THERAPIST VARIABLES IN CRISIS INTERVENTION THERAPY

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I hereby declare that this dissertation is my own work and that I have not submitted it for a degree award to any other University.

P. KING.

I dedicate this dissertation to my parents, Goldie and Willie, with love and gratitude.

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CONTENTS

CHAPTER 1. INTRODUCTORY PERSPECTIVE.

1.1 Orientation to the present study.

There is perhaps nothing more complex than the psychological well-being of another human being. The intrinsic complexity of the psyche makes its study by even the most astute scholar [illegible]. Even after over 100 years of psychology we penetrate only the surface of understanding. [illegible] still less is really known of the [illegible] process, and even less of what [illegible] identify the [illegible] ingredients of [illegible] and psychotherapy [illegible] limited.

[illegible] say:

> [illegible] today, the field of psychotherapy is in a state of healthy [illegible] eclecticism. Few therapists actually believe that a single technique or theory can encompass the complex range of problems and applications they must meet.
> ([illegible] & Tomlinson, 1970, p.8)

This eclectic attitude is very different from the earlier days of psychotherapy which developed almost exclusively around the work of Freud and the psychoanalytic tradition.

The psychoanalysts believed that mental illness was constitutional, and the aim of therapy, or analysis, was to free the unconscious of the 'bad' pathology embedded there. Originating from the medical pathological model in which Freud was trained, the focus of analysis was on the patient's intrapsychic dynamics and developmental

their worlds and, in particular, the self. In contrast to the psychoanalytic emphasis on interpreting drives, [illegible] character development, Rogers placed increasingly more emphasis on perception, feelings, subjective self-report, [illegible].

> I have little sympathy with the rather prevalent concept that man is basically irrational and that his impulses, if not controlled, will lead to the destruction of others and self. Man's behaviour is exquisitely rational, moving with subtle and ordered complexity toward the goals his organismic nature is endeavouring to achieve.
> (Rogers, 1961: p. 194)

Rejecting the assumptions of the European medical tradition Rogers' humanistic and optimistic assumption about the nature of man led directly to his approach to therapy. Since man's nature is regarded by Rogers as essentially positive, the direction of his movement is toward self-actualization, maturity and socialization.

The therapeutic approach Rogers developed suited the belief that 'man has within him' to actualise his fullest potentials. Concentration on the client, Rogers posited that successful psychotherapy depended less on technical skills of therapist (e.g. interpretation) or theories of personality, than on certain conditions provided by the therapist within the relationship. These conditions were empathy, congruence and unconditional positive regard.

With philosophical roots in humanism and phenomenology Rogers began to demystify the role of the therapist as omniscient doctor and the client as a patient with mental disease. Instead, Rogers sought to reinstate the client's self-respect whereby the therapist was a relatively passive

agent of change. Originally the role of the therapist's approach non-directive, the therapist's role was primarily to provide certain conditions which would facilitate client change. It was in later years when people began looking more at the role of the client in therapy that there was a shift away from non-directiveness toward client-centredness. Even with this shift however, people tended to see their role as facilitative therapist conditions.

In the year's or outreach of the service - present, while recognizing the importance of the facilitative therapist conditions as exist as before, now has need to include other, more action-oriented activities of the therapist in a model of psychotherapy. Included the function model Parkhurst said the same thing.

> ... facilitative and action-oriented therapist roles are complementary functions in the process leading to ...

An increasingly convincing body of research in-chapter 2) focuses on both the facilitative and action-oriented therapist conditions as two important and effective ingredients in successful therapeutic outcome.

It is [illegible] dissatisfaction with the traditional medical approaches to helping distressed individuals.

Experience gained [illegible] psychiatrically with combat casualties during the Second World War, and increasing awareness of the role of psychological factors which could precipitate crisis situations, led to the development of immediate-access, client-oriented outpatient treatment centres. Together with growing dissatisfaction

with treatment by hypnosis and environmental manipulation or psychotherapeutic procedures to deal issues for a short-term, easily accomplished goal of treatment whose price was limited, but appropriate goal was to restore the individual's level of functioning to its previous state, crisis-precipitation to prevent growth was a necessary aim.

By very definition of the crisis state (see Chapter II), the therapeutic communication is that 'something needs to be done now' and this places two injunctions on the therapist. First, that the therapeutic focus should be on the central issues of the immediate problem, that time is of the essence and the therapist must be active, confrontive and [illegible]

Helped crystal by crisis, the client (though possibly not the practice of crisis intervention) is [illegible] and [illegible] to [illegible] and [illegible] and [illegible] and anxiety, according to Puryear and Mitchell:

> ...we agree vigorously all exponents of psychotherapy with regard to the common elements in a wide variety of approaches to psychotherapy and counselling. (Puryear & Mitchell, 1967, p.53)

It appears that to date only two theories (Parkhurst, Lemy, Lindemann, Caplan) have tentatively postulated the interlinking of both facilitative and action-oriented variables for crisis therapy (see Chapter II). While it is possible that facilitative client-centred variables have not been monitored in the actual practice of crisis intervention, the proposition that both variables are necessary has not been empirically ascertained.

1.2 Broad Focus of the Present Study.

A major theoretical trend backed by a substantial body of research has recognized the importance of certain facilitative therapist conditions to a variety of helping relationships. The rationale behind the need for these facilitative conditions is that they allow the helpee to develop and grow.

As seen in Chapter 4 crisis therapy requires immediate intervention and has the primary goal of restoring the helpee to a pre-crisis state, the issue of psychological growth being secondary. Possibly because of this, therapist facilitativeness has mainly been neglected in crisis theory which has conventionally emphasized action-oriented therapist behaviour.

The problem [illegible] is not both facilitative conditions and action-orientedness crucial therapist ingredients? The focus of the present study is to investigate the extent to which both these conditions may in fact be instrumental [illegible] crisis resolution of clients. More specifically this study is also interested in comparing therapist facilitativeness with action-orientedness in so far as these conditions may help clients resolve their crises.

[illegible]

THERAPIST VARIABLES

1.1 Introduction.

[illegible] recently introduced in the [illegible] literature of psychotherapy has become barely an different therapeutic schools, beginning to develop, rather [illegible] theoretical models, investigating [illegible] A considerable preoccupation [illegible] to the development of psychotherapy, there exists [illegible]

> ... our lack of interest in understanding the process in therapy and in developing systematic procedures may [illegible] to an overconcentration with specific techniques and to neglect of the quality of what happens between [illegible] the most specific phase of the therapeutic process [illegible] psychotherapy [illegible] the interpersonal relationship [illegible] (Rogers & Dymond, 1954, p. xiii)

As early as 1942, [illegible] investigated the [illegible] investigators [illegible] the concept of relationship in therapy, and found [illegible] the therapist's non-relation to their relationship. In [illegible] chapter 1, in the [illegible] investigation of [illegible] of psychotherapy, Rogers stressed that [illegible] facilitative conditions were necessary and sufficient characteristic attitudes for successful psychotherapy.

1.2 [illegible] variable.

Cutting across [illegible] theories of psychotherapy [illegible] appeared to be [illegible] as to [illegible] -2 the element which [illegible] as a unique relationship.

Rogers (1957) [illegible] that psychotherapeutic

writers (Ferenczi 1950; Alexander, 1948; Schafer 1959; Halpern and Lesser 1960), client-centred therapists (Strunk 1957; Raush and Bordin, 1959; Hobbs 1962; Fiedler and Goldin 1963), and client-centred therapists (Raymond, 1949; Rogers 1957; Jourard 1959) have all emphasized the importance of the therapist's ability to understand sensitively and accurately the inner experiences of the client. These writers, continues Rogers, have also stressed such qualities as the maturity of the therapist and his personal integration or genuineness within the relationship. Finally, they have stressed his warmth and his acceptance of the individual with whom he is working.

The focus therefore has shifted from the therapeutic method to the therapist's person. It is not so much what the therapist does in therapy as how he does it.

Rogers (1957) presented a formalized theoretical statement in which he hypothesized that certain characteristics of the therapist in the relationship, when adequately communicated to the client, constituted the necessary and sufficient conditions for successful therapeutic outcome.

The conditions were that the therapist be genuine or self-congruent; that he experience an unconditional positive regard for his client; and that he communicates a sensitively empathic understanding of the client's phenomenological world. Carkhuff (1969) terms these the core, facilitative dimensions necessary for therapeutic change.

'Congruence' is defined by Van der Veen as:

> a condition within the person in which his feelings, his awareness of his feelings and expression of them to the other person, all correspond or are congruent with one another
> (in Hart & Tomlinson, 1970; p.25)

validated scales of the three facilitative conditions. Therapists' levels of these conditions were then correlated with various outcome measures.

Findings from one such research programme, which is both more comprehensive and recent than the bulk of studies in this area, are presented below.

This five year study, called the Wisconsin Schizophrenic Project (Rogers, Gendlin, Kiesler and Truax, 1967) involved collecting data from sixteen randomly selected schizophrenic patients and their controls, from therapists and ward personnel. Outcome data was collected by two methods. The first was by rating tape recorded segments of therapeutic interaction for client process movement from early to late interviews. The second method involved pre-and post-testing on a battery, including the MMPI, TAT and Rorschach tests.

[illegible] the degree of therapist congruence, empathy and unconditional positive regard was not related to the patients' process movement from early to late therapy. A possible reason for this, the authors suggest, is the limitation of measuring outcome on the basis of process movement.

A second major result was that the therapist conditions were higher when there was greater pre-to post-test change by the patient. This result supports the postulate which predicts a better outcome of therapy when the therapist is more congruent, empathic and positive in his regard.

These facilitative conditions have also been related to constructive outcome in group therapy (Truax, 1961;

Truax, Carkhuff and Kodman, 1965; Truax, Wargo and Silber, 1966; Truax and Wargo, 1966) as well as with subsequent psychiatric hospitalization (Truax, Lieberman, Carkhuff and Kodman, 1967), subjective evaluation (Berenson, 1967; Carkhuff and Berenson, 1967; Truax, Carkhuff and Kodman, 1965), and continuously measured psychotic talk and self-exploration (Truax, 1966).

All the above studies have consistently shown that the degree to which therapists provide the facilitative conditions (as rated from positive scores on Truax scales or Barrett-Lennard scale for a wide variety of patients, experienced psychiatric or therapeutic orientations, and in a variety of settings) is related to patient outcome in different studies.

A comparable amount of research into therapist facilitative qualities was reported by Carkhuff (also Truax & Carkhuff, 1967), in this instance relating the facilitative conditions to outcome in group therapy with hospitalized mental patients.

Carkhuff (1969) in his thorough facilitative conditions and training text reviewed the research relating client change, he wrote:

> The need to expand existing models that account for constructive client or helpee change has become imperative. The already considerable evidence relating the level of facilitative conditions offered by the helper to indexes of constructive helpee change of daily ... must be complemented by additional dimensions if we are ever to account for a significant degree of really effective helping processes. Thus

This is the upward phase or what Carkhuff terms the period of emergent directionality. Finally the client engages in that action, goal or conflict resolution which is labelled the outcome criterion.

The model Carkhuff proposes is that during the initial phases of therapy the helper offers high levels of facilitative conditions such that the helpee explores deeper and deeper levels in an experience of a warm, accepting and genuine atmosphere. The client is then ready to do something about the problems that were explored and that have come to be understood.

During the second phase of helping the helpee comes not only to learn to act in terms of experiential dimensions but also,

> to become involved in more cognitive, problem-solving type activities ... The issue is, "Now what are we going to do about what we understand?" (ibid; p.11)

Carkhuff ... prescribes three possible actions:

> (1) "We are going to consider the various alternative courses of action available to you;"
>
> (2) "We are going to consider the advantages and disadvantages, short term as well as immediate, of each;"
>
> (3) "We are going to take steps to operationalize the best possible action available."
>
> (ibid; p.31)

Carkhuff does make the point that the two phases of helping are not always distinctive and sequential. In fact the helping process is highly interactional with the facilitative and action-oriented dimensions frequently converging to make the total helping process effective.

Carkhuff furthermore proposes that both these therapist

conditions are essential to all helping relationships including those where client is in a crisis. He suggests that in a crisis situation the experience for both the therapist and the client is one of heightened intensity of both the facilitative and action-oriented dimensions.

Schmidt's (as yet unpublished) theory is, as will be seen in chapter 3, not well-formed and hardly fits the criteria of 'critical theory' as applied to crisis intervention. Nevertheless its emphasis on breakdown and resolution of the crisis echoes crucially important therapist behaviours (p.[illegible]).

2.4 Research into the Variables

There have been numerous empirical investigations into relationships of the separate facilitative conditions of empathy, congruence and unconditional positive regard to therapeutic process.

Gurman [illegible] and Carkhuff's postulation of the necessity for both facilitative and action-orientated dimensions, a number of studies have investigated therapists' success in relation to use and non-use of the combination of these variables. Little attempt has been made to research the facilitative and action-oriented dimensions separately as required by the present study.

Measuring therapist conditions or traits, overall ratings of therapist functioning on a five point scale (Carkhuff, 1969; p.[illegible]), a number of studies have investigated the effects of overall high and low functioning therapists on outcome. Since these overall measures are not directly

compatible with the aims of the present study this research will not be quoted here. For present purposes Carkhuff (1969) summarizes the position:

> The accumulated evidence from a number of naturalistic studies is extensive and consistent; helpees of high-level functioning helpers demonstrate constructive change on a variety of indexes while those of low-level-functioning helpers do not change or even deteriorate (Berenson and Carkhuff, 1967; Carkhuff and Berenson, 1967; Rogers, Gendlin, Kiesler and Truax, 1967; Truax and Carkhuff, 1967).
> (Carkhuff 1969; p.24)

Similar results have been demonstrated in education (Aspy, 1969; Aspy and Hadlock, 1969; Pierce-Jones, Carkhuff and Berenson, 1969); supervision (Pierce, 1969); and parent-child treatment (Carkhuff and Berenson, 1969).

Only one study has separated therapist facilitativeness from action-orientedness. Bierman (1968) provides results which support Carkhuff's low-facilitative model of therapy. Analysing tape recordings of twenty clients of eight therapists of varying orientation in a psychiatric clinic, Bierman showed that effective helpers move from facilitativeness to action-oriented ones. All therapists began therapy with a more or less passively responsive disposition. Those therapists whose clients remained in treatment and became involved in constructive therapeutic process, became more affectionate and active. Those therapists whose clients terminated treatment and or did not become involved in constructive movement, either remained passive-rejecting or moved to being active-rejecting. It was those therapists who moved from passive-to active-affectional functioning who had the most constructive effects upon client functioning.

2.5 Summary and Comment.

In the attempt to expand existing models Carkhuff (1969) has developed a theoretical model which postulates that the effective ingredients of successful helping are both therapist facilitativeness and action-orientedness.

The relationship of these two variables to outcome in psychotherapy is supported by an impressive body of research. However there are two major limitations to this research:

1. No attempt has been made to investigate the extent to which these variables may be operative in Crisis Intervention Therapy.

2. The body of research has investigated these two variables in concert, that is, operating together to a high or low degree. Besides the study by Bierman (1968) little attempt has been made to separate facilitativeness from action-orientedness so as to investigate the differential effects of each variable in therapy.

Thus in the pursuit for therapeutic ingredients this study intends firstly to investigate the application of facilitativeness and action-orientedness to the field of crisis intervention. Second, in an attempt at differentiation, this study will investigate the relative importance of both these variables as each may be instrumental to outcome in crisis intervention therapy.

CHAPTER 2

CLIENT CENTERED THERAPY

2.1 Introduction

It was Rogers' belief in the potential capacity that the client possesses for self-direction and self-growth which led him to develop a therapeutic technique which would provide the optimal conditions for the client to utilize his own resources in dealing with his problems.

The basic principles which differentiate client-centered therapy from other approaches to psychotherapy are concerned with the client's own perception of himself, his relationship to others, and his environment. Instead of the therapist's diagnosing the client's problem, interpreting the client's behavior, and directing the course of therapy, the client is encouraged to explore his own feelings and attitudes in order to gain insight into his problems and to develop a more adequate self-concept. Rogers (1951) has summarized the basic assumptions of client-centered therapy as follows:

2.2 Client-Centered Theory of Personality

Rogers has a theoretical orientation which emphasizes the importance of the individual's perception of himself and his environment. He says, "Behavior is basically the attempt of the organism to satisfy its needs as experienced, in the field as perceived" (Rogers, 1951, p. 491). Thus, in order to understand or predict behavior, it is necessary to know how the individual perceives the situation in which he finds himself. Rogers (1951) has developed a theory of personality and behavior which is based on the concepts of self and self-actualization. The self is described as an organized, consistent conceptual gestalt composed of perceptions of the characteristics of the "I" or "me" and the perceptions of the relationships of the "I" or "me" to others and to various aspects of life, together with the values attached to these perceptions. It is the way in which the individual perceives himself in relation to his environment, his experiences are interpreted in terms of the self-structure. Self-actualization is the tendency inherent in all organisms to develop all their capacities in ways which serve to maintain or enhance the organism. It is the inherent tendency to develop all the potentialities and capacities in the direction which makes for the maintenance and enhancement of the organism. Self-actualization is the basic motivating force in human behavior. Rogers (1951) has described the process of self-actualization as a continuous one which is present in every individual at all times. It is the urge which underlies all motivation, however complex. It may be most simply described as the tendency to express and activate all the capacities of the organism in ways which serve to maintain the organism and further its development. Rogers (1951) has stated that the process of self-actualization becomes more evident as the individual is provided with a more adequate psychological climate. It is the tendency which is evident in the child who learns to walk, to talk, to become independent, to explore, to manipulate, to learn. It is the tendency which is evident in the adult in his attempts to express and activate more fully all the capacities of the organism. It is the tendency which motivates the person in therapy to move from fixity to fluidity, from rigidity to flexibility, from stereotyped judgments to a process orientation, from dependence to autonomy, from denial of experience to awareness of experience, from being the object of his own evaluation to being the evaluative center, from being a stranger to himself to being the companion of himself, from being out of touch with reality to being in touch with reality, from being unable to live comfortably with others to being able to live deeply in relationship with others, from being a maladjusted person to being a fully functioning person. Self-actualization is the tendency which is evident in the process of therapy as the client moves from a point where he is unaware of many of his feelings, where he is unable to accept many aspects of himself, where he is unable to establish meaningful relationships with others, where he is unable to perceive his environment realistically, to a point where he is able to accept himself, to trust himself, to establish meaningful relationships with others, to perceive his environment realistically, to be open to his experiences, to be his own evaluative center, to be in touch with reality.

clients' experiential level from tape interviews.

In an attempt to refine the measurement of client process, a scale for the rating of experiencing (Mathieu and Klein, 1969)[*1] was developed with interrater and rate-rerate reliability values ranging from [illegible] (Kiesler, Mathieu and Klein, 1967). This scale is used by trained raters on tape recorded segments of the therapeutic interview.

The measurement of 'experiencing' refers to the individual in his [illegible]:

> [illegible]

2.2 Client Process Outcome.

While [illegible] process [illegible] of [illegible]. This will not be [illegible]. By definition [illegible] not concerned with the [illegible] continuously in the individual [illegible] with person in [illegible] by specific [illegible] of process.

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*1) This scale is Mathieu and Klein's revision of Gendlin and Tomlinson's scale of experiencing developed from the original Rogers and Rablen process scale.

level showed more variability over both tasks, both positive and negative, than clients functioning at a lower level.

Possibly the largest and most reasonable research study on the effects of clients' self processes level on outcome is the Wisconsin Schizophrenic project (Rogers et al, 1967)[*] using the Experiencing Scale to measure initial process level. It was found that the clients' initial process level was positively associated with number of sessions attended.

Moreover, because of the initial relationship of the process of clients' verbal behavior to outcome,

> it seems apparent that verbal processes which reflect deep personal concern, or the lack of it, at the beginning of therapy, are highly significant in patient self-investment, and may be important factors to be considered in any therapeutic attempt. Attitudes such as concern may be necessary if there is to be subsequent success in any therapeutic effort. Without this concern, it seems reasonable to assume that the patient will not be motivated to change.
> (Gendlin et al, 1968, p. 220)

Gendlin further discusses empirically the hospital implications of therapy and recommends that the level of initial involvement be considered in therapeutic decisions.

There being a minimal level of self involvement,

> one will attempt, against unproductive odds, to engage the client in the therapeutic relationship, and to see what the response of client-centered therapy can affect.
> (Gendlin, 1962, p. 213)

Conversely, beyond a certain point of self involvement, perhaps quite early, the therapist's help is unnecessary or possibly even detrimental to the immediacy of potentially positive processes (or effective treatment).

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[*] Cf. Chapter 2.

* See Patent Abstracts, Paragraphs

CHAPTER 3.

CRISIS INTERVENTION

3.1 [illegible] background to crisis theory

[illegible] and [illegible] ([illegible]) [illegible] that [illegible] intervention is [illegible] the [illegible] of [illegible].'

A relatively new field, crisis theory developed as a branch of [illegible]. At present [illegible] of crisis intervention is a mixture of many [illegible], from psychological and social work theories and principles.

Important influences in the development of this field stem from [illegible] who [illegible] treatment during the second world war (Jacobson et al, 1980).

Another important contributor to this field was Lindemann (1944). He [illegible] situations that would lead to typical and predictable grief reactions. [illegible] Coconut Grove nightclub fire, [illegible] described [illegible] persons [illegible] the death of a relative, he [illegible] of a person to grieve appropriately could potentially lead to future emotional illness.

Other sources [illegible] of the changing Western ethos with 'urbanisation', 'technology' and subsequent awareness of socio-cultural factors precipitating crises (Jacobson et al, 1980). There was also disillusionment

about many of the factors in their early childhood, long term treatment methods.

Many authors, notably Sanders (1970) feel that one of the most important influences in the normal development of a family intervention was the development of psychoanalysis. Sanders quotes Ackerman's preference and Bowen's concept of mental hygiene, the use of psychoanalytic ideas. Erikson, Toch (Erikson,1959) Sade, 1958) commented on self-fulfilment (1958) termed the 'primary conflicts of the self'. They maintained 'conflict free' egos, i.e., autonomous and working independently of instinctual influences.

[illegible] the [illegible] was also [illegible] (Sanders, 1970) [illegible] intervention therapy. Ackerman [illegible] emphasis [illegible] the dynamic principle of continuity and adaptation, namely stability and corresponding responses when pressures present. He favours intervention [illegible] at points of conflict to be used to observe changes in the pattern of roles and the present restricted situation. The [illegible] person [illegible] the family to the outside [illegible] and [illegible] the fluidity of family limits.

The influence of couple approach [illegible] is related [illegible] in this [illegible] when [illegible] system treatment approaches and their [illegible] [illegible] advantages. Other [illegible] [illegible] [illegible] should [illegible] [illegible] [illegible] [illegible] teaching theory, role [illegible], communication and [illegible] theory.

While today crisis intervention increasingly gains respect as an independent discipline, even though allied to social work, it is still compounded of a wide variety of intervention theories and techniques and this makes its paradigm rather elusive.

4.2 Definitions.

Conceptualized from such diverse and eclectic foundations and lacking a consistent theoretical framework, the term 'crisis' has somewhat arbitrary, varying and even elusive qualities currently associated with it.

The term 'crisis' has become the convenient 'catch-all' concept used to designate certain brief, identifiable and transitory emotional experiences. It is important that there is clarity in definition since, for a study of this nature, it is necessary to ascertain with some degree of certainty that an individual is, in fact, in a state of crisis.

A number of theorists have however been able to delimit the major conceptual boundaries of a crisis and have [illegible] It is within these parameters that a working definition has been developed for this study.

Hirschowitz (1972) maintains that a crisis is regarded as a state of temporary disequilibrium which is precipitated by life-change events which are inescapable and for which the individual's existing coping repertoire is inadequate.

Golan (1969) has identified five operational stages of the actual crisis situation, three of which (Stages 1,2 and 4)

are directly relevant for the purposes of definition:

Stage 1 The Precipitating Event: an initial force which triggers off the reaction leading up to the crisis state. This may be internally derived (e.g. a developmental stage such as adolescence) or external and unanticipated (e.g. a death). The major concept of threat derives from loss or impending loss or a hazardous future.

[illegible]

Stage 3 The Disequilibrium State

Caplan (1968) on specific use of these stages in his definition of crisis:

> [illegible] a situation comparable to a relatively short period of psychological disequilibrium in a person who confronts a hazardous situation that for him constitutes an important problem which he can for the time being neither escape nor solve with his customary problem-solving resources.
> (Kaplan 1968; p.152-153)

The concept of psychosocial disequilibrium is appropriate since, viewed in general systems terms, the person's usual state of (relative) equilibrium, maintained by com-

dicated interchanges between the individual and significant persons in the environment, is upset. This points to precipitant-centred stressful events (whether internal, i.e. [illegible] derived) and shifts the focus of the crisis away from traditional intrapsychic and dynamic concepts of psychopathology.

Crisis must not be confused with mental illness. Kaplan (1968) claims that crisis is definitely an entity distinct from psychoses and neuroses, having its own peculiar characteristics and stages.

While [illegible] extremely difficult to [illegible] pathogenesis since it [illegible] each and every individual, the concept of the crisis state is self-limiting in the temporal sense [illegible] (ibid). It is in acute state of disequilibrium [illegible] the individual. [illegible] that, even though [illegible] frequently awaken [illegible] Strictly speaking of course, the two can [illegible] be separated. The present individual can never be divorced from his past experiences and behaviour even though crisis intervention treats the crisis as if he could be. Since the problem of differential will only be resolved by sophisticated research on etiology, for the present it will of necessity suffice to conceive of an acute-chronic split which recognizes that the crisis state is not primarily caused by intrapsychic psychopathological dynamics.

From the above sources and discussion, the crisis state, for the purposes of this study, has been defined as follows:

1. The person has been confronted with some kind of threat of loss, or a hazardous situation of psychologically meaningful import, which for the time being he or she can neither escape nor cope with his or her customary problem solving repertoire.

2. The person is in a state of disequilibrium characterized by acute stress, the cardinal symptom of which is pathological anxiety, and by the use of trial and error attempts at solving the crisis, during which a variety of emotional problems may emerge from the person's inherent past.

3. The person is in need of immediate help from

   a. risk of suicide;

   b. [illegible]

   to relieve his helplessness, ineffectiveness, and confusion about his or her problems.

While this definition is no doubt broad it is considered adequate for the present study since it descriptively and clearly differentiates the crisis state from other pathological conditions, a necessary criterion for selecting subjects for such a study.

4.3 Existing Treatment Strategies.

Although Rapoport (1970) points out that:

> there is as yet no well developed treatment methodology in crisis-oriented brief treatment,

any more than there is in any other known approach,
(Rapoport, 1970; p.217)

certain broad patterns for tackling the problems of crises seem to have emerged in the growing body of literature surrounding this new field.

Stemming from the somewhat arbitrary, but practical, reaction to a situational ha[illegible], it was the primary, minimum goal of crisis intervention therapy to restore the individual to his or her level of functioning that existed prior to the present crisis. A maximum goal is improvement in functioning above the pre-crisis level.

Crisis theory explicitly discards the medical model which conceptualizes maladaptation and problems in living in terms of illness. There is thus a shift in etiology, and consequently in treatment procedures, away from an almost exclusive concern with intra-psychic determinants to a more balanced concern with reality-based stimuli.

In conventional psychoanalytic psychotherapies, actual events in living are depreciated and subsumed to the extent that they are secondary to the psychological a priori of the disturbed inner psyche. In crisis theory however, the locus of distress has its roots in the very real-life events that impose on the (relatively) intact inner psyche

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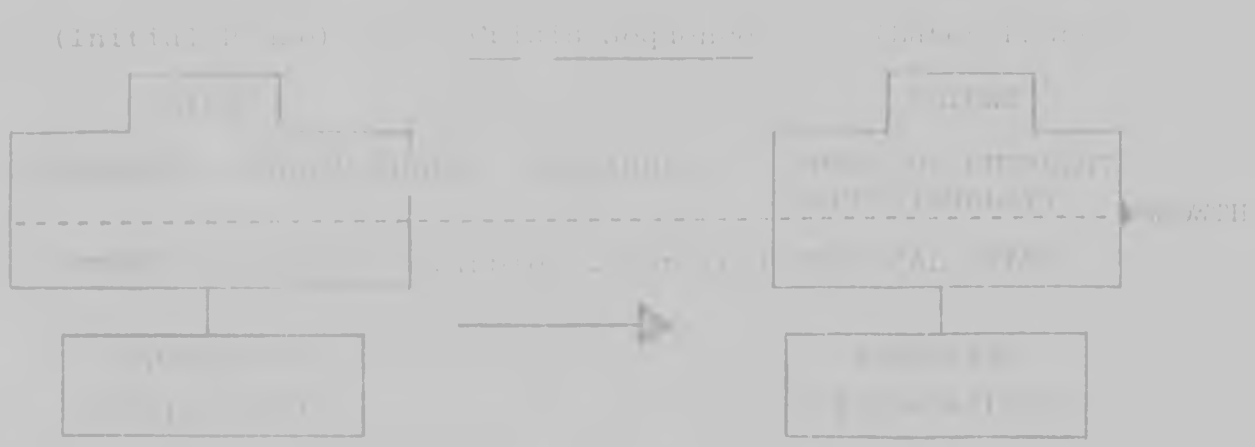
[1] The term 'situational hazard' is used here in a broader sense, to include both external as well as internal events, such as maturational or role changes. The point is that the crisis is a consequence of events.

behaviour to create a suitable climate for interaction. During the consequent phase of what Carkhuff calls 'emergent differentiality' or the time that Ziegler and Barling term the 'critical gap' there is a potential for growth and requirement for action oriented therapist behaviour. (see figure 1 below)

Figure 1: Diagrammatic representation of the Helping [illegible] (Carkhuff & Berenson (1977):



[illegible] two [illegible] model appear [illegible] and the two variables [illegible] exclusive in their [illegible] specific phases [illegible] isolated for the sake [illegible], it is actuality there [illegible] no such clear-cut [illegible] proposed that during the later [illegible] when the therapist is [illegible] that client [illegible] criterion viewpoint which [illegible] presented essentially by [illegible] writers.

Whi[illegible] is concerned with investigating which therapist [illegible] more important one to relate to [illegible] it is beyond the scope of

CHAPTER

OUTCOME - CRISIS RESOLUTION.

5.1 The Problem of Outcome (Crisis Resolution).

Crisis intervention as a 'helping' therapy [illegible] problem of validating help performance and not some criterion of effectiveness or success. The problem of outcome research is surely the most [illegible] research debate with fewer certain conclusions than any other clinical area. Meed (1974) writes :

> Everyone familiar with the area of research in psychotherapy knows that no consistent evidence ever has been presented to substantiate the benefits of psychotherapy in terms of the outcome of treatment with patients. With crisis intervention services, the data obtained are likely to be confounded by extraneous factors.
> (Meed, 1974; p.275).

[illegible]

As with any treatment aimed in order to ensure outcome 'has a sharp' requires clarification of its goals. Describing a typical theoretical progression from psychoanalysis to [illegible] crisis intervention, Aguilera et [illegible] (1970) attempt to describe the goal of crisis intervention

> The minimum therapeutic goal of crisis intervention is psychological restoration of the individual's immediate crisis and restoration to at least the level of functioning that existed prior to the crisis period. A maximum goal is improvement in functioning above the pre-crisis level.
> (Aguilera et al, 1970; p.14)

The minimum and maximum goals Aguilera et al describe above are not mutually exclusive, but represent a continuum of outcome evaluation. The range of this continuum is so

an economically 'social' measure. With it to do not take the crucial issue of the client's psycho-social adjustment which is the major impediment to the crisis situation defined. Such measures may be appropriate to evaluate a single client, but as a standard procedure for a sample of clients with heterogeneous problems, they are inadequate.

5.4 Conclusion.

The above discussion has highlighted the problems and complexities of conventional methods of measuring outcome in the crisis situation. The problem then is how to measure crisis [illegible] appropriately. Woods (1974) suggests:

> It is time that there was a very low adequate [illegible] in a suicide and [illegible] intervention survey or, but some of [illegible] all centre's [illegible] (Woods, 1974:p.10)

6.2 Hypothe[illegible].

Hypothesis 1. Bas[illegible] n the above-mentioned rationale the first hypothesis of this study is that both therapist facilitativeness and action-orientedness are necessary and important for successful crisis outcome; that is,

CLIENTS OF THERAPISTS WH[illegible] RATE HIGH IN FACILITATIVENESS [illegible] HIGH IN ACTION-ORIENTEDNESS, HAVE HIGHER RATINGS OF CRISIS OUTCOME THAN CLIENTS OF THERAPISTS WHO RATE LOW ON EITHER OR BOTH OF THESE VARIABLES.

Hypothesis 2 (a). Bas[illegible] n Rogers' statement on the importance and universality of therapist facilitativeness and the impressive body of research to support this proposition, the second hypothesis of this study is that therapist facilitativeness is a more important [illegible] resoluti n than therapist action-orientedness; more specifically,

CLIENTS OF THERAPISTS WHO RATE HIGH ON FACILITATIVENESS AND LOW ON ACTION-ORIENTEDNESS HAVE HIGHER CRISIS OUTCOME RATINGS THAN CLIENTS OF THERAPISTS WHO RATE HIGH ON ACTION-ORIENTEDNESS AND LOW ON FACILITATIVENESS.

Hypothesis 2 (b). (Converse). Based on the theory of crisis [illegible] the alternative second hypothesis is that therapist action-orientedness is a more important variable in crisis resolution than therapist facilitativeness; more specifically,

CLIENTS OF THERAPISTS WHO RATE HIGH ON ACTION-ORIENTEDNESS AND LOW ON FACILITATIVENESS HAVE HIGHER CRISIS OUTCOME RATINGS THAN CLIENTS OF THERAPISTS WHO RATE HIGH ON FACILITATIVENESS AND LOW ON ACTION-ORIENTEDNESS.

is best described by the 'atmosphere', or as was commonly described, the 'vibe' at the clinic.

I became well-known in the community of Johannesburg as a warm, relaxed yet dynamic 'hive' where the very least one got was a cup of coffee and a friendly chat. It was well recognised for its intimacy, confidentiality and the keen concern of its young, volunteer staff. After the data for this study was collected the structure and organization of the crisis clinic was changed. The climate now, it appears, is very different from that at the time of the study.

7.1.4 Client description.

The statistical information presented below is not to be understood as descriptive and accurate, since [illegible] Moreover, the information covers a two-year period from January 1974 until December 1974. Since the actual number of clients who attended the clinic had greatly increased during the period of study, the information below is presented in percentages. It should merely be viewed as a descriptive distribution of the types of clients attending the clinic. The information was reported in a paper presented to the 27th Annual Congress of the South African Psychological Association by J. Barling and A. Zibbler (1975).

1. Sex Distribution.

(a) Males: [illegible]

(b) Females: [illegible]

Age Classifications.

(a) 0 - 19 years = 23

(b) 20 - 29 years = 33

(c) 30 - 39 years = 20

(d) 40 - 49 years = 14

(e) 50+ years = 10

Percentage Clients from Lower and Lower - middle class = 84

Percentage Clients from Hillbrow and the City Centre = 40

Classifications of Presenting Problems:

(a) Substance dependence = 9

(b) personality problems = 20

(c) Psychological problems (Depression etc.) = 12

(d) Other problems (marital, sexual, parent-child etc.) = 30

(Barling & Zimbler, 1980)

The Therapists.

7.2.1 Number and Selection of Therapists.

Twenty-two volunteer therapists were originally chosen as subjects for this study.

In order to be selected, each therapist was required to respond to 10 tape-recorded client stimulus expressions (see section 7.4.1 and Appendix B).

Of the original 22 therapists, six were not included in the final sample. They either dropped out on their own record or were eliminated for reasons which will

7.2.3 Briefing.

The therapist subjects were assembled and briefed on only the broad outline of the project in which they were participating. They were not informed of the hypotheses of the research project. Two particular aspects of the briefing were:

(1) Definition of the Crisis Event.

This definition was clearly discussed with the therapists. It was explained that only clients presenting with crisis as defined, (see Chapter 3)

(2) Initial Process Level.

The use of the Truax Accurate Empathy Scale, (see Appendix A), was explained and discussed by the experimenter with each therapist individually. A brief oral test was completed to ensure that each therapist was familiar with the various levels of process.

7.3 The 'Client'

7.3.1 Number and Selection of Clients

Walk-in/right 'walk-in' client's to the Crisis Clinic were selected as subjects for the study. They were selected on a 'first-come-first-served' basis in so far as they were interviewed by one of the 16 pre-selected therapists.

Certain criteria were required to be met before a walk-in client was selected for this study. These were:

(1) The client had to be in a state of crisis

(3) Initial Process Level — No.

Level 3 or 4 — r = .48 (.00

.4 Rating and

Carkhuff (1969) has develop

measuring a helper's level of

orientedness (hereafter referred to as PO and

tively).

which might typically occur in a therapeutic

Helpers are required to generate therapeutic responses

to these helpee expressions as if they were brought up

during the course of a typical

responses are then rated by qualified raters for their

level of PO and AO to provide an overall score of each

helper's level of these variables.

With regard to the presentation of the helpee

demonstrated a close relationship between both verbal and

tape-recorded presentations of the helpee expressions and

the written responses of subjects. Carkhuff (1969) however,

has had extensive experience with his scale and feels

the situation thus:

> The written form would seem [illegible] when the taped procedure is not possible ... In general, [illegible] presentation of the recorded helpee stimulus expressions and the written recording of the prospective helper is recommended as yielding maximum efficiency (Carkhuff 1969; pp. 109-110)

Applying Carkhuff's recommendation to this

study, the 16 helpee expressions were tape-recorded by an

FIGURE 3

DISTRIBUTION OF FAC AND ACT SCORES
OF PARTICIPANTS IN HEADSTART.

Rater 1	56	71
Rater 2	[illegible]	83
Rater 3	[illegible]	80
Rater 4	42	66
Rater 5	41	64
Rater 6	46	56

TABLE

Basic Data of the Three Raters

Rater	Age	Sex	Highest qualifications
Rater 1		M	Psychology Honours
Rater 2	25	M	Psychiatric Social Work
Rater 3	23		Psychology Honours

7.4.3

was done by consensus

Selltiz, Deutsch & (1965) maintain:

> Reliability is usually enhanced when ratings by have worked as a team, with independent ratings discussing discrepancies, and having reached independent judgements ... Further

> "... studies of judgement that are available, it would seem that three independent estimates of the traits commonly judged are the minimum requirements for satisfactory work."
> (Selltiz et al, 1965; p.354)

The rating procedure in this study was as follows:

1. For each helpee stimulus expression the 16 therapist responses were rated out in random order, the sequence altering with each helpee stimulus expression.

2. Raters made independent judgements and then compared their ratings and discussed discrepancies until a final consensus judgment was made.

3. For each helpee stimulus expression, therapist responses received a rating out of 10 along the FAC and ACT dimensions.

1. According to Zax and Klein (1960: In Tabachnik, 1975) two important criteria of outcome are:

(a) measurement of the patient's self-evaluation of progress or outcome;

(b) external features of the patient's behaviour.

Scale 1 and Scale 2 are attempts to meet these criteria.

2. Since outcome measures are notoriously difficult, an attempt was made to avoid sophisticated and specific variables of improvement pertaining to any theoretical framework. Instead the measure for simplicity and clarity with regard to defining a greater or global sense of having been helped. The rationale was to see also succeeded in overcoming the problem: the scale determines the extent to which an individual's presenting problem or outcome is growing

7.5.2 Client Ratings Scale.

A five-point Likert scale ranging from 'strongly disagree' to 'strongly agree' was developed and consisted of ten simple and unambiguous statements describing the feelings and experience of having undergone a crisis and possibly its resolution (see APPENDIX C).

The ten statements were selected from a multitude of others according to three major criteria:

1. They are mostly related to resolving the issues described in the definition of the crisis state used in this study;

2. They were approved by two experienced and expert crisis interveners.

3. The simplicity of statement and self-report suggest strong face-validity. This face-validity is acceptable according to Paul's (1967) contention that:

> Irrespective of any theoretical position the real question of outcome on logical and ethical grounds is whether or not the clients have received help with the distressing behaviours which brought them to treatment in the first place.
> (Paul, 1967;p.122)

While a number of the statements were reversed in direction to prevent a 'halo' effect, all ten statements were unidirectional and essentially overlapping in intent: for example,

> [illegible] "Nothing seems worthwhile anymore";
>
> [illegible] "Life seems worthwhile and interesting";
>
> [illegible] "My condition at the present time [illegible]
> [illegible] to [illegible]
> [illegible] I was when I first entered the clinic."

[illegible] unidirectionality and overlapping intensity, it was decided to obtain a final outcome score for each client by assigning scores of 1 - 5 for strongly disagree - strongly agree. The mean score of the ten statements was that particular client's rating of outcome.

7.5.3 Therapist Rating of Outcome.

APPENDIX D shows the therapist rating scale of

outcome. This scale, for the sake of simplicity, is identical to the client outcome scale [illegible] reversal of the [illegible] relationship of each statement.

The method for obtaining the final outcome score for this [illegible] identical to that described for [illegible] scale above.

(c) Follow-up [illegible]

[illegible]

[illegible] were returned [illegible] return rate.*1 [illegible] inspection of these returned scales there was virtually [illegible] eight weeks later.

Therefore, because of the limited response rate and the obvious [illegible] limitations of those

---

*1 While 29[illegible] is a disappointing response rate for the purposes of this study, it is understood by the author who consulted a major market research firm specializing in postal surveys, that usual postal response rates (even after personal contact) range between 10 and [illegible], more frequently in the lower region. The relatively higher return in this study probably has to do with the unspoken 'therapeutic contract' established between clients and their therapists, completed eight weeks previously.

TABLE 4

High TAC – High RPT			Low TAC – High ACT			High TAC – Low ACT			Low TAC – Low RPT		
Therapist No.	OUTCOME RATING Client	Therapist	Therapist No.	OUTCOME RATING Client	Therapist	Therapist No.	OUTCOME RATING Client	Therapist	Therapist No.	OUTCOME RATING Client	Therapist
1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	6	[illegible]	[illegible]
2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]						
			[illegible]	[illegible]	[illegible]						
N = 16			N = [illegible]			N = 3			N = [illegible]		

* see APPENDIX [illegible]

TABLE 5.

Multivariate t-Test Comparisons of Patterns and Individual Components for Matched-Couples Data

PAC and ACT Conditions	n_1	n_2	t^2 Critical Value	df_1	df_2	Level of Acceptance (α.5
1. High PAC - High ACT Vs Extra PAC - Low ACT - Low PAC - High ACT - Low PAC - Low ACT						
Client Outcome Pattern	4	4	22.11	4	3	$p < .05$*
Therapist Outcome Pattern	4	4	22.11	4	3	$p < .05$*
2. High PAC - High ACT Vs Low PAC - High ACT						
Client Outcome Pattern	4	4	22.11	4	3	$p > .05$
Therapist Outcome Pattern	4	4	22.11	4	3	$p < .05$*
3. High PAC - High ACT Vs High PAC - Low ACT						
Client Outcome Pattern	4	4	22.11	4	3	$p > .05$
Therapist Outcome Pattern	4	4	22.11	4	3	$p > .05$

* Significant at $p < .05$ level.

*1 According to Cohen's criterion of the non-centrality index, a value of .05. [illegible] 1977, p. 27).

*2 If the observed value of t^2 [illegible] exceeds the critical value, except R_2, criterion re[illegible]

Table 6

Rank-Ordered Tissue Compositions of Calculated and Corresponding Values for Irradiated Pig and Chicken*

Pig and Hen Compositions	%	%	Calculated Values*	%	% Deviation Between Corresponding Values
Lean Pig - Loin Roast					
Lean Pig - Ham Roast					
Chicken Composite Breast	1			1	> 5
Chicken Composite Thigh	2			2	> 5

*Corresponding values in the same row of the table are not necessarily from the same animal.

TABLE 7.

	CHEMISTRY CONDITION	CORRELATION COEFFICIENT	P-VALUE	LEVEL OF SIGNIFICANCE
1	Carbon Dioxide (Urine only (N = 14)			
2	Urea & Sodium (All Scores (N = 18)			
	High FAC - High Score Urine only (N = 9)			
	High FAC - High Score All Scores (N = 13)			
3	High FAC - Low Score Urine only (N = 5)			
	High FAC - Low Score All Scores (N = 5)			
4	Low FAC - Urine only (N = 8)			
	Low FAC - All Scores (N = 12)			

*

*1 The Low FAC [illegible] Urine only [illegible]

*2 [illegible]

*3 [illegible]

TABLE 3:

Goodness-of-fit Test between Observed Mean Yield and Their Theoretical Values in Relation

Mean Yield Vs Mean Theoretical Values of Yield	$\bar{Y}_{ij}$	$\bar{Y}_{ij}$	*) Critical value	*) U_{p1}	*) U_{p2}	Level of Significance
1. Under all four conditions	16	16	16-16	0.00	0.00	P<0.01 **
2. With FYM+Lead Ash condition	4	4	[illegible]	[illegible]	[illegible]	[illegible]
3. With FYM+Lead Ash condition	4	4	[illegible]	[illegible]	[illegible]	[illegible]
4. With FYM+Lead Ash condition	4	4	[illegible]	[illegible]	[illegible]	[illegible]

** significant at 1% level

* significant at 5% level

*) According to Cochran & Cox (Experimental Designs, 2nd Edition) 1950, 172 and 173

*) If the numerical value of U_{p1} is between the two values presented in critical values except U_{p1} corresponding to U_{p2}

TABLE 9.

Number & Percentage of Fully Scales returned for Different Therapist Conditions.

THERAPIST CONDITION	Number of Clients	Percentage Returns
High FAC - high ACT	[illegible]	47
High FAC - low ACT	[illegible]	25
Low FAC - high ACT	[illegible]	22
Low FAC - low ACT	[illegible]	[illegible]
[illegible]	36	29

TABLE 10.

[illegible] matrix [illegible] one [illegible] FAC [illegible]

THERAPIST CONDITION	Observed Value	*	If	Level of Significance
High FAC - high ACT	[illegible]	[illegible]		p < .[illegible]
High FAC - low ACT				
Low FAC - high ACT				
Low FAC - low ACT				

* Significance of [illegible] test at [illegible] level.

*1 According to Table [illegible] Critical Values of Chi-Square. McCall (1970; p.371)

*2 If the observed value of X^2 is greater than or equal to the tabled value, reject H_0.

9.2 Hypothesis 2 and Convergent Differences.

The second hypothesis stated that clients or therapists who rate high in FAC and low in ACT have higher outcome ratings than clients [illegible] low in FAC.

TABLE 6 demonstrates a significant difference between high FAC - low ACT therapists and low FAC - high ACT therapists when rated by client [illegible]. This result [illegible].

The evidence here supports that [illegible] are predominantly [illegible] and those who are predominantly [illegible], and those [illegible] tunities usually in both FAC and ACT. Those without the other prerequisite [illegible] will [illegible] variance.

[illegible] 'group' [illegible] on number of items in the correlation coefficient 'group only' and 'all scores' method. Since the number of subjects in the 'group only' method is very small in some cases, there is [illegible] of the correlation, somewhat will be made only for the 'all scores' method of correlation.

There is a significant correlation between client and therapist ratings of outcome over the entire sample ($N = 41$) ($p < .05$). This suggests that, overall, clients and therapists

significance of such low incidence [illegible] the [illegible]

[illegible]

[illegible] by that all three clients of the only low FAC low [illegible] therapist [illegible] very [illegible] worst of all [illegible]

[illegible] therapists into the different therapist conditions [illegible] In Chapter 4 it was [illegible] writings on Client-Centered Therapy emphasize [illegible] therapist behaviour [illegible] Indeed the distribution of therapists into the different conditions demonstrates [illegible]

[illegible] however, [illegible] on a first-come-first-served basis, there were so many [illegible] may have happened [illegible] major criterion for selection, initial process level, [illegible] judged by the therapists themselves.

10.[illegible] Initial Process Level.

[illegible] there [illegible] research demonstrating the relationship of initial process level to therapy outcome (Hart & Tomlinson, 19[illegible]; [illegible] Veen, 19[illegible]7; Kirtner and Cartwright, 1958; Gendlin, [illegible] 19[illegible]; Rogers et

r sent study r ther s an i r ·ariable such ·lients' age,
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The ideal way of m asuri process level is by

tape-recording lient in e ions, r my wh wished
r main anony . Ju nitia ch therap during the ni .l fift en
minutes ir int rview with client. Even ugh
therapists were arefully brief and orally tes l on the

evident. Fi st, th udgments were singu.ar

il 1967; x ml rkh , 19 ; Pl et al,

of thi var able was made

h s study he act th t li nts' initial proc ss level
olled a all. This was dom originally because o
ll the evidenc wh h ha r l ed initial p ocess level t
ou come. In Ch pt r I it was sh wn that clients below
certain minimum init l level of process do not benefit from
therapy; that is, initial process level y be a good predictor

qualitative therapist response [illegible] that facilitativeness and [illegible] exclusive variables and that the different rated ratings in [illegible] reason why therapists were described as high and low levels of both variables (i.e., division by quadrants) and why 'extreme' therapists were eliminated by cut-off levels.

[illegible]

The development of client and Therapist rating scales of outcome specifically for this study was discussed in Chapter 7. Unfortunately no other outcome measures were available to assess the validity of the scales used. Since they are self-report scales [illegible] therapy, the [illegible] validity. With regard to their reliability, [illegible] correlation ($r = .93$; $t = 2.4$) between

[illegible]

is with any self-report scale, it is that a client's own evaluation is open to distortion. This may be particularly so in the present study.

[illegible] the view that, if anything, client's may 'fake good' [illegible] results shown in TABLE 8. While it has been suggested that some discrepancy between actual client and therapist ratings is due to therapist variables (as seen for the different therapist conditions) the evidence also supports the notion that overall four therapist conditions clients rated outcome significantly higher than did therapists ($p < .01$).

[illegible] low ACT conditions, the two conditions where the difference between client and therapist ratings were not significant ([illegible]), the trend [illegible] still [illegible] mean client [illegible] mean therapist ratings. In fact [illegible] can be seen in TABLE [illegible] client ratings [illegible] [illegible].

Therefore, although it has been shown that therapist [illegible] that, when [illegible] the outcome, [illegible] of what [illegible] required of them (Orne, 1962; [illegible]vy, [illegible]).

[illegible] relief. Another factor to consider [illegible] when terminating therapy, clients may feel obliged to [illegible] approval, either [illegible] experienced themselves or, [illegible] likely, out of a residual [illegible] therapists even though they were assured of the anonymity of their ratings. It is noteworthy that clients make no monetary payment for [illegible] their therapists irrespective of their therapeutic outcome.

11.2. Follow-up data.

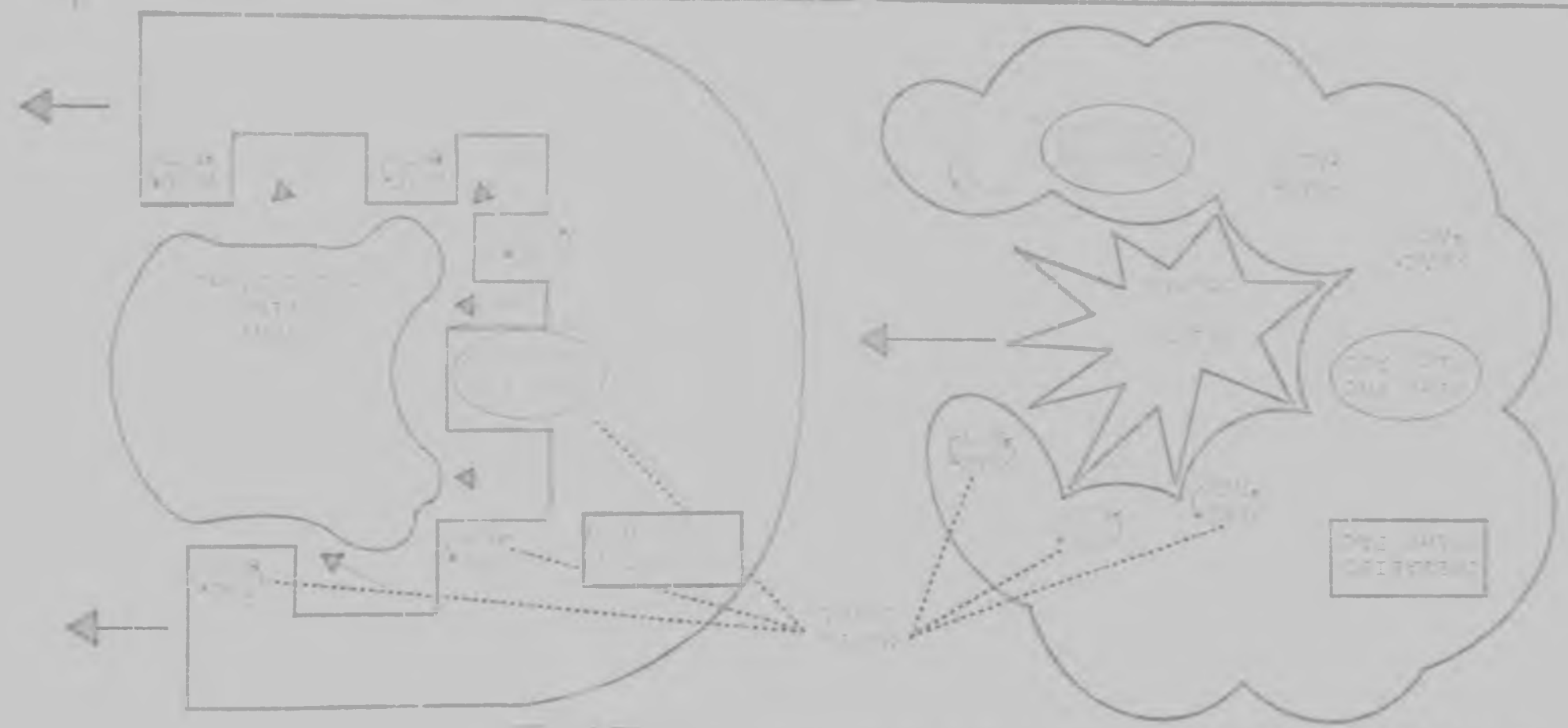
It is paradoxical that the very failure of the follow-up data to initially produce us, led to [illegible], possibly more important conclusions. While it is questionable whether the significantly higher return rate for high FAC - high ACT therapists ($p < .05$) over the other therapists offering lower conditions, [illegible] the use of return-rate as a measure of outcome [illegible]

(i) The downward or inward or exploratory phase, and

(ii) The upward or outward phase or phase of emergent creativity.

During the initial phase the goal of helping is to learn not only the nature of the client's problems but also how he relates to them. During this phase the operative therapist provides facilitative conditions coupled with the conditions of a warm, accepting and genuine atmosphere, the client is able to explore deeper levels of his experience. This enables the therapist to understand the client's subjective experience and details of his crisis including its severity and [illegible]. Providing facilitative conditions the therapist [illegible] what Aspler et al (1967) [illegible] of crisis [illegible] stage 1.

[illegible] understanding. During this [illegible] the therapist directs [illegible] of the client. What Carkhuff [illegible] client directionality depends on the [illegible] effectively explored himself [illegible] emotional understanding of himself and his particular crisis, the therapist directs the client not only [illegible] in terms of experiential dimensions but also [illegible] involved in more cognitive, problem-solving-type activities. The client is, 'Now what it we going to do about what we understand'. (Carkhuff 1969; p. 1). This phase



quoted by Cr

demonstrated the combination of

Bierman (1968) wa

he was more concerned with

psychotherapeutic

centred approach, originating fr non-directive framework

nd unconditionality,

the facilitative dimensions. The client-centred approach

dness, although

past ten years interest has developed in what one might possibly

call action-oriented variables, viz. concreteness (see

, Dowd and Markhuff, I

and Berenson, 1967).

the existential aggression with its

assumptive roots in phenomenology. The notion of

is anathema to its modus operandi towards a basis of choice

and responsibility which require basically non-directive

facilitation more than anything else.

The psychoanalytic approach, though more especially

the neoanalytic tradition, is not that dissimilar from the

Wolpe (1958) stated that from one to two interviews should be spent obtaining a complete case history as possible. Whatever is said is accepted without question, with warmth. [illegible] any form of evaluation. A number of more [illegible] therapy researchers, especially those dealing with [illegible] Wilson, 1973) have recognized the [illegible] which are not to [illegible] the concept of facilitativeness referred to as 'therapeutic [illegible] psychotherapy'. [illegible] psychotherapy [illegible] therapist facilitativeness was perceived as [illegible] that therapist variables are necessary but being related [illegible] therapy facilitativeness is only [illegible]

[illegible] presents more [illegible] client-oriented, 'inspiring to attend', and [illegible] little doubt about its [illegible]. Much [illegible] the 'deserved' [illegible] crucial variable in crisis therapy and the [illegible] variable in behaviour therapy, [illegible] not always considered appropriate in the conventional psychotherapies. Nor is it difficult to see why this is so.

[illegible] an [illegible], the person in crisis is a fundamentally [illegible] personality (or 'ego') even though it may not be

ctually selecting pers n t t n n the

As st ndard d and v lid t

scales may be, asures

of th rapist funct ning. In r, n nly t stab

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also to inv st gate s the c plex ry and inter-

, more sensitiv and specific m s r s need to le developed.

While the ratings of tape-recorded

sitive instrum nts

r t d te, this method does

situ t. n. The ch l eng

develop sensitive

, nd esp cially to measure

, f r x pl , what therap st

r through the su s-

ful resolut n a

And v en when such fine t ols nd m sures are

t our disp l, wh n w truly feel w re on the way to

dis ov ring bj ctiv ly ver , lawful relationships in

human hav r , ev n then, as in physics, we will r lise that we c nnot obs rve and

ubtle a sp cts of human experience

without lt ring the v ry phenom non it lf. Perhaps more than

any other ar in psych l gy, this applies most to the study

of the th rapeutic m ting.

CHAPTER 11.

SUMMARY.

Drawing heavily on Rogers' views of the necessary and sufficient conditions for therapy, Truax & Carkhuff (1969) has developed a model which includes [illegible] action-oriented [illegible] all emotional helping relationships. The present study has [illegible] shifting these variables to [illegible] in crisis intervention, a discipline which has traditionally been [illegible] theory, although probably also facilitative in practice.

Sixteen therapists at the Johannesburg Crisis Clinic were rated by three selected and trained raters on their responses to eight stimulus expressions for their [illegible] had three clients (with standardized initial [illegible] of which both clients and therapists completed simple outcome rating scales [illegible] given at three-monthly follow-up scales for completion and return eight weeks in the future. Although the actual number of returned scales was too few to be used in the originally intended manner, the returns did provide some alternative measures of client outcome with heuristic possibilities.

Therapist levels of FAC and ACT were then related to client outcome yielding the following results:

got higher out[illegible] who were low [illegible] ited ly both clien[illegible] supp rted the first hypothe is.

However when clients [illegible] therau[illegible] who were [illegible] with [illegible] whos therapists were low on either variable [illegible] The exceptio[illegible] was for therapi t ratings in the low FAC - [illegible]

2. [illegible]

facilit.tiv[illegible]hion [illegible] v e v :

Subsidiary findin s we[illegible]

(i) The[illegible] w[illegible]rr[illegible]tion b[illegible]tween client and th[illegible]rapist [illegible] overall (N 48) and with [illegible] clients and their therapists who were high [illegible]

(ii) Actual client ratings of outcome were signific ntly higher than [illegible] therapist ratings over all four c ndi i ns (N 48) and specifically in the low [illegible] high [illegible] conditions.

(iii) Follow-up mail return rate for clients of therapists who were [illegible] on both facilitativeness and activeness or ... than ... return rate ... or both [illegible]

The major theme of the above results is that therapists who were high on [illegible] and ... more important aspects of the ... therapy.

While high ... with variables are so crucial to ... clients level ... therapy.

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APPENDIX A

A SCALE FOR THE RATING OF EXPERIENCING

Eugene T. Gendlin & F.M. Tomlinson.
Reviewed by Philippa L. Mathieu & Marjorie H. Klein (1963).

SUMMARY RATING GUIDE FOR INITIAL INTERVIEW LEVELS:

[illegible]

LEVEL 1

[illegible]

LEVEL 2

[illegible]

LEVEL 3

[illegible]

Stage 3:

The client is primarily involved in telling a story in which personal referents are used. He goes beyond the story at times to make parenthetical comments about his reactions and associations, but these associations are based on the external events only. Such comments can be an account of his feelings about the story, his feelings at the time of the events described, comments about the personal significance of the events to him. These parenthetical comments must contain personal referents. The person's focus is upon telling his story 'better' by elaborating upon it, but he does not use the story to show what he is like as a person.

Summary:

After [illegible] go beyond referent but possibly [illegible]. Expressions [illegible] and 'why' [illegible] parenthetical [illegible] narrative. [illegible] still [illegible] completely [illegible] with the [illegible], [illegible] relationships in terms of deepening personal meaning or significance.

Stage 4:

The client is now clearly telling something about himself but [illegible], using himself as the referent. While these comments may be made in the context of the story, their function is not [illegible] the self. In ways to describe itself and [illegible] this difficulty is not sufficient to [illegible].

The client is now aware of his feelings and reactions and [illegible] them. He is doing this in order to [illegible] is interested in a struggle to explore himself and in his feelings is the basis for self understanding.

[illegible] always be: 1) the expression of many feelings, [illegible] and time spent elaborating on it in terms of the significance for self-image; or 2) to offer expression to the fact that the feelings exist, but that [illegible] to express them.

Stage 5:

The client is now using his feelings in a struggle to explore himself. This may take several directions. The client may start with his feelings in a given area and work to understand these feelings, to differentiate them, or to understand how and in what situations they arise. The

client may also start with [illegible] assumption he has about himself and work to understand how this assumption came about or clarify the implications that this assumption has for him.

The client at stage 5 is clearly engaged in a process of self-exploration in order to achieve self understanding; this process may be extremely difficult for the client and may not be maintained throughout the moment. The expression of difficulty in achieving self understanding is sufficient basis to rate [illegible] if the client is able to express and elaborate his feelings at present clearly his self image (as in stage 4).

Summary: Defining a problem of [illegible] feelings and attempts to explore this: i.e. explanation of (a) the situation or aspect of self [illegible] involving my feelings and their potential relationship, [illegible] feelings (if well described) and if [illegible] meaning my situations examined in terms of the common feelings or significance involved.

Stage 6:

The client [illegible] examining the significance of his feelings [illegible] concepts and is able to arrive at conclusions about them, [illegible] the results of this self-assessment [illegible] structure [illegible] self-[illegible] between any [illegible] expression of feelings. In [illegible] the [illegible] of self-examination [illegible] more self-understanding.

Summary: Already arrived at conclusions based on insight into the [illegible] his feelings [illegible] content. If there are [illegible] they are understood in terms of the [illegible] the feelings associated with [illegible]

Stage 7:

The client does not need a narrative as a point of departure. He can travel freely among feelings and understands them quickly. The client has no difficulty in tying together what he is saying and presenting a clear picture of himself - what meaning his thoughts, actions, and feelings have for him. He moves easily from one inward reference to another and is able to integrate them into his experiential frame of reference.

Summary: Proceeds to move among feelings and their significance from an experiential frame of reference: i.e. the client does not need a narrative as a point of departure. He can travel freely among feelings and understands them quickly. The client has no difficulty in tying together what he is saying and presenting a clear picture of himself - what meaning his thoughts, actions and feelings have for him. He moves easily from one inward reference to another and is able to integrate them into his experiential frame of reference.

HELPEE STIMULUS EXPRESSIONS

Below are the 16 helpee stimulus expressions. After each expression there are four possible therapist responses.

1. Therapists were chosen for this study by being required to generate their own responses to each helpee statement. These responses were then rated for levels of FAC and ACT by Raters.

2. Raters were chosen by being required to rate each of the four therapist responses to each helpee expression as either high or low, FAC or ACT.

NOTE: For convenience, the correct ratings of the four possible [illegible] are presented in brackets after each therapist response.

The following introductory matter preceded the helpee stimulus expressions:

"The following 16 excerpts represent client stimulus [illegible] come to you in a time of need. I would like you to respond as you would if someone came to you seeking assistance in a time of distress.

In formulating your responses keep in mind that the client [illegible] life. The expression will be played [illegible], so listen carefully before you formulate your response.

In summary, formulate responses to the person who has come to you for help. [illegible] range of client expressions [illegible]; however [illegible] relate any one expression to a previous expression. [illegible] formulate a meaningful response to the client's immediate expression." (Adapted from Carkhuff [illegible])

Example

[illegible] with the particular group I was with.

[illegible]

(1) [illegible] (HF-LA)

(2) [illegible] (HF-HA)

(3) [illegible] You have to be your own person. (LF-HA)

(4) So you have a [illegible] problem involving [illegible] with others. (LF-LA)

[illegible]
(1) Sounds like you found someone who really matters to you. (HF-LA)
(2) Why do these kind of people accept you? (LF-LA)
(3) It's a real [illegible] to have someone to trust and share with. I really hope it can be me. (HF-HA)
(4) Now that you have found these people who care about you and who you care about, spend your time with these people. Forget about the other twits who make you anxious. Spend your time with the people who can make you laugh and be warm with you. (LF-HA)

Excerpt 10

[illegible] I'm really excited. We are [illegible]. I have one to have a second [illegible]. He LF-LA love our job. It's great. It's not that I don't believe in true love or great. I have a structural problem. I don't want to have a part-time job where I think I will see you every night. I'm in bed when the kid gets home from school. I like to travel to be in interesting [illegible] horizons are endless. I just don't want to get tarted. It's great.

[illegible]
(1) Don't [illegible] by your [illegible] than you can [illegible]. Don't worry about [illegible] care for. [illegible] (LF-HA)
(2) Hey, that's [illegible]. Even [illegible] (HF-HA)
(3) [illegible] Don't be so hard [illegible]. (LF-LA)
4 It's [illegible] (HF-LA)

[illegible] [illegible] obviously [illegible] marvelously. They [illegible] together. However, I feel they would. They're a little older [illegible] I know [illegible] really upset because there [illegible] that [illegible]. Unfortunately, [illegible] painful [illegible] there. [illegible] I'm not. I don't want to lose it. It marvelous!

[illegible] (HF-LA)
[illegible] I wish I were happy before. But you never stood it [illegible] (LF-HA)
[illegible] (LF-LA)
4 How [illegible]. However the problem is, you know there will be [illegible] (HF-HA)

Excerpt 11

[illegible] I'm really [illegible] the way it is now. I'm great at home with my husband. It [illegible]. We're [illegible] that now [illegible] happy. I don't know [illegible] but I'm not so pleased. I don't know what else to say.

[illegible]
(1) It's a real [illegible] (HF-LA)
(2) I'm really excited to be closer again. I feel we finally seem to be in [illegible] (HF-HA)
3) I was [illegible] (LF-LA)
4) I would [illegible] in this right now. There will be problems that [illegible] bring the [illegible] that you have these problems I want you to remember will be [illegible] to the moment in time. (LF-HA)

APPENDIX C

CLIENT RISKING SCALE (CRS)

BIOGRAPHICAL DATA SHEET

Below you will find an short questionnaire. All of you are kindly requested to fill in as precisely as possible. Please be sure to use the envelope provided and your responses will strictly confidential. (Your responses will not come to discussed with your counsellor.)

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APPENDIX "C".

BUDGET RATING - SCALE OF INCOME

JOHANNESBURG CRISIS CLINIC.

Please fill in the questionnaire below as correctly as possible.
Your responses will be treated confidentially.

NAME .....

ADDRESS .....

TELEPHONE .....

OCCUPATION:

1. Husband's occupation (if married)

2. Your occupation (if married, female, working) Please supply details of husband's occupation if applicable.

3. Are you employed on a permanent basis? (Yes/No) If not, please indicate your source of income.

4. Do you receive any regular financial assistance from any other source? (Yes/No) If so, please indicate the amount and source.

5. Are you responsible for anyone else? (Yes/No) If so, please indicate how many and their relationship to you.

6. Do you own your own home? (Yes/No)

High TAC - High ACT Condition			
Therapist No.	Client No.	Outcome Ratings: Client	Therapist
2	1 2 3	4.1 4.2 4.0	4.2 4.0 4.0
	$\bar{x}_2$	4.0	4.1
3	1 2 3	3.8 4.0 4.0	3 2.8 4.0
	$\bar{x}3$	3.9	3.3
5	1 2 3	4.2 3.2 4.4	3.4 3.5 3.3
	$\bar{x}5$	3.9	3.6

Low TAC - High ACT Condition			
Therapist No.	Client No.	Outcome Ratings: Client	Therapist
11	1 2 3	4.0 3.4 4.0	3.4 3.8 3.6
	$\bar{x}11$	3.8	3.6

Low TAC - Low ACT Condition			
Therapist No.	Client No.	Outcome Ratings: Client	Therapist
2	1 2 3	4.0 3.4 4.0	3.6 3.8 4.0
	$\bar{x}2$	3.8	3.8
3	1 2 3	3.4 3.4 3.6	3.6 3.4 3.6
	$\bar{x}3$	3.8	3.6
5	1 2 3	3.4 4.0 3.8	3.4 3.5 3.8
	$\bar{x}5$	3.8	3.7

Low TAC - Low ACT Condition			
Therapist No.	Client No.	OUTCOME RATINGS: Client	Therapist
16	1 2 3	3.4 2.1 3.7	2.8 3.1 2.2
	$\bar{x}16$	3.1	2.7