be suitable and would make it a little easier for everyone involved.

4. Wow, you really have yourself in a situation that is so confusing that it's difficult to be rational and think up a solution. _____

11

Rate each response using the following scale. Rate each response independently of the others.
Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt#6

흣 Helpee: I'm sort of in a bind--I don't know if you can help me, but, well, I've gotten very interested in my roommate's old fiance'. Since he and I have started to become friends she has been treating me very coolly. We were good friends before she moved in too. I asked her if it bothers her and she said no. I don't think that she has the right to tell me who to see, but I don't want to jeopardize our friendship.

Helper Responses: 1. So you want to continue seeing the guy but you don't want your relationship with your roommate to suffer? _____

2. Have you talked to your roommate in depth about this ?   _____

3. I can see the conflict. If you and your roommate are really being truthful with each other, maybe the problem isn't the fact that you are dating the guy, but how tactfully you handle the _____
                              situation.

4. She sounds like she is really a sore loser.   _____

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13

Rate each response using the following scale. Rate each response independently of the others.
Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-	Partial re-	Minimally	Signifigantly	Optimally
ful in recog-	ognition of	helps the	helps the per-	aids the
nizing the	problem and/	person in	son in recog-	person in
problem;may	or feelings	recognizing	nizing the	in deal-
hinder com-	towards it.	the problem	problem and	ing with
munication.		and his	dealing with	his
		feelings to-	it.	problem.
		wards it.		

Excerpt#8

Helpee: I've been running into some people who are really messing me up. It seems like for the last few months I've been meeting nothing but Jesus freaks, The type that say "hi" and then ask if you have accepted Christ. The first few times it was interesting to rap with them, but now I'm getting tired of it, but I don't know how to politely tell them to shut up. At the same time, I am not sure that I want to make the commitment, and I hate having it constantly shoved down my throat.

Helper Responses: 1. Sounds like you're frustrated with two problems: one, how to deal with people you don't want to be _____ involved with and two, how to deal with yourself, your own feelings. Let's discuss it and see if we can come up with some alternatives.

2. Why don't you tell them to be quiet and leave you alone? You _____ don't have to let them lecture you.

3. Do you beleive in God? _____

4. Sounds like you're having some problems determining if if you can deal with these people and with yourself as well. _____

ccDI[__._]

cols46/47[   ]

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Significantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt # _C_

Helpee: Sometimes I question my adequacy of rasing three boys, especially the baby. I call him the baby--well he is the last. I can't have any more. So I know I kept him a baby longer than the others. He won't let anyone else do things for him. If someone else opens the door, he says he wants mommy to do it. If he closes the door, I have to open it. I encourage this. I do it. I don't know if this is right or wrong. he insists on sleeping with me every night and I allow it. And he says when he grows up he won't do it anymore. Right now he is my baby and I don't discourage this much. I don't know if this comes out of my needs or if I'm making too much out of the situation of if this will handicap him when he goes to school--breaking away from Mamma. Is it going to be a traumatic experience for him? Is it something that I'm creating for him? I do worry more about my children than I think most mothers do.

Helper Responses:
1. So you find yourself raising a lot of questions as to if what you are doing is right for your child. _____

2. Is it perhaps possible for you to have the child become involved in a situation such as some experiences in a public park where the child could play and perhaps at a distance you could supervise---where the child can gain some independence? _____

3. Could you tell me--have you talked to your husband about this? _____

4. While you are raising a lot of questions for yourself about your-self in relation to your youngest child, you are raising some more basic questions about yourself in relation to you. In lots of ways your not certain where you are going--not sure who you are. _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Signifigantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt # D

Helpee:It's not an easy thing to talk about. I guess the heart of the problem is sort of a sexual problem. I never thought I would have this sort of problem. But I find myself not getting the fulfillent I used to. It's not as enjoyable--for my husband either, although we don't discuss it. I used to enjoy and look forward to making love. I used to have a orgasm but I don't anymore. I can't remember the last time I was satisfied. I find myself being attracted to other men and wondering what it would be like to go to bed with them. I don't know what this means. Is this symptomatic of our whole rela-tionship as a marriage? Is something wrong with me or us?

Helper Responses:
1. Perhaps you feel your marriage and your role of mother is hold-ing you back and preventing you from being something else you want to be. Your resentment here against your husband is manifested in your frigidity. Perhaps it is your way of paying him back for keep-ing you down in this role, for confining you, for restricting you. _____

2. What about your relationship with your husband, his role as father and companion?   _____

3. You don't quite know what to make of all this but you know some-thing is dreadfully wrong and you are determined to find out for yourself, for your marriage.   _____

4. What's happened between you and your husband has raised a lot of questions about you, about him, about your marriage.   _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help- ful in recog- nizing the problem;may hinder com- munication.	Partial re- ognition of problem and/ or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to- wards it.	Signifigantly helps the per- son in recog- nizing the problem and dealing with it.	Optimally aids the person in in deal- ing with his problem.

Excerpt # E

Helpee: Gee, those people! Who do thet 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 anxious. I get angry at my- self. 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 that I just Can't do it.

Helper Responses:
1. They really make you very angry. You wish you could handle them more effectively than you do.   _____

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

3. Why do you feel that these people are phony? What do they say to you?   _____

4. Maybe society itself is at fault here--making you feel inade- quate, giving you this negative view of yourself, leading you to be unable to successfully interact with others.   _____

Rate each response 1.0,1.5,2.0,2.5,3.0,3.5,4.0,4.5, or 5.0

1.0 1.5	2.0 2.5	3.0 3.5	4.0 4.5	5.0
is not help-ful in recog-nizing the problem;may hinder com-munication.	Partial re-ognition of problem and/ or feelings towards it.	Minimally helps the person in recognizing the problem and his feelings to-wards it.	Signifigantly helps the per-son in recog-nizing the problem and dealing with it.	Optimally aids the person in in deal-ing with his problem.

Excerpt# _G_

Helpee: He is 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 to do? Who does he think he is anyway?

Helper Responses:
1. It really angers you when you realize in how many ways he has tak-en advantage of you.   _____

2. Tell me, what is your concept of a good marriage?   _____

3. Your husband makes you feel inferior in your own eyes. You feel incompetent. In many ways you ~~want~~ make him sound like a very cruel and destructive ~~mind~~ man.   _____

4. It makes you furious when you think of the one-sidedness of this relationship. He imposes upon you everywhere, particularily in your own struggle for your own identity. And you Don't know where this relationship is going.   _____

Appendix G: Carkhuff Empathy Rating Scale

Ratings of Empathic Understanding in Interpersonal Processes

Level 1: The verbal and behavioral expressions of the helper either DO NOT ATTEND TO or DETRACT SIGNIFICANTLY from the verbal and behavioral expressions of the helpee in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself.

Level 2: While the helper responds to the expressed feelings of the helpee she does so in such a way that she SUBTRACTS NOTICEABLE AFFECT from the communication of the helpee.

Level 3: The expressions of the helper in response to the expressions of the helpee are essentially INTERCHANGEABLE with those of the helpee in that thet express essentially the same affect and feeling.

Level 4: The responses of the helper ADD NOTICEABLY to the expressions of the helpee in such a way that expresses feelings a leval deeper than the helpee was able to express himself.

Level 5: The helper's reponses ADD SIGNIFICANTLY to the feeling and meaning of the expressions of the helpee in such a way as to

accurately express feelings levels below what the helpee himself

was able to express or, in the event of ongoing deep

self-exploration on the helpee's part , to be fully with him in

his deepest moments.

I am a 24 year old single male who moved to Vancouver from Edmonton six years ago. I have been working in the same office doing filing, etc ", for the last six years. I don't spend much time with the people at work. The men all like to go out to the bar after work and then home to their families. The women all like to go to discos. I don't like to drink or go to discos at all. I live in an apartment in the West End of Vancouver. I have lived there for the last four years but I don't know any of my neigbours. I stay home and read a lot of science fiction. I find it very hard to meet people. I am worried that they will think I am a "turkey" when I try to talk to them and say stupid things so I don't try. I have tried taking a night course but I didn't meet anybody. I don't like physical exercise much.

I have only had one relationship with a woman. She was my high school sweetheart from Edmonton. When we graduated she wanted to get married but that freaked me out so I left Edmonton. She couldn't have loved me because I heard that she got married to another guy 6 months after I left. All my family is in Edmonton but I don't keep much contact with them.

I have talked to my family doctor about this and he gave me some tranquilizers (valium). Occasionally, I have thought that this just isn't worth it. I haven't thought specifically about how I would end it.

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