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THERAPIST VARIABLES IN CRISIS INTERVENTION THERAPY

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Dissertation submitted to the Faculty of Arts, University of the Witwatersrand, in partial fulfillment of the requirements for the degree of Master of Arts in Clinical Psychology.

Johannesburg 1978.

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

[illegible]

P. KAHN.

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

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Chapter 1: Introduction and Overview

1.1 Orientation to the Present Study.

There is perhaps nothing more revealing than the [illegible] on which we base our [illegible] the [illegible] complexity of the psychic organism. For many [illegible] the most widely accepted [illegible] have rested upon [illegible] over [illegible] years. A notion that has persisted only [illegible] and misunderstandings [illegible] is readily [illegible] as the [illegible] [illegible] and even [illegible] of [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] identify, the [illegible] [illegible] [illegible] [illegible] and [illegible] [illegible] [illegible] [illegible] [illegible]

> [illegible]
> [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

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 terming his approach non-directive, the therapist's role was primarily to provide certain conditions which would facilitate client change. It was in later years when Rogers 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, Rogers did not lose sight of his core, facilitative therapist conditions.

In the 1950's an outgrowth of the American movement, while recognizing the importance of the facilitative therapist conditions as spelt out by Rogers, saw the need to include other, more action-oriented activities of the therapist in a model of psychotherapy. Because of the American model Carkhuff held the view that both,

> ... facilitative and action oriented dimensions serve complementary functions in the process leading to construction helper [illegible] (Carkhuff 1969a, p.40).

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

From another perspective altogether there was also dissatisfaction with the traditional medical approaches to helping distressed individuals.

Experience gained from dealing psychologically with combat casualties during the second World War, and increasing awareness of the role of socio-cultural factors which could precipitate crisis situations, led to the development of immediate-access, crisis-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.

CHAPTER 2.

THERAPIST VARIABLES.

2.1 Introduction.

Until fairly recently investigation into the effective ingredients of psychotherapy has been mainly on different therapeutic methods, according to certain, rather fixed theoretical models, investigators have generally a theoretical parochialism which has contributed little to the development of psychotherapy, since [illegible] that:

> [illegible] the [illegible] of therapy and in developing a psychotherapy [illegible] with specific techniques and [illegible] the product of what [illegible] the [illegible] of the interpersonal [illegible] by psychotherapy [illegible] (In Frank & Jerkins [illegible])

As early [illegible] the first investigators [illegible] the interpersonal relationship in therapy, and [illegible] the therapist's contribution to this relationship. As mentioned in chapter 1, in his original [illegible] of psychotherapy, Rogers stressed that [illegible] facilitative conditions were necessary and sufficient therapist attitudes for successful psychotherapy.

2.2 Facilitating variables.

Cattell [illegible] theories of psychotherapy [illegible] to be [illegible] as to an [illegible] of the elements which are [illegible] in a unique relationship.

Rogers et al (1967) [illegible] mentions that psychoanalytic

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 test battery, including the [illegible], [illegible] and Rorschach test.

[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 scale 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 of his experience in 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.31)

Carkhuff [illegible] prescribes [illegible] 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, long term as well as immediate, of each;"
>
> (3) "We are going to take steps to operationalize the best mode of 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 clients are 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.

Carkhuff's two phase dimensions of therapy (a, as will be seen in chapter 3) not unlike Fenning and Hartlingt's (1973) notion of "Critical Incidence Theory" as applied to crisis intervention, this theory also attempts a breakdown and extension of the crisis sequence regarding concomitant therapist behaviours [illegible].

2.4 Research into Our Conditions.

There have been numerous research studies demonstrating the relationship of the separate facilitative conditions of empathy, congruence and unconditional positive regard to therapeutic [illegible].

Relative [illegible] and Carkhuff's postulation of the necessity for both facilitativeness and action-orientedness in therapy, a number of studies have investigated therapeutic outcome in relation to high and low levels 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 by gross, overall ratings of therapist functioning on a five point scale (Carkhuff, 1969, p.135), 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.

[illegible] [illegible]

It is argued by [illegible] the development of client [illegible], a scale for the rating of [illegible] and Klein, 1969[*]) was developed with acceptable and [illegible] reliability values (ranging from [illegible] (Rogers, Gendlin and Klein, 1967). This scale is used by trained raters on tape-recorded excerpts of the [illegible] interviews.

The assessment of [illegible] can be considered [illegible] to be [illegible] dimension (Rogers

[illegible]

[illegible]

[illegible]

level showed more variability and [illegible] values, both positive and negative, than clients' [illegible] at a lower level.

Possibly the largest and most [illegible] research study on the effects of clients' initial process level on outcome is the Wisconsin Schizophrenic project (Rogers et al, 1967)[*1] [illegible] the [illegible] scale to measure initial process level, it was found that the clients' initial process level was positively correlated with number of [illegible] outcome.

Moreover [illegible] the process of [illegible]

> [illegible]
> (Rogers et al, 1967, p. [illegible])

Carkhuff [illegible] the helper's [illegible] and recommends that the level of helper involvement [illegible] the [illegible] stage, there being a minimal [illegible] that [illegible]

> [illegible]
> (Carkhuff, [illegible])

Conversely, [illegible] helpers who [illegible] the [illegible] helper, to engage in the immediacy of [illegible] for offering treatment.

---

*1 cf. Chapter 2.

Thus, clients' initial process levels are important interaction variables in therapeutic relationship. Consideration of this has been already overlooked in outcome research of therapist variables [illegible] Those studies demonstrated the [illegible] therapists' facilitative conditions and outcome.

Since there has been a confounding of therapist and client variables in the therapeutic relationship, the exact nature of the association among therapist conditions and outcome has become obscure. The presence of uncontrolled initial process differences [illegible] and low therapist conditions makes it impossible to pinpoint the exact [illegible] therapist conditions operating in the therapeutic process.

[illegible]

> In the future [illegible] of [illegible] [illegible] [illegible] process factors [illegible] factors will [illegible] experimental control.
> ([illegible])

[illegible] clients' initial process levels [illegible] been [illegible] in the present study in order to reduce the confounding effect of initial process level with the independent variable, viz. therapist functioning.

---

* The present author's parenthesis.

CHAPTER 4.

CRISIS INTERVENTION

4.1 Organizational background to Crisis

Pedersen and Wasik (1972 p.74) make an initial historic introduction to the concept of crisis intervention:

"A relatively new trend, crisis therapy developed as a branch of community psychiatry. It could well be considered an intervention in a crisis of any kind, from economic to psychological and could include counselors and friends."

Apparent influences on the development of this field stem from emergency aspect [illegible] and also include research of early life development which [illegible] and [illegible] in [illegible].

Lindemann (1944) [illegible] the [illegible] of [illegible] situations that would [illegible] and predictable crisis reactions. [illegible] [illegible] [illegible]

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 Hazardous Event or 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 of a hazardous situation.

[illegible]

[illegible]

[illegible] individual's subjective state where [illegible] organization and psycho[illegible] [illegible] in. The individual has [illegible] his sense of self [illegible]

[illegible]

Stage [illegible] The Reintegration Stage

Kaplan (1968) incorporates some of these stages in his definition of crisis:

> [illegible] situation is equal to a relatively short period of psycho-social 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-

plicated interchanges between the individual and significant persons in the environment, is upset. This points to present-centred stressful events (whether internally or externally derived) and shifts the locus 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 it is extremely difficult [illegible] pathogenesis since it [illegible] each and every individual, the concept of the crisis state is 'self-limiting in the temporal sense' [illegible] (1963). It is an acute state of disequilibrium [illegible] with [illegible] the individual.

[illegible] that, even though acute, the crisis may frequently awaken [illegible] Strictly speaking of course, the two can [illegible] be separated. The present individual can never be divorced from his past [illegible] and behaviour even though crisis intervention treats the crisis as if he could be. Since the problem of differentiation 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 [illegible] or threat of loss, or a hazardous situation of psychologically meaningful import, which for the time being [illegible] she can neither escape nor solve with his or her customary problem solving [illegible]

2. [illegible] acute state of disequilibrium [illegible] pathological condition (even though the crisis may awaken or reflect unresolved problems [illegible] from the near or distant [illegible]).

3. The person [illegible] disequilibrium [illegible]

   a. rise of anxiety;

   b. [illegible]

   feeling of 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 [illegible] subjects [illegible] this 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 casework 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, [illegible] reaction to a situational hazard[*], it [illegible] 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 treatment procedures, away from an historical, intrapsychic determination towards more present-centred, reality-precipitated [illegible]

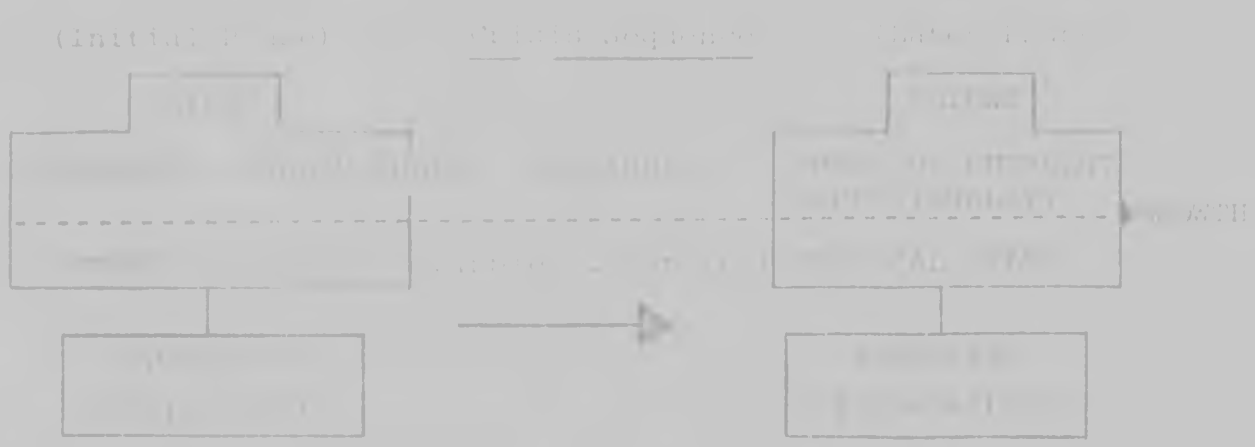
In conventional psychoanalytic psychotherapies, actual events in living are derealized and subsumed to the extent that they are secondary to the psychological a priori of the disturbed inner psyche. In crisis theory however, the locus of distress has its roots in the very real-life events that impose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

---

[*] The term 'situational hazard' is used here in [illegible] 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 later action. During the consequent phase of what Carkhuff calls 'emergent directionality' in the time that Zimbler and Barling term the 'critical stage' 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] (1969), Zimbler & Barling (1975):



[illegible] two [illegible] model appear [illegible] and the two variations [illegible] exclusive in their respective phases, [illegible] for the sake [illegible], for in actuality there [illegible] no such clear-cut [illegible] proposed that during the later [illegible] when the therapist is action-oriented that client 'growth' [illegible] American view-[illegible] which [illegible] presented essentially by [illegible] conditions.

Whi[illegible] 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 helper performance against some criterion of effectiveness or outcome. The problem of outcome research is surely the most [illegible] research debate with fewer certain conclusions than any other clinical area. McGee (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 outcome estimate [illegible] confounded by extraneous factors.
> (McGee, 1974; p.275).

[illegible]

As with any treatment method in order to measure outcome this concept requires clarification of its goals. Describing a logical theoretical progression from psychoanalysis to [illegible] crisis intervention, Aguilera et al (19[illegible]) [illegible] describe the goal of crisis intervention:

> The minimum therapeutic goal of crisis intervention is psychological resolution 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 precrisis 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

are essentially 'social' measures which do not tape the crucial issue of the client's psycho-social adjustment which is the major ingredient of the crisis state as 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 and other methods of measuring outcome in the crisis situation. The problem then is how to measure crisis [illegible] appropriately. McGee (1974) suggests:

> It is true that there are very few adequate tools [illegible] in a suicide and [illegible] intervention service, but [illegible] all centres from making some effort to develop local methods.
> (McGee, 1974:p.[illegible])

[illegible] this contention that the author finds existing methods of measuring crisis outcome inadequate and has developed two simple scales for use in this study.

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

3. Percentage Clients from Lower and Lower - middle class 84

4. Percentage Clients from Hillbrow and the City Centre 46

Classifications of Presenting Problems:

(a) substance dependence 39

(b) personality problems

(c) [illegible] (etc.) = 12

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

(Barling & Zimbler, 19[illegible])

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 16 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 accord 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 State.

This definition was clearly discussed with [illegible] crisis as defined. (see Chapter [illegible])

(2) Initial Process Level.

[illegible] (see Appendix A), was explained and discussed by the experimenter with each therapist individually. A brief oral test was conducted to ensure that each therapist was familiar with the various levels of process.

7.3 The Client

7.3.1 [illegible] Selection of Clients

Forty-eight 'walk-in' clients to [illegible] 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 Pro[illegible] Leve[illegible]	No.
	Level 3 or 4	[illegible] 48 100

.4 Rating and [illegible]

[illegible]

Carkhuff (1969) has develop[illegible] measuring a helper's level of [illegible] orientedness (hereafter referred to as FAC and [illegible] tively).

[illegible] if helpee express[illegible] which might typically occur in a therapeutic [illegible] Helpers are required to generate therapeutic responses to these helpee expressions as if they were brought up during the course of a typical interview. [illegible] responses are then rated by qualified [illegible] for their level of FAC and ACT to provide an overall score of each helper's level of these variables.

With regard to the presentation of the helpee [illegible] monstrated 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 [illegible] the situation thus:

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

Applying Carkhuff's recommendation to this study, the 16 helpee expressions were tape-recorded by an

actress affecting the [illegible] propriate [illegible] emotion. Each expression was played over twice [illegible] the therapists as a group to record their individual responses in writing.

The therapist responses were then rated out of ten points for FAC and ACT by three specially selected and highly trained raters (see section 7.4.[illegible]).

Table 1 and Figure 2 below show the distribution [illegible] The dotted lines on Figure 2 show the arbitrary cut-off points made between 4, [illegible] and [illegible] both dimensions in order to eliminate 'borderline' therapists. Four such therapists fell into this region of rejection and were eliminated from the sample. A further two therapists withdrew from [illegible] The remaining [illegible] therapists participated in the study.

7.4.2 [illegible]

In addition to the 16 helpee stimulus expressions described above, Carkhuff (1969) provides four possible helper responses to each. According to expert judgements, each of these four possible responses is either a high FAC - high ACT; high FAC - low ACT; low FAC - high ACT; or low FAC - low ACT response (see APPENDIX B).

To test a person's ability to describe each response in terms of FAC and ACT is to test their discriminative ability of these variables. In order to qualify as a rater therefore, prospective raters were required to discriminate which of the four possible helper responses provided was high or low on both FAC and ACT dimensions. With four possible helper responses to each of the 16 helpee stimulus expressions, 64 discriminative ratings were required.

FIGURE 2

DISTRIBUTION OF FAC AND ACT RATINGS
OF PROBABILITY OF DEADPOINT.



Six prospective raters were individually and carefully briefed on the concepts of FAC and ACT, and a [illegible] practice examples administered, discussed and corrected by the experimenter. Thereafter the prospective raters discriminated the 64 responses for the levels of FAC and ACT in their own time.

Scores for the six potential raters are presented in TABLE [illegible]. In TABLE 2, two clusters of raters discriminative abilities are evident, [illegible] and less, and [illegible] 8[illegible] and above. Because of their relatively low percentage correlation with experts, raters no. 4, [illegible] no. 6 were eliminated. Therefore three raters of at least 80 correlation with experts qualified to rate the therapists in this study.

TABLE 3 presents basic [illegible] the raters [illegible] of approximately [illegible] different genders.

TABLE 2.

Potential Raters [illegible]

Potential Raters	[illegible] of 64)	Percentage Correlation with Experts
Rater 1	56	[illegible]
Rater 2	[illegible]	83
Rater 3	[illegible]	80%
Rater 4	42	66
Rater 5	41	64
Rater 6	36	56

TABLE

Basic Data of the Three Raters

Rater	Age	[illegible]	Psychological Qualifications
Rater 1		M	Psychology Honours
Rater 2	25	M	Psychiatric Social Work
Rater 3	23	[illegible]	Psychology Honours

7.4.3 [illegible] ting

[illegible] rapists was done by consensus. Selltiz, [illegible] Deutsch & [illegible] (1965) maintain:

> Reliability [illegible] usually enhanced considerably by [illegible] working as a team, making independent judgements, comparing their ratings and discussing discrepancies, and making second independent judgements [illegible] averaged to give a final [illegible] ... Such research has demonstrated the superiority [illegible] consensus, of the judgements of [illegible] that of the individual ... Porfenberger [illegible] written:
>
> > "[illegible] studies of judgement that are available, it would seem that three independent estimates of the traits commonly judged are the [illegible] requirements for satisfactory work."
>
> (Selltiz et al, 1965; [illegible] 354)

The rating procedure in this study was as follows:

1. [illegible] helpee stimulus expression the 16 therapist responses were read 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 rating 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 measures 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 aims were for simplicity and clarity with a goal of eliciting a general or global sense of having been helped. This global outcome measure also succeeded in overcoming the problem of the scale discriminating the outcome criterion as either restoration of the individual to a pre-crisis state or outcome as growth.

7.5.2 Client Ratings of Outcome.

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 intervenors.

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]

[illegible] worthwhile experience [illegible];

[illegible] Statement 4. 'My counsellor at the clinic [illegible]

[illegible]

[illegible] Statement 7. [illegible] better able to deal with the stressful situation that brought me to the clinic now, than when I first entered the clinic.'

[illegible] discussed above, (unidirectionality and overlapping intent), it was decided to obtain a final outcome score for each client by assigning scores of 1 - 5 for strongly disagree to 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

[illegible]

[illegible]

[illegible]

TABLE 4

[illegible]

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

TABLE 5.

Mann-Whitney U-Test Comparisons [illegible] Hypothesis [illegible]

FAC and ACT Conditions	[illegible]	[illegible]	*1 [illegible]	*2 [illegible]	*2 [illegible]	Level of Acceptance [illegible]
1. High FAC - High ACT Vs High FAC - Low ACT - Low FAC - High ACT - Low FAC - Low ACT						
Client Outcome Rating		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Therapist Outcome Rating		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
2. High FAC - High ACT Vs Low FAC - High ACT						
Client Outcome Rating		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Therapist Outcome Rating		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
3. High FAC - High ACT Vs High FAC - Low ACT						
Client Outcome Rating		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Therapist Outcome Rating	[illegible]	[illegible]	2 - [illegible]	[illegible]	[illegible]	[illegible]

* Significant at [illegible]

*1 According to [illegible] .05. [illegible] 1970 [illegible]

*2 If the [illegible] except [illegible] [illegible]

TABLE 6

Mann-Whitney [illegible] Comparisons of [illegible] and [illegible] Values [illegible] Hypothesis 2 and [illegible]

[illegible]	[illegible]	[illegible]	[illegible] *	[illegible]	[illegible]	[illegible]
[illegible]						
[illegible]						
[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]

*[illegible]

TABLE 7.

SPEARMAN RANK ORDER CORRELATIONS OF PLEASANT AND THERAPIST RATINGS OF OUTCOME (means only [illegible]) *1

	THERAPIST CONDITION	CORRELATION DEVELOPED	CRITICAL VALUE	LEVEL OF ACCEPTANCE
1	Entire Sample (means only [illegible])	[illegible]	[illegible]	[illegible]
	Entire Sample (all scores [illegible])	[illegible] *2	[illegible]	[illegible]
2	High FAC – High [illegible] means only [illegible]	[illegible]	[illegible]	[illegible]
	High FAC – High [illegible] all scores [illegible]	[illegible]	[illegible]	[illegible]
3	High FAC – Low [illegible] means only [illegible]	[illegible]	[illegible] *3	[illegible]
	High FAC – Low [illegible] all scores [illegible]	[illegible]	[illegible]	[illegible]
4	Low FAC – High [illegible] means only [illegible]	[illegible]	[illegible]	[illegible]
	Low FAC – High [illegible] all scores [illegible]	[illegible]	[illegible]	[illegible]

* [illegible]

*1 The Low FAC [illegible]

*2 [illegible]

*3 [illegible]

TABLE 4.

Mann-Whitney [illegible] Mean Client and

Mean Therapist Ratings of Outcome

Mean Client Vs Mean Therapist Ratings of Outcome	N_A	N_B	Critical Values *1	U_A *2	U_B *3	Level of Acceptance
1. Over all Four Conditions	16	11	16-116	[illegible]	[illegible]	$p < .01$ **
2. High PAP-High RCT Condition	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
3. High PAP-Low RCT Condition	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
4. Low PAP-Low RCT Condition	[illegible]	[illegible]	[illegible]		[illegible]	$p < .01$ *

** Significant at [illegible] level

* Significant at [illegible] level

*1 According to Table [illegible] Critical Values of the Mann-Whitney U for a Two-Tailed Test [illegible] Mosteller (1970, 372 and [illegible])

*2 If the observed value of U falls between the two values presented as critical values, [illegible] U_A [illegible] U_B

TABLE 9.

Number & Percentage [illegible] Scales [illegible]turned for Different Therapist Conditions.

THERAPIST CONDITION	Number [illegible]	[illegible] of Client	Percentage Returns
High FAC - high ACT	[illegible]	[illegible]	47
High FAC - low ACT	[illegible]	[illegible]	25
Low FAC - high ACT	[illegible]	[illegible]	22
Low FAC - low ACT	[illegible]		[illegible]
[illegible]	[illegible]	14	29

TABLE 10.

[illegible] FAC [illegible] Therapist [illegible]

THERAPIST CONDITION	[illegible] Value	[illegible]	df	Level [illegible] Significance
High FAC - high ACT	[illegible]	[illegible]		$p < .[illegible]$
High FAC - low ACT				
Low FAC - high [illegible]				
Low FAC - low [illegible]				

* Significant [illegible] test at [illegible] level.

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

*2 If the observed value [illegible] X^2 obs[illegible] greater than or equal to the tabled value, reject H_0.

9.2 Hypothesis 2 and Converse Client Hypothesis.

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

TABLE 6 demonstrates no significant difference between high FAC - low ACT therapists and low FAC - high ACT therapists when rated [illegible] client [illegible]. This result [illegible]

The evidence here suggests that [illegible] are predominantly facilitative [illegible] therapists who are predominantly action-oriented, [illegible] successful therapists [illegible] function highly on [illegible] and ACT. The one without the other procure [illegible] facilitativeness [illegible] variables.

[illegible] in Chapter 8 demonstrates the correlation coefficients [illegible] 'mean only' and 'all scores' [illegible]. Since the number of subjects in the 'mean only' method is very small in some cases, therefore [illegible] the power of the correlation, comment 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 = 48) ($p < .05$). This suggests that, overall, clients and therapists

significance of such l w [illegible] the

[illegible] By that [illegible] all three [illegible] the only low FAC

l[illegible]w 'T the[illegible]p[illegible]st[illegible] t[illegible]d very [illegible], [illegible]

worst of all [illegible]

[illegible] ther[illegible]pi[illegible] into the differen'

ther[illegible]pi[illegible] c[illegible]li[illegible]

In Chapter 4 it was [illegible]

writin[illegible]n Cri[illegible] T[illegible]ajy[illegible]ha[illegible]z[illegible]-ri-n[illegible] ther[illegible]pist

b[illegible]h[illegible]vi[illegible]r t[illegible] [illegible]v[illegible] [illegible]lu[illegible]n [illegible]

Indeed the distr[illegible]buti[illegible]n [illegible]f th[illegible]r[illegible]p[illegible]s[illegible] [illegible] [illegible] diff[illegible]r[illegible]nt

c[illegible]nd[illegible]tions de[illegible] t[illegible]at [illegible]

[illegible]

[illegible]

[

[illegible] in the present study rather than for variables such as clients' age, sex, social class and [illegible]

The ideal way of measuring process level is by [illegible] tape-recording clients in crisis, many [illegible] who wished to remain anonymous. Judgment of initial [illegible] each therapist during the initial fifteen minutes of [illegible] first interview with each client. Even though therapists were carefully briefed and orally tested on the [illegible] evident. First, the judgments were singular [illegible] Second, even at this early stage of therapy [illegible] al 1967; [illegible] rkh f , 19[illegible] ; Pl[illegible] et al, [illegible]). [illegible] of this variable was made [illegible]

[illegible] this study is the fact that clients' initial process level [illegible] controlled at all. This was done originally because of all the evidence which has related initial process level to outcome. In Chapter 3 it was shown that clients below a certain minimum initial level of process do not benefit from therapy; that is, initial process level may be a good predictor

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

[illegible] Scales

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] ity. With [illegible] their reliability, [illegible] relation (r [illegible]),453; t = 2, [illegible] between [illegible] is with any self-report scale, 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 [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 ($p < .01$).

...low ACT ...conditions, the two ...main... where the ...ffe...nce b...tween ...client and therapist ratings was not ...ant (...), the ...trend ...'ll ...one ...een client ... ...in m...in ther...pist ... ...rs. In f...t ... ...m b... seen in TABLE ... ...client ratings ...e ..., ...h ... ...n lif...

Therefor..., ...although ... ...been shown that ther...pist ... ...

10.2. Follow-up Scale.

It is paradoxical that the very failure of the follow-up scale of it[illegible] originally [illegible] 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 [illegible] return-rate as a measure [illegible] outcome [illegible]

[illegible]

Carkhuff's (19[illegible]) [illegible] that both FAC and ACT are necessary therapist qualities for positive client outcome. However [illegible] facilitativeness and action-orientedness in this study were rather gross, overall measures of therapist functioning and have contributed little [illegible] in-depth understanding of the crisis sequence per se. In [illegible] therapy measures of therapi[illegible] is that, by [illegible] high [illegible] when these two variables, the therapist's level of functioning is a fait accompli and constant throughout the therapy. While this may indeed be the case, it [illegible] worthwhile to examine more closely the possible roles of facilitativeness and action-[illegible] sider the relationship [illegible]

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

(ii) The upward or outward phase or phase emergent [illegible].

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 attitude is facilitative [illegible]. Provided with the conditions of a warm, accepting and genuine atmosphere, the client is [illegible] to explore deeper levels of his [illegible]. This enables the therapist to understand the client's subjective experience and details of his crisis [illegible] including its severity and [illegible]. Providing facilitative conditions the [illegible] what Aguilera et al (197[illegible]) describe [illegible] of crisis [illegible] as stage 1.

[illegible] understanding. During this [illegible] constructive direct[illegible] resolution of the client. What Carkhuff [illegible] emergent directionality depends on the therapist's [illegible] orientedness. Having effectively explored himself [illegible] functional understanding of himself and his particular crisis, the therapist directs the client not only to act in terms of experiential dimensions but also [illegible] involved in more cognitive, problem-solving-type activities. The [illegible], 'Now what are we going to do about what we understand'. (Carkhuff 196[illegible]; p. 1). This phase

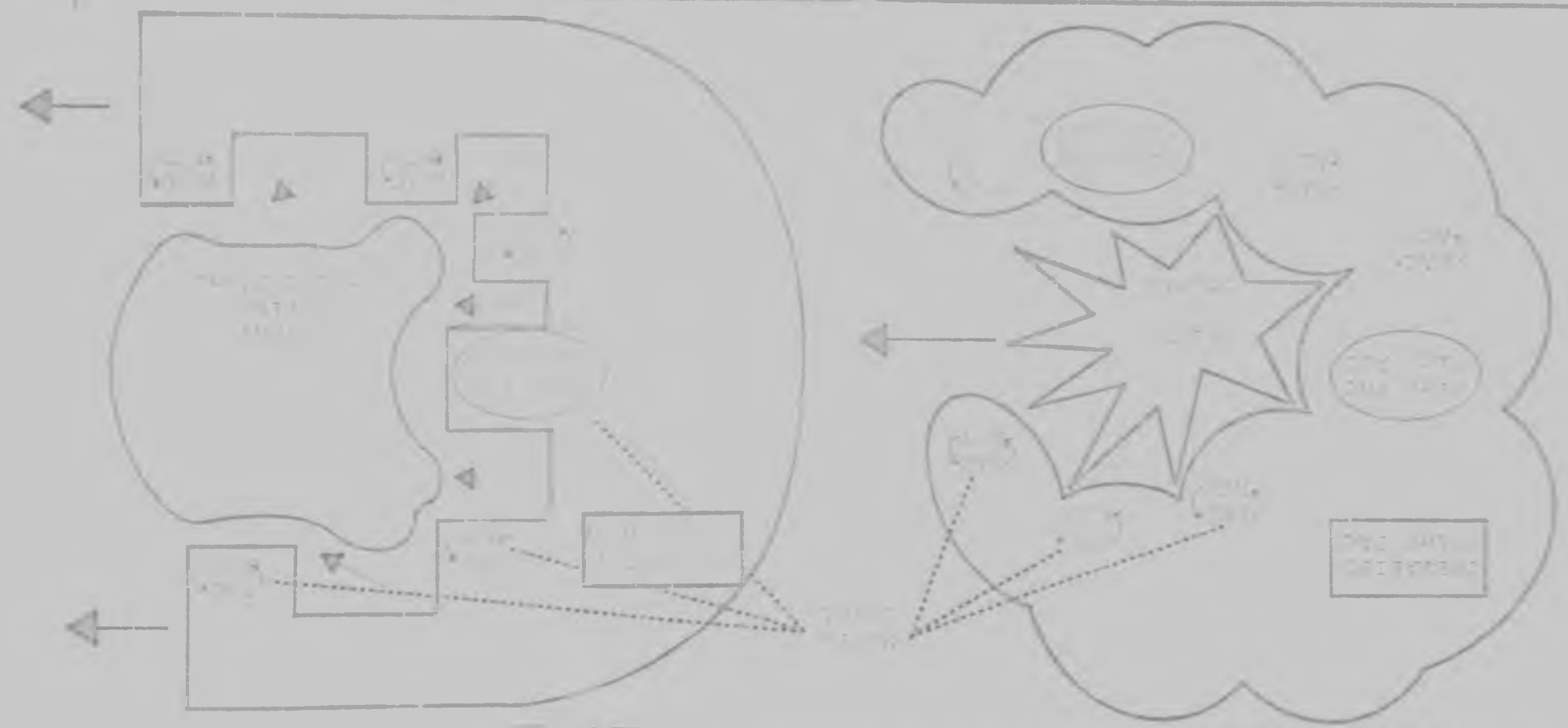
is similar to stems [illegible] and 3 [illegible] the '[illegible] model' and stage 3 and 4 of Golan's model of crisis intervention.

[illegible] 'two [illegible] described above is not [illegible] critical stage' [illegible] empirically confirm the latter's view [illegible] warm, supportive, [illegible] while the critical stage [illegible] directive [illegible] (p.6) the [illegible] their view by [illegible] therapist [illegible] In the light of the results of this [illegible] model, the present author [illegible] critical stage model recognizing [illegible] necessary need for [illegible] facilitative [illegible] instruments not [illegible] 'propitious moment' from the [illegible]

[illegible]

The [illegible] the model is [illegible] viewpoint [illegible] above.

[illegible] 3 [illegible] diagrammatic representation of [illegible] and [illegible] perspectives of the helping process. The [illegible] the shift from the exploratory [illegible] of emergent directionality. [illegible] the 'propitious moment' [illegible] moment [illegible], and his therapist is correspondingly



[illegible] quoted by [illegible] [illegible] of facili[illegible] demonstrated [illegible] the combination of these so called core [illegible]. The [illegible] Bierman (1968) was [illegible] however he was more concerned with [illegible] rejection and [illegible]ection, [illegible] [illegible]ny.

[illegible] psychotherapeutic [illegible] centred approach, originating fr[illegible] non-directive framework [illegible] nd unc[illegible]ity, [illegible] the facilitative di[illegible]ns. [illegible] client-centred approach [illegible] dn[illegible]s, althc[illegible] past ten years int[illegible]t has leve[illegible]d in what one might possibly call acti[illegible]n-[illegible]nted vari[illegible]les, viz. concreteness (see [illegible] [illegible], D[illegible]d [illegible] [illegible]rkhuff, [illegible] and Beren[illegible], [illegible]967).

[illegible] the existenti[illegible] approach with its assumptive re[illegible] in phenomenology. The notion of [illegible] is anathe[illegible] to its modus operandi towards [illegible] of choice and responsibility which require basically non-directive facilitation more than anything else.

The psychoanalytic approach, though more especially the neo-analytic tradition, is not that dissimilar from the

Wolpe (1958) stated that from one to twelve interviews should be spent obtaining as complete a case history as possible. Whatever is said [illegible] without question, with warmth but avoiding criticism [illegible] any form of evaluation. A number of more [illegible] therapy approaches, especially those dealing with [illegible] and Wilson, 1973) have recognized the [illegible] which are not to [illegible] concept of facilitativeness referred to in [illegible]

10.3. [illegible] psychotherapy.

[illegible] major [illegible] psychotherapy [illegible] therapist facilitativeness was pervasive [illegible] this therapist variable are necessary [illegible] ful helping relationship, [illegible] in this study [illegible] facilitativeness is only [illegible]

[illegible] concept of action-orientedness presents more [illegible] ubtle meaning, 'inspiring to action', [illegible] little doubt about its im- [illegible]. While action-oriented in the 'directive' [illegible] crucial variable in crisis therapy and the [illegible] variable [illegible] behaviour therapy, it is not however considered appropriate in the conventional psychotherapies. Nor is it difficult to see why this is so.

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

actually selecting persons to function in the [illegible]

As standardized and validated [illegible] scales may be, [illegible] measures of therapist functioning. In order, not only to establish [illegible] in training of [illegible] 'action-oriented' but also to investigate [illegible] the complementary and inter-[illegible] action-orientedness, more sensitive and specific measures [illegible] to be developed. While [illegible] the ratings of tape-recorded [illegible] sensitive instruments [illegible] to date, this method does [illegible] situation. The challenge [illegible] develop sensitive [illegible] and especially to measure [illegible] for example, what therapist [illegible] through the successful resolution of a [illegible].

And even when such fine tools and measures are at our disposal, [illegible] when we truly feel we are on the way to discovering objectively ver[illegible], lawful relationships in human behavior, even then, [illegible] part of physics, [illegible] will realise that we cannot observe and [illegible] subtle aspects of human experience without altering the very phenomenon itself. Perhaps more than any other area in psychology, this applies most to the study of the [illegible].

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:

1. [illegible] both FAC and VPS got higher outcome [illegible] of therapists who were low [illegible] rated by both clients [illegible] supported the first hypothesis.

   However when clients of therapists who were [illegible] with [illegible] whom therapists were low on either variable [illegible] The exception was for therapist ratings in the low FAC - [illegible]

2. [illegible] facilitative [illegible] higher [illegible] [illegible]

Subsidiary findings were:

   There was [illegible] correlation between client and therapist [illegible] overall (N [illegible] 48) and with [illegible] clients and their therapists who were high [illegible]

   iii. Actual client ratings of outcome were significantly higher than [illegible] therapist ratings over all four conditions (N [illegible] 48) and specifically in the low [illegible] high [illegible] conditions.

(iii) Follow-up [illegible] return rate for clients of therapists who were [illegible] on both facilitativeness and action-orientedness was [illegible] higher than the return ra[illegible] either or both of these [illegible].

The major theme of the above results is that therapists who were high on [illegible]litative[illegible] and [illegible]ntedness [illegible]stly:

(i) had clients who received [illegible] clients [illegible] were more accurate wi[illegible] client [illegible] rating [illegible] than other therapists;

[illegible]

the crisis [illegible]. It w[illegible] speculated, following Zimbler and Barling, that high levels of each variable may be [illegible]ively more important at different [illegible]ges of the crisis therapy.

While high levels of both variables are so crucial to [illegible] client's level [illegible] process a[illegible] she enters 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 [illegible], 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, or 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' or elaborating upon it, but he does not use the story to show what he is like as a person.

Summary:

After [illegible] does go beyond specific content but passes by deeper meanings, i.e. Expressions of personal and 'owned' feelings and parenthetical comments to narrative. Personal feelings are still [illegible] tied completely to situations in which they [illegible], [illegible] elaborated in terms of deeper personal meaning or significance.

Stage 4:

The client is now clearly telling something about himself (his feelings, [illegible]), using himself as the referent to his comments. While these comments may be made in the context [illegible] if a story, their function is not [illegible] the self. In [illegible] ways to describe himself and [illegible] of this difficulty alone is sufficient to [illegible] 4.

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

[illegible] several ways [illegible] can be 4: [illegible] fluid expression of many feelings, [illegible] feeling and time spent elaborating on it in terms of the significance for self-image; or a specific expression of the fact that the feelings exist, but that [illegible] required to express them.

Stage 5:

The client is now using his feelings in a struggle to explore himself. This may take one of 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 [illegible]ment. The expression of difficulty in achieving self understanding is sufficient basis to rate [illegible] long as the client is able to express and elaborate his feelings or to present clearly his self image (as in stage 4).

Summary: Defines a problem in terms of feelings and attempts to explore this: i.e. Exploration of (a) [illegible] situation or aspect of self image involving many feelings and their potential relationship, or one feeling area (if well described) and its personal significance. [illegible] many situations examined in terms of the common feelings or significance involved.

Stage 6:

The client [illegible] clearly examining the significance of his feelings or self-concept and is able to arrive at conclusions about [illegible], or to use the results of this self-assessment at [illegible] further self-[illegible] between any [illegible] expression of feeling. In [illegible] of self-examination [illegible] deeper and more [illegible] self-understanding.

Summary: Able to arrive at a conclusion based on insight into the [illegible] his feelings [illegible] content. If there are [illegible] they are understood in terms of the personal significance of 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: Freedom 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.

APPENDIX B.

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 response 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: The correct ratings of the four possible responses are given in brackets after each therapist response.

The following introductory matter preceded the helpee stimulus expressions:

"The following are statements a client might make to you in a time of need. I would like you to respond as you would if someone were saying it to you in a time of distress.

Try to put yourself in the place of the client and imagine that you are telling your own life experiences. The expressions will be played to you one at a time, so listen carefully before you formulate your response.

In this way, I want to present the person who has come for help. The following client expressions can [illegible] however [illegible] elicit any one expression to a previous expression. Respond to each as carefully and genuinely as you can." (Adapted from Carkhuff [illegible].)

1. [illegible] I'm not going to [illegible]. But I [illegible] people [illegible] me. I [illegible] more by the fact that I [illegible] I [illegible] I [illegible]

HELPER RESPONSES

(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) That's a real [illegible] feeling to have someone to trust and share with. Finally, I can be [illegible]. (HF-HA)
(4) Now that you have found these people who enjoy you and whom you enjoy, spend your time with these people. Forget about the other types who make you anxious. Spend your time with the people who can understand and be warm with you. (LF-HA)

Excerpt 10

HELPER: I'm really excited. We are [illegible] California. I'm going to have a [illegible] and [illegible] job. It's great. It's [illegible] I can't believe it's true. It's great! I have a secretarial job. I [illegible] mother [illegible] can have a part-time job which I think I will [illegible] very much. I can be home when the kids get home from [illegible]. It's [illegible] to be true. It's [illegible] ting. [illegible] horizons are [illegible]. I just [illegible] to get started. It's great!

HELPER RESPONSES

(1) Don't [illegible] think you [illegible] a little bit more than you can [illegible]. Don't [illegible] [illegible] (LF-HA)
(2) Hey [illegible] [illegible] (HF-HA)
(3) [illegible] Don't be too hard [illegible] (LF-LA)
(4) It's [illegible] (HF-LA)

HELPER: [illegible] just marvelously. They [illegible] they get along together. It [illegible] I never [illegible] they would. They seem a little older [illegible] I know [illegible] really [illegible] raise three [illegible] peful [illegible] It's marvelous!

[illegible] (HF-LA)
[illegible] happy before but you never noticed it [illegible] Is he [illegible] (LF-HA)
[illegible] (LF-LA)
(4) Hey [illegible] We [illegible] the problem [illegible] you know there will be [illegible] the positive side of it. (HF-HA)

Excerpt 11

HELPER: I'm really [illegible] the [illegible] at home with my [illegible] We [illegible] other now [illegible] happy. I didn't know [illegible] I'm just so pleased. I don't know what else to say.

HELPER RESPONSES

(1) It's a [illegible] feeling when things are [illegible] (HF-LA)
(2) It's really [illegible] to be alive again to feel your body [illegible] to be in [illegible] (HF-HA)
(3) [illegible] (LF-LA)
(4) [illegible] in this right [illegible] There will be problems that [illegible] that you have these problems I want you to remember well the [illegible] in this 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 [illegible]

THERAPIST RATING SCALE OF OUTCOME

JOHANNESBURG CRISIS CLINIC.

Please fill in the questionnaire below as [illegible] as possible.
Your responses will be [illegible] confidential.

NAME .....

[illegible] .....

[illegible] .....

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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

Author Kahn R
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