Helper empathy and retention of empathetic skills on hotline telephone

Gail Wood Robertson

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HELPER EMPATHY AND RETENTION OF EMPATHIC
SKILLS ON HOTLINE TELEPHONE.

THE COLLEGE OF WILLIAM AND MARY IN VIRGINIA,
ED.D., 1978

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HELPER EMPATHY AND RETENTION OF EMPATHIC SKILLS ON HOTLINE TELEPHONE

A Dissertation
Presented to the
Faculty of the School of Education
College of William and Mary in Virginia

in Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Gail W. Robertson
March, 1978
APPROVAL SHEET

We, the undersigned, do certify that we have read this dissertation and that in our individual opinion, it is acceptable in both scope and quality as a dissertation for the degree of Doctor of Education.

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Acknowledgements

Sincere thanks are extended to committee members, Dr. Kevin E. Geoffroy and Dr. Charles O. Matthews, for their constructive criticism during the formation of this research. And appreciation to the chairman, Dr. Fred L. Adair, who served as my advisor and as my friend.

Special recognition is extended to Nancy S. Musika for her continued support and encouragement and to Patricia M. Ahern for her gift of time in typing the proposals and dissertation.

Without the understanding and patience of my three children, David, Dean, and Martha, and my husband, Jim, this mother would never have finished the long and time consuming task of graduate school.
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HELPER EMPATHY AND RETENTION OF EMPATHIC SKILLS ON HOTLINE TELEPHONE
Chapter I

Introduction

Volunteer telephone services, usually called hotlines or crisis centers, have multiplied rapidly over the past few years. The telephone is increasing as a link for help to troubled people (McGee, 1968, 1974; Haughton, 1968). In most cases, the person who calls the volunteer service is having a serious problem that results in the call becoming a counseling interaction.

These hotlines depend on the volunteer to provide counseling via telephone to the disturbed caller. With the proliferation of crisis centers in the last 15 years, reliance on paraprofessionals as volunteers has grown steadily (Thompson, 1973). This is partially because of the number of volunteers required to man 24 hour, 365 day a year crisis centers, and sufficient numbers of professional counselors are unattainable. Research is demonstrating that volunteers are equally effective, with limited training, and sometimes more effective than professionals in handling problem situations (Carkhuff, 1966; Carkhuff, 1968; Truax and Carkhuff, 1967; Oden, 1974).

The type of training received by the volunteers is dependent upon each centers' preference and need; however, national organizations provide a minimum standard which must be met in terms of training requirements.

Historically, these volunteers were trained primarily in crisis theory and suicide prevention (Farberow, 1969), but statistics have shown that only a small percentage of calls are from suicidal persons (Haughton, 1968; Farberow, 1968). By far the majority of calls come
from people who are having relationship difficulties or who are lonely.

Research studies have further shown that the greatest benefit of hotlines is to provide a listening service (Tucker et al., 1970; Oden, 1974) which is characterized by an empathic atmosphere. McCord and Packwood (1973) noted that the most desirable characteristic of telephone workers is empathy and that it is the a priori step in establishing contact with the caller. Psychological research has revealed that empathy is "a major element in role-theoretical accounts of interpersonal behavior (Greif & Hogan, 1973, p. 280)," a necessary condition for personality change (Rogers, 1957), and the major ingredient in a helping relationship (Carkhuff, 1969).

With this research in mind, many centers have shifted their training emphasis away from crisis theory towards developing the necessary ingredients needed in a helping relationship.

Since empathy is such a valuable and necessary condition, it is imperative for hotline personnel to select those volunteers who are capable of learning the skills and theoretical background needed to become a capable hotline phone worker (Ziskin, 1970). Studies have been conducted in an attempt to provide a selection procedure for hotline volunteers.

In the past, selection of paraprofessionals has ranged from carefully screened persons to self-selected people who volunteer their services (Carkhuff, 1968; Ziskin, 1979). Those services which tend toward screening have used one of two models: (a) the use of selection criteria similar to methods used in graduate
counseling programs (Rloche et al., 1963), and (b) attempts to select psychologically healthy persons, i.e. those who express "a sincere regard for others, tolerance and ability to accept people with values different from one's own, a healthy regard for self, a warmth and sensitivity in dealing with others, and a capacity for empathy (Harvey, 1964, p. 349)." Still other programs have an open admissions policy which assumes that those individuals who are unsuited will self-select out (Ziskin, 1971). This type of policy raises ethical problems if the person fails to de-select himself. The agency has a responsibility for the psychological well-being of the callers and should not allow unqualified people to work as volunteers for the hotline.

Other research has demonstrated methods of rating procedures evaluating volunteer's effectiveness in dealing with callers and their problems (Slaikeu, et al., 1975; Carkhuff, 1966). Researchers have also devised numerical rankings for empathic levels reached by the volunteers (Carothers and Inslee, 1974; Holder, 1969). But no studies have considered the question of retention of empathy as a necessary ingredient of selection and training objectives.

Volunteers can be trained and can score well on empathic skills directly after training (Holder, 1969), but does that empathic level continue after a year or more on hotline telephones? Since empathy is the key, can selection procedures be developed which will allow hotline personnel to make a decision based on the retention of empathy? Since volunteers generally man the phones for several years,
their retention of empathy becomes all important. Which volunteers will maintain a high level of functioning?

Theoretical Background

Empathy

At the beginning of the 20th century, Lipps (1909) coined the term, "Einfühlung," which means feeling into, together with, or empathy. Lipps was mainly concerned with one's relationship to physical objects rather than the shared feelings of people. Fifteen years later Lipps (1926) altered his original position and viewed empathy as the response to a person rather than an object and the sharing of understanding.

Kohler (1929) specified that an empathic response was the observer's understanding of affect alone. His major emphasis was the observation of body languages and the clues that the body can give to the mental processes.

Researchers began to conclude that empathy was reacting subjectively and physiologically to their perception of another's state. In these types of responses, there is no self-other distinction. It becomes affect mimicry (Freud, 1961; Sullivan, 1940; Escalona, 1945).

The lack of self-other distinction continues as May (1939) defines empathy as "the feeling, or the thinking, of one personality into another until some state of identification is achieved (p.77)." And Adler defines empathy as occurring "in the moment one human being speaks with another. It is impossible to under-
stand another individual if it is impossible at the same time to identify one's self with him . . . ." (in May, 1939, p.79).

Rogers provided a definition for empathy which took it away from affect mimicry when he said, "To sense the client's private world as if it were your own, but without ever losing the 'as if' quality - this is empathy, and this seems essential to therapy (Rogers, 1957)." He later refined his definition and presented it in a 1975 paper. He said,

The way of being with another person which is termed empathic has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his/her world as you look with fresh and unfrightened eyes at elements of which the
individual is fearful. It means frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive. You are a confident companion to the person in his/her inner world. By pointing to the possible meanings in the flow of his/her experiencing you help the person to focus on this useful type of referent, to experience the meanings more fully, and to move forward in the experiencing (p.8).

Barrett-Lennard (1962) gave yet another definition: Qualitatively it is an active process of desiring to know the full present and changing awareness of another person, of reaching out to receive his communication and meaning, and of translating his words and signs into experienced meaning that matches at least those aspects of his awareness that are most important to him at the moment. It is an experiencing of the consciousness "behind" another's outward communication, but with continuous awareness that this consciousness is
originating and proceeding in the other (p.3).

The common element in these definitions seems to be that empathy is an active process which reaches into the inner world of another not only to understand what he/she is saying but also to attempt to understand what he/she cannot say. Empathy, implicitly or explicitly, seems to be an important part of all psychotherapy.

Research has found that the highest ranking goal for all therapists, despite their orientation, is empathy. This statement is based on a study by Raskin (1974) who asked therapists to rank twelve variables. For the therapists, it was all-important that they attempt to understand the client as sensitively and accurately as possible. And this understanding must be from the client's point of view (Raskin, 1974).

Raskin's study substantiated an earlier study by Fiedler (1950) in which Fiedler had therapists from differing orientations describe the most important elements in an ideal therapeutic relationship. It was discovered that all the therapists ranked "an empathic relationship" as the main criteria for a working therapeutic relationship.

Rogers (1975) believed that current research points to the "conclusion that a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning (p.3)." Empathy has the potential for unleashing the power within a person and
causing that individual to bring about self-directed change. By being empathic, the counselor can help the client focus on his experiences and draw meaning from them. Empathy does not mean that the counselor has the power, rather that by pointing out the "felt meaning," the client can draw his own conclusions and make his own decisions.

As the counselor correctly identifies the feelings for the client, the client is able to flow with the experience and share at an even deeper level of self-exploration. What causes some counseling interactions to flow and others to become stymied? Rogers believes it is the level of empathy and the care with which the counselor listens to the, perhaps unexpressed, feelings (Rogers, 1975).

The client has the ability to enhance his/her own growth if his/her experiencing is unblocked. According to Rogers (1975), this unblocking occurs when the client feels an acceptant quality of empathy. This acceptance allows him/her the freedom to understand his/her own behavior and find his/her own identity.

What Rogers has theorized, Carkhuff made operational by his Empathy Rating Scale (Carkhuff, 1965). Carkhuff felt that empathy could be taught and could be measured (Truax and Carkhuff, 1967). Carkhuff's definition of accurate empathy is similar to Roger's - it is an "as if" quality which reaches beyond what the person is expressing.

Empathy, then, is important in all relationships and most
important when a person is lonely, bewildered, anxious, and alineated. These are the situations that counselors deal with most often. "In such situations deep understanding is, I believe, the most precious gift one can give to another (Rogers, 1975, p. 30)."

Statement of the Problem

Since a review of the literature shows that empathy is one of the most important variables in counseling and psychotherapy (Bergin, 1966; Carkhuff & Berenson, 1967; May, 1969; Rogers, 1975), it seems important not only to train people in empathy but to test their utilization of empathic skills over an extended period of time.

There is a large commitment of time when one contracts to take a course to train for a hotline center. Centers generally require a minimum number of hours of training before one is allowed to man the phones. These hours represent loss for the volunteer and the center if the volunteer is unable to meet the standards needed to adequately man the telephones. Much time could be saved if there were an effective manner in which to pre-screen perspective paraprofessional volunteers.

Various methods have been used to screen these volunteers before training begins. Dicken (1969) ran a battery of tests on Peace Corps Community Development Workers and found that "pretraining assessment is virtually as valid as anything else" in determining who will make an acceptable worker by
the end of training. Some centers use the MMPI as a screening device; it is geared toward a psychiatric population and in fact, will screen out disturbed people. But, research has not been done to determine which volunteer will be effective over time.

**Limitations**

Generalizations based on this study are limited to CONTACT Peninsula, Newport News, Virginia.

The lack of a controlled research design implies that no conclusions can be made regarding causality. Relationships that exist may have been produced by causes (i.e., maturation, further training) over which the researcher has no control.

**Definition of Terms**

Practice Shifts - four hour shifts on the phones in which the trainee is observed by an accredited worker.

Empathy - is an ongoing process which involves the ability to sense deeply the moment-to-moment experiencing of another's inner or private world as if it were his own. Operationally defined as a 3.0 or better rating on a 5 point Carkhuff Scale.
Hotline Service

The telephone service as a psychological aid for people is becoming an established fact in the United States today. Before 1958, there were only three centers providing the service (Dillon, 1971), and today there are hundreds.

It has been found that most calls to hotlines are not related to suicide (Brockopp, 1967). Brockopp (1967) reported that approximately 80% of the calls to the Suicide Prevention Center were for problems other than suicides. Hotline statistics show that the largest number of calls concern marital problems, loneliness, and adolescent problems. This has resulted in training being geared more toward warm, empathic listeners rather than crisis interveners.

There are many characteristics of telephone counseling that are unique: (1) the client can remain anonymous; (2) client has power to terminate easily; (3) most people have access to telephones; (4) immediacy when client is in distress (Lester, 1974). Anonymity is important for the caller when he/she is already in a vulnerable state. The caller can feel secure, because in a telephone situation he/she has the control. He/she can choose to self-disclose in greater amounts and still terminate if he/she feels negative consequences without ever giving away his/her identity.

Today, there is a telephone in most homes and, if not, certainly one is available on the corner. The caller can reach out into the
world with the telephone and begin the process of relating. Also, when a caller is in a crisis situation, the telephone is an available means of therapy. The caller does not have to make an appointment and wait to see someone. And often, going to therapy is humiliating and frightening. In an office, the client has no control but with the telephone, the caller has immediate help in a non-threatening atmosphere (Lester & Brockopp, 1973).

Lester and Brockopp (1973) have identified four situational categories which appear to respond best to telephone therapy. They are (1) the adolescent, (2) the desperate, (3) the one-shot caller, and (4) the isolate.

Adolescence is a time for trying out new self-images and learning independence. To admit to any weaknesses is threatening to that self-image, so a telephone service is the least threatening manner in which an adolescent can seek help. He/she "can remain anonymous and has a great deal of control (p.86)."

The desperate are those "who need immediate help as a result of a sudden psychological shock (p.87)." The telephone becomes, then, a way to contact reality while offering a voice which will be caring and supportive.

The one-shot caller is the person who needs help temporarily. He/she does not want to become involved in a long term counseling relationship. He/she may just need feedback for a particular situation and sees going for therapy as a loss of self-esteem.

The isolate is the severely distressed person who is unable to
seek any outside relationships or enter into any new situations. If the caller will make contact, it can, perhaps, prevent his/her complete isolation.

Tucker et al. (1970) studied 246 calls to a college hotline in a seven month period and found that the major problem area was interpersonal relations, including dating (27%), family (19%), loneliness (12%), and pregnancy (9%). The volunteers' effectiveness of listening was positively evaluated in terms of their judged empathic ability (Dillon, 1971, p.10).

In another study by Garrell (1969), calls were tabulated for a three month period to the Los Angeles Hotline Service which operates out of the Children's Hospital. It was found that the calls lasted from 1 minute to 3½ hours with an average of 20 minutes. The types of problems related to interpersonal relationships (20%), school (4%), social isolation (3%), social inhibition (3%), and pregnancy (3%).

Of all the hotlines, there is only one which is nationally and internationally organized. CONTACT/LIFELINE International has 75 centers nationally and 127 internationally. There is a national director and an International Secretariat. In order to become accredited by CONTACT National, a center must meet certain designated criteria. One of these is that it maintain a 24 hour service.

CONTACT Peninsula, Newport News, Virginia, receives from 800 - 1000 calls a month with the largest category of calls being
loneless/marital. The listeners must undergo at least 100 hours of training in order to provide three primary functions: listening, information, and referral.

Garrell (1969) specified assumptions from the Los Angeles Hotline Service, and these basic assumptions fit CONTACT National’s Principles.

1. Those who call the service do so because they face some conflict or uncertainty that they have not yet been able to resolve on their own.

2. Effective resolutions of problems can only evolve out of the context of the individual’s own experience.

3. Persons with problems benefit little, if at all, from direct advice, ready-made solutions, or any kind of action that displaces responsibility.

4. Unconditional concern and respect for the caller, effectively communicated to him, are prerequisites for constructive interaction between the staff member and the caller (p.178).

In summary, hotlines have grown in numbers and in scope over the last 20 years. They have moved from being basically suicide prevention centers to centers which offer listening for all types of problems.

McGee (1974) views the future of hotlines as favorable. He sees the hotline forming the core for increased mental health
services offered to communities.

Volunteers as Helpers

There is a large amount of research directed toward the volunteer working in a therapeutic milieu. The title, paraprofessional, is becoming well accepted, and a definite use is being made of their services in medical fields, teacher's aides, counseling, and psychiatric aides (Harvey, 1964; Cowen, 1967; Albee, 1968). These non-professionals are drawn from all walks of life, including high school and college students, housewives, teachers, ministers, and senior citizens (Cowen, 1967).

In the 1960's, there was a large body of research done to prove that the layman or volunteer was effective in mental health fields and the utilization of the volunteer was on the increase (Sobey, 1970). Laymen or volunteers have been able to produce as significant or more significant results than professionals when working with mental health patients.

Carkhuff (1971) stated,

For most purposes and most problems, these lay people can learn to help as effectively and often more effectively than professional helpers, that is, teachers, guidance counselors, psychologists, psychiatrists, and social workers. Lay persons can learn to understand others as well or better than professionals and they can learn to act
upon this understanding as well as or better than professionals (p.168).

Five lay hospital personnel were trained by an approach integrating didactics and the experiential method which emphasizes development and growth of the counselor. Eight therapeutic groups of 10 hospitalized mental patients were seen regularly by the trained personnel for a total of 24 sessions. Results demonstrated significant improvement in the patients treated by lay counselors when compared to control patients who were seen by their regular therapists (Carkhuff & Truax, 1965).

Carkhuff (1966, 1968), in a review of literature concerning lay versus professional counselors, found widespread evidence that lay counselors can be trained to function at facilitative levels related to constructive client change. These minimally facilitative levels can be achieved in a short period of time. An inference, drawn by Carkhuff, is that constructive client change is possible with people other than professionals, and that graduate schools should consider adopting selection and training procedures used by lay counseling programs.

Studies have been done comparing trained therapists with trained volunteers. Sines, Silver, and Lucero (1961) found that psychiatric aides did not produce change in chronic psychiatric patients, but there was no control group of therapists to see if anyone could, in fact, produce a change in chronic patients. The mean length of hospitalization was
12.5 years, so it is doubtful whether any implications can be drawn based on the population and no control group of therapists.

Poser (1966) found that lay therapists achieved slightly better results than did psychiatrists. The lay therapists were totally untrained; they were essentially selected "off the street." 343 patients from a psychological facility were chosen for the project. Six groups served as controls, 28 groups were assigned to a randomly picked therapist. Therapists consisted of 11 totally untrained college students, and seven professionally trained psychiatrists and social workers. Each of the 18 leaders met one group 5 times per week for a 5 month period. Both trained and untrained leaders were free to run their group any way they chose. By comparison to an untreated control group the lay therapists achieved slightly better results than psychiatrists and psychiatric social workers during group therapy with similar patients.

Poser attributes their success to "naive enthusiasm" and less stereotyping of patients. Rosenbaum (1966) refutes the validity of Poser's study. In Poser's study, no allowance was made for the difference in time factor, sex difference and motivation of volunteer and therapist. He agrees that enthusiasm may be a crucial variable but doubts the layman's ability to handle deep-seated problems of the patient.

Verinis (1970) set out to check the optimism variable.
Twenty chronic psychotic patients were divided into a treatment and a control group. The groups were matched demographically. The treatment group was composed of volunteers who were asked to meet with the patient once a week for 5 months. Seven of the volunteers were given an optimistic picture of their patient's chance for improvement, and six of the volunteers were given a pessimistic picture of their patient's chance for improvement. By the end of the treatment, five of the patients were released from the hospital while none of the control group was released. The optimism/pessimism attitude made no difference. What made the difference was that someone cared and spent time with them. The volunteers willingness to provide warmth, interest, caring, and empathy to the patients made a difference in their behavior.

Truax and Lister (1970) did an interesting study using three case management conditions (counselor alone, counselor with aide, and aide alone) to see which condition produced the greatest client improvement. It was found that aides alone produced the greatest improvement. These findings are consistent with the literature which states that traditional methods of teaching in academic settings usually neglect the facilitative conditions necessary for client improvement.

Knickerbocker (1972) found that non-professionals showed significantly more warmth and empathy than did professionals.

Appleby (1963) and Warme (1965) indicated that hospital aides who functioned as lay therapists were able to stimulate significant
improvement in schizophrenics. And Greenblatt and Kantor (1962) described the therapeutic effect of college students who worked with the chronically ill in a state mental health hospital. The students worked either as occupational therapists or social workers. The study was conducted over a 2 year period with regressed, apathetic patients. The results showed significant change in the wards in which the students worked. Further results showed that of 55 chronic patients, 20% were improved enough to leave the hospital.

In an extremely comprehensive training program for paraprofessionals, Rloch et al., (1963) trained eight mature housewives in their forties as mental health counselors. In a 3 year follow-up, done by Magoon and Golann (1966), the eight paraprofessionals were employed in the mental health field. Results tended to be very stable, and their supervisor's rating placed the paraprofessionals equal or above in competence compared with new therapists, MSWs, and with other reference groups (school counselors). Their co-workers also gave them very positive ratings on performance.

Harvey (1964) reported that 85% of the counselors in 24 marriage counseling centers in Australia were trained paraprofessionals. They were chosen because of their maturity and their success in personal relationships. They reported a 15% solution rate and in 25% of their cases, the situation was noticeably improved.
In a companionship program in Boston, college students were paired with one patient for weekly visits throughout a 9 month period. Anecdotal data indicated that the patients became more verbal than they had in years. The professional staff reported that the patients showed more self-confidence, a better appearance, and improved social interaction as a direct result of the volunteers (Holzberg & Knapp, 1965).

Zunker and Brown (1966) researched student counselor's ability in handling academic adjustment of entering freshmen. Students who were counseled by professionals and by student counselors were matched on (a) sex; (b) age; (c) scholastic ability; (d) study orientation; and (e) high school rank. The results showed that the student counselors were better accepted than the professionals and that the student counselors were as effective in communicating information as the professionals. These results were obtained by grades at the end of the year and fewer problems in study habits and motivation.

In summary, the research literature points to the fact that paraprofessionals can create constructive changes in clients whether the clients are hospitalized, out-patients, students, neurotics or depressed normals. Several well-designed studies have shown that paraprofessionals are equal to or surpass the abilities of professionals. Paraprofessionals operate effectively in a variety of ways and can lessen the manpower shortage in the mental health field, and particularly in the manning of hotline telephone services.
Selection, Training and Empathy Retention of Non-Professional Therapists

Selection

It is generally agreed that selection and evaluation in human services programs is extremely difficult. This already difficult task becomes next to impossible when evaluating a hotline service. A handful have tried, however, and are presented below.

Gray et al., (1976) developed an empathic listening test as a means of selection of hotline workers. The 60 item instrument measures three dimensions of Empathic Listening, (a) understanding, (b) interest, and (c) response-ability. The test is based on the premise that empathy is the most important variable on the telephones and that "individuals do differ in their ability to listen empathically (p.204)." This test is designed to aid hotline centers in pre-screening volunteer applicants.

Another method for rating volunteer effectiveness was explored by Slaikeu et al., (1975). They attempted to prove that volunteers who were effective on the telephones would have clients show up for face-to-face counseling. The response elicited from the "no-shows" had very little to do with the telephone worker's abilities, and was consequently judged unreliable. Generally, the "no-shows" responded that they had gone to another agency (e.g. Alcoholics Anonymous) or that "things got better."

Rudow (1970) suggested paper and pen exams, interviews, and assessment of Carkhuffian techniques as a means to select and
evaluate the paraprofessional.

Tucker et al. (1970) judged the effectiveness of volunteers by their ability to be empathic. Although the assessment method is not described, Garrell (1969) says that positive regard and respect for the caller, properly communicated, are prerequisites for constructive helping. It seems that empathy, warmth, and genuineness are essential for helping over the telephones.

Jamison and Johnson (1975) wanted to assess the personality variables of empathy and the A - B therapist orientation of volunteer phone workers, paid workers, professional therapists, and a control group. An "A" orientation is concerned with personality oriented goals; a "B" orientation is more problem-centered and more concerned with symptom reduction. The paid and volunteer workers were so much alike that they were combined into one group for the statistical analysis. Male phone workers were significantly higher in empathy than professionals and college students. Phone workers also showed a "B" orientation. They concluded that:

We do not see a problem-centered orientation as being completely contradictory to the existence of empathic understanding. To elaborate, the phone worker may have a high degree of empathy for his caller. At the same time, however, the parameters of the situation (a time-limited single phone
contact with a person in acute crisis) may compel the phone worker to be quite direct and problem focused in his attempts to help the caller rather than focusing primarily on the communication of empathy (p.273).

Jamison and Johnson recommended that workers be chosen for their high degree of empathy, and that their performance be carefully evaluated. They do not recommend how the evaluation should be accomplished. They simply state, based on past research, that careful screening should take place.

Truax (1970) advocated selecting non-professionals by use of testing devices. He felt that an agency is looking for a person with "high, stable ego strength (p.8)." He further recommended that selection be based upon non-professionals actual performance with clients. Through assessment of their performance skills, determination could be made concerning their skills with the therapeutic triad. It is the purpose of this research to provide an easy and quick method of evaluating a potential worker's ability to retain empathic skills.

Training

All hotlines use their own techniques to train their workers based on reading manuals, educational experience of trainers, and research literature. The prime goal of training seems to be to train volunteers in facilitative conditions in an atmosphere which
also includes personal growth.

Farberow et al. (1966), Nolan and Cooke (1970), Riessman (1967) have described techniques for training volunteers to work in mental health fields. The most frequently used training manual, written by Farberow et al. (1968) has been devoted primarily to crisis intervention techniques - techniques which hotline centers have most often emulated.

Various techniques have been employed to train volunteers for therapeutic roles. Carkhuff et al. (1964), Carkhuff and Truax (1965), and Truax (1970) suggested an integrated approach using didactic and experiential training methods. They found that trainees could be brought to function at effective levels of therapy commensurate with professional therapists in less than 100 hours of training. Martin and Carkhuff (1968) implemented this approach and found high facilitative levels in volunteers trained with this didactic/experiential approach.

These positive results obtained by Carkhuff and his cohorts indicate that such a training program is not only expedient but also highly effective in its usefulness for training lay personnel.

Berenson et al. (1966) randomly assigned college students to three groups. Group I trained using research scales and quasi-therapeutic experience. Group II trained but used no scales or group therapy. Group III was control group. Results showed that Group I demonstrated the greatest amount of change in all facilitative skills. Obviously, checking one's skills against scales
and having some therapeutic experience provided Group I with far superior training than Group II. The need to not only teach empathy but to have it rated and provide feedback makes a significant difference in one's increasing their facilitative abilities.

Rudow (1971) has selected the components which he feels are mandatory for any paraprofessional training program. He divides training into two areas: general and specific. Interpersonal skills are taught in the "general" area with emphasis on workshop, t-groups, and role playing. "Specific" training includes job-related skills, such as mechanics, working with clients, and ethics. "Specific" training can be accomplished through lectures in the classroom setting.

Many researchers (Hadley et al., 1970; Thompson, 1970; Ziskin, 1970) stress that training should enhance the growth of the paraprofessional, both in interpersonal skills and in intrapersonal functioning. They believe that training should aid in developing healthy attitudes and behaviors and is, in fact, a form of psychological education. They advocate that part of the training program should include t-groups or encounter groups as a way of increasing awareness among the paraprofessionals.

Carkhuff and Truax (1965a, 1965b) feel that training will create a personality change in the trainee. And they focus on training being a growth experience which aids in the development of a new self-concept. It is agreed that providing new experiences in learning and in self-awareness will lead the paraprofessional
into a higher level of interpersonal functioning.

Retention of Empathy

Truax et al. (1966) were able to demonstrate that therapists, and not clients were in control of the therapeutic conditions of empathy, genuineness, and warmth. Forty outpatients were assigned, 10 patients each to 4 different therapists, with the assumption that if clients controlled the level of the therapeutic conditions, variations would appear in taped responses over a four month period. Results demonstrated that the therapist was in control of the situation and that the level of his responses were consistent over time. That is if he demonstrated high levels of empathy, genuineness, and positive regard during the first session, later sessions would be maintained at the same level of proficiency. That being the case, the retention of empathy becomes a valid research question.

Rioch (1967) argues that volunteer's enthusiasm and facilitative skills tend to "burn out" if not used often enough. She does not specify the frequency needed, but it is of particular interest to this researcher to find out if trained volunteers who use their skills a minimum of 4 hours a month, will, in fact, lose their original empathy level.

Only one other research study dealt with retention of empathy. Holder (1969) used 24 nurses to measure retention of empathy. The nurses were divided into three groups of eight each. One group was given 5 hours of empathy training; another group had 10 hours; the third group had 15 hours. Post-training measures were taken
using Carkhuff's Empathy Scale. All measures were from written responses of the nurses to a written situation. At 1 month and 2 month intervals, measures were again taken to see if their empathy levels held. All measures were taken by reviewing written responses of the nurses. All three groups improved significantly writing and rating empathic remarks. Nowhere in the study were the nurses rated as they actually participated in an interaction. One cannot automatically assume that verbal skills will improve if written skills improve. This researcher will correct this fault by having an actual behavioral rating of the volunteer as he talks with a caller.

In summary, there is a definite need for an adequate selection procedure for volunteers. While some research has been done which offers directions for volunteer selection, each selection procedure has drawbacks.

Once selected, training procedures for various organization have also shown a wide deviance. The most promising, however, as based on research (Carkhuff et al., 1964; Carkhuff & Truax, 1965a, 1965b; Hadley et al., 1970) indicated that a didactic and experiential approach aimed at creating positive personality change for the volunteer has had the best results.

Truax et al. (1966) demonstrated the necessity for empathy in a counseling situation and pointed out the need for evaluating the retention of empathy over time.

Glaringly vacant in research has been the evaluation of the
trained paraprofessional over time. The next logical step is an investigation of the retention of learned empathic skills. This study will attempt to fill this research gap, for without retention of learned skills, training is of questionable value. It, further, is aimed at providing an easy and quick method of evaluating potential workers.

**Effects of Empathy**

Understanding, or empathy, is the ability to see the world through the other person's eyes. In helping, it is as if the helper "crawls" inside of the helpee's skin and feels things the helpee feels, and experiences the world the way the helpee experiences it (Carkhuff, 1971, p.170).

A substantial body of evidence exists which states that therapists or counselors who are high in empathy will create an atmosphere for effective personality change (Truax & Carkhuff, 1967).

Carkhuff (1971) further states that if a helper is not high in empathy (cannot sense the real problem) than the helpee will not share fully with the helper. It is imperative for the helpee to share and explore himself fully in order for the helpee to understand his problem fully thus leading to behavioral changes.

Among these studies which support the above statement is one done at Johns Hopkins by Whitehorn and Betz (1954) and Betz (1963). Seven psychiatrists whose schizophrenic patient improvement was 75% were compared with seven psychiatrists whose improvement rate was 27%. The differences found between the psychiatrists were
not in their theoretical background but in their relationship style - a style which included a high level of empathy.

Using the Accurate Empathy Scale, Bergin and Soloman (1963) showed that accurate empathy was significantly related to the ability to produce constructive personality change.

Carkhuff and Alexik (1967) manipulated a counseling situation to see the effect upon high and low functioning counselors. The counselors were divided into two groups (a) those over level 3 on Carkhuff's scales (b) those below level 3 on Carkhuff's scales. The client saw all the counselors and explored the same problem. During the first one-third of the interview and the last one-third she self-disclosed. During the middle segment, she talked about non-essential items. The high level counselors continued to function at high levels throughout the interview and the low level counselors allowed the client to ramble. An example of the middle segment with a high functioning counselor:

Client: Amherst is so very different from Washington . . . geographically . . . .

Counselor: And the people are different - for you.

Client: Well, I have a nice house here . . . .

Counselor: But, it's lonely and no one seems to care.

The client's statement about the low functioning counselors is interesting. She said, "The tenacity of these therapists not to get involved with anything human was frightening."

Empathy, thus, seems to be a necessary condition in
counseling (Bergin, 1966). One of the goals of counseling is to get the client to self-explore and this self-exploration will be accomplished in a warm, sensitive atmosphere (Rogers, 1975). Shapiro, Kruas, and Truax (1969) showed that psychotherapists who were high in genuineness, empathy, and warmth led to greater self-exploration by the client. Evidence is overwhelming that it is the therapist who is responsible for the therapeutic climate created by empathy (Truax & Carkhuff, 1967).

Lesser (1961) attempted to establish the relationship between counseling progress and empathic understanding with his study of 11 staff counselors at Michigan State University and 22 students and student wives who had sought counseling. Counselor and patient each were tested with the Q-Sort before counseling began. Final data collection was at three possible times; at the termination of counseling; after 12 hours of counseling; at the semesters termination regardless of length of time in counseling. Post-testing consisted of Q-Sort, rating by patient of counselor on the Empathic Understanding Scale, and counselor rated self on the Empathic Understanding Scale. Counselors were also asked to rate themselves on feelings of similarity towards each of their clients.

Results disputed the generally accepted view that empathic understanding is important to counseling progress. Counselor progress and counselor empathic understanding, as rated by clients and counselors, were not related to each other.
The study also found that similarity between client and counselor self-perceptions was negatively related to counseling progress. Correct awareness, however, did relate to counseling progress. Empathic understanding was not related to similarity, to correct awareness of similarity, or to overestimations of similarity. Several criticisms of this study tend to question the validity of results. The use of the Q-Sort is questionable as a reliable indicator of change - based on patient bias and the difficulty of objectivity. Counselor ratings also tend to be biased. Neutral judges, for rating, would have strengthened the credibility. Testing of counselor's feelings were determined by a scale devised for the purpose of the paper leaving validity and reliability in question. Judge's rating of the Empathic Understanding Scale were not described in terms of interjudge reliability. Also, the fifth judge, the author, tended to indicate bias. The small number of clients involved in the study make it difficult to assess both credibility and generalization ability.

Long and Schultz's (1973) study focused on group leader's level of empathy and the effect it had on the depth of self-exploration. They found that those group leaders who scored high on the Truax Scale of Accurate Empathy created more self-exploration among group members.

Truax (1961) compared the levels of accurate empathy on four hospitalized patients who showed improvement and four who showed deterioration. A total of 384 2 minute samples was selected from
therapy sessions. The findings indicated that the psychotherapists whose patients had improved rated higher on accurate empathy than those whose patients deteriorated ($p < .01$). Further, the therapists' level of empathy was consistent over a 6 months period.

Again, Truax (1967) found that accurate empathy was directly related to positive outcome in hospitalized patients. He discovered that therapy with the "failure" cases was characterized by low and inaccurate empathy ($p < .05$).

Pierce et al. (1967) found that those counselors who offered a high degree of empathy elicited the greatest amount of constructive gain in their clients. Also, those clients of the high functioning counselor did not drop out of therapy while the clients of the low functioning counselor withdrew prematurely.

Truax et al. (1974) stated that it is of the utmost importance that human relations' specialists be assessed as high in therapeutic skills. These skills are imperative to facilitate a wide range of behaviors and that low levels of these skills are not helpful and are often harmful to the recipient.

In summary, evidence is overwhelming that clients who are seen by therapists communicating empathy will generally make constructive changes. Without empathy, the client will make no change or will deteriorate. If empathy is present, the client will self-disclose which leads to self-exploration which leads to counseling progress.
Sample

The population will be a group of volunteers who completed their training for CONTACT Peninsula in May, 1976. They have all been manning the phones monthly since that time. There are 20 men and 32 women ranging in age from 19 to 71 with a mean age of 38.5. Mean educational level was 14.8 years. Only one has had previous training in the mental health field.

Recruitment of Volunteers

Two months before training begins, CONTACT Peninsula, Inc. begins an active recruitment program. Notices about the beginning of training are put in all the Peninsula churches newsletters and/or bulletins. Announcements are sent to all radio stations, newspapers, and agency and club newswires. Speakers, from CONTACT's Speaker's Bureau, are sent to any radio station, TV show, club, agency, or church who requests to know more about the training class and CONTACT's requirements.

Anyone who is interested in taking CONTACT's course must call the office and make an appointment to be interviewed by the Director, fill out an application, take the California Psychological Inventory, (CPI), and have a tour of the phone room.

Screening the Volunteers

The volunteer must go through certain screening procedures before he/she is allowed to take training and additional screening throughout the training classes. He/she must have an interview with the Director,
fill out an application, and take the CPI.

During the interview, training and commitment to the program are explained. The Director also finds out why the applicant wishes to take the course, any pertinent experience, and the applicant's ability to be non-judgmental.

The application and CPI are reviewed before the volunteer is accepted into the program. The volunteer is reminded that he/she is being evaluated during the entire training course and completion of the course does not necessarily mean they will be accredited. Also, attendance at all training sessions is mandatory unless in case of an emergency.

Training of the Volunteer

The training program was a 10 week course with meetings two nights a week plus a Saturday workshop. One night was a lecture and the other night was a small group meeting. The lectures included the following topics:

1. Saturday workshop - Theological Foundations

   This workshop begins with a lecture concerning CONTACT's theological foundation, and the rest of the day is spent in values clarification exercises designed to stimulate thinking about one's own religious convictions. It is also important that one be able to accept others with differing convictions.

2. Transactional Analysis

3. Transactional Analysis
4. Empathy - This lecture explains the empathic levels, the importance of empathy, and its effects. The participants see a demonstration role play, respond to taped statements with empathic comments, and do their own role plays.

5. Listening Skills - This lecture includes further emphasis on empathy, warmth, genuineness, and confrontation. It teaches active listening responses.

6. Family Problems - Included in this are adolescent, marital, and geriatric problems.

7. Pregnancy, Adoption, and Abortion

8. Sexually Disturbed Callers and Venereal Disease - The sexually disturbed caller includes the homosexual, masturbating caller, transvestite, incestuous relationship, and fetishes.

9. Suicide and Depression

10. Rape and the Sexually Molested Child

Small group leaders were chosen for their leadership ability and empathic skills. Research points out that empathy is best learned from empathic people. Empathy can be learned and is likely to be learned if supervisors are empathic (Aspy & Roebuck, 1975; Bergin & Solomon, 1970). Trainees tend to move in their functioning to the level of their trainers (Carkhuff, 1969, Pierce, Carkhuff, Berenson, 1967).

The small group meetings were for the purpose of getting to
know oneself better, to interact with others, to get to feelings about problem areas, and to role play. Intensive role playing begins after the lectures on empathy. The group breaks up into triads with a caller, a listener, and an observer. The observer records all his comments and gives feedback to the listener. Each member of the groups taped a role play which was critiqued, line by line, by a professional counselor. These tapes and comments were returned to the trainees with instructions to listen to themselves and read the comments. At other times, the triads were taped and the group listened immediately to a playback while the group members gave feedback.

At the end of the 10 weeks, the trainees went away for an overnight retreat. On the retreat, they worked in dyads and triads to improve their listening skills and empathic responses.

In the last two weeks of training, each trainee must pull three practice shifts. On the first shift, they only listen to the calls; on the second shift, they take half of the calls and their supervisor takes the other half; on the third shift, they take all the calls while the supervisor listens and critiques.

**Research Design**

The volunteers were administered the California Psychological Inventory (CPI) prior to training. The tests were self-administered at the hotline office. Scores were obtained with CPI's Subscale on Empathy being the pre-test measure.

After a year on the phones, the volunteers were again given
the CPI to obtain a score for the CPI Empathy Subscale. The purpose of the posttest was to determine the retention level of empathy on a written test.

As a behavioral measure of empathy, the volunteers received a "fake" phone call which was recorded. Each call was made by the same person relating the same problem. The caller was trained to be authentic and to use the same basic statements.

Carkhuff's five-point Empathy Scale (1969) was used to rate volunteers on their empathic ability (See Appendix I). The raters listened to the first four minutes of the tape (Dillon, 1971; Zunin & Zunin, 1972) in order to get an empathy rating. A mean of their scores served as the volunteer's final rating.

The empathy raters were trained in empathy by a 10 week course entitled Empathy: Tune-In (Tubesing & Tubesing, 1973). (See Appendix II).

Statistics.

A t-mean was used for the pre and posttest on CPI's Empathy Subscale in order to measure the retention of empathy.

A linear correlation was used for the posttest and the behavioral ratings. The researcher realized that the two scales may be measuring different aspects of empathy, but it was important to see if pen and paper tests correlated with behavior.

A regression analysis was computed with the behavior on the telephone as the dependent variable and the pretest on CPI Empathy Subscale as the independent variable. A discriminate
analysis was run to determine what factors were most significant in predicting behavior.

The regression was run for the first 26 volunteers, randomly selected. The resulting equation was used for the second 26 volunteers to determine if the equation predicted the judge's scores. It is the hope of the researcher that CPI's Empathy Scale can be used as a screening device.

**Hypotheses**

1. Pre and posttest CPI Empathy Subscale will demonstrate maintenance or increase of empathic skills over time.

2. The telephone behavior will correlate significantly with the posttest on CPI's Empathy Subscale.

3. The pretest on CPI's Empathy Subscale will prove valuable as a prediction of the telephone behavior, i.e., subjects scoring 18.5 or above will be rated as having appropriate telephone behavior (3 or above on Carkhuff's Empathy Scale).

**Instrumentation**

**Hogan's Empathy Scale**

Hogan (1969) developed and validated an Empathy Scale using combined MMPI-CPI item pool. It is a 64 item scale with 31 items from the CPI, 25 from MMPI and 8 from various experimental testing forms used in studies at IPAR in Berkeley.

The validity of the scale is reported to be .80 using the Spearman-Brown formula. A test-retest correlation after a 2
month interval was .84. Extensive studies were done by Hogan to obtain both validity and reliability.

Using the CPI items alone, the CPI Empathy Subscale correlates at .92 with the full-scale score. This researcher intends to use the CPI Empathy Subscale.

Carkhuff's Empathy Scale

Assessment of empathy relied on the scale developed by Carkhuff (1969a). This is a revised five-point scale developed from the original nine-point Truax scale (Truax & Carkhuff, 1967). Level three is the minimal level of facilitative functioning. At the lowest level, the helper does not demonstrate he is listening, comprehending or sensitive to obvious feelings of the helpee. At the maximum level, the helper responds with total awareness of the other person and full and precise empathic understanding of the other person's deepest meanings.

Much research has been done using Carkhuff's Empathy Scale, and it is often most accurately used in judging taped sessions (Authier & Gustafson, 1976; Dilley et al., 1971; Carkhuff et al., 1968; Kurtz & Grummon, 1972; Slaikew et al., 1975; Tapp et al., 1974; Zimmer & Anderson, 1968).
Chapter 4

Analysis of date and findings

The purpose of this study was to determine if (1) pre and posttest CPI Empathy Subtest Scales will demonstrate maintenance or increase of empathic skills over time; (2) the telephone behavior will correlate significantly with the posttest on CPI's Empathy Subscale; (3) the pretest on CPI's Empathy Subtest Scale will prove valuable as a prediction of the telephone behavior, i.e., subjects scoring 18.5 or above will be rated as having appropriate telephone behavior (3 or above on Carkhuff's Empathy Scale); (4) demographic variables have any bearing on maintaining empathic skills.

The California Psychological Inventory was administered to 52 trainees prior to the commencement of the training program. Of these 52 trainees, 20 were male and 32 were female. Their ages ranged from 19 to 71, with a mean of 38.5. 38 were married, four were single, nine were divorced, and one was widowed. Their educational experience ranged from a G.E.D. to 20 years of schooling with a mean educational level of 14.8 years.

After the volunteers had been on the telephones for one year, they were again given the CPI in order to determine their score on the Empathy Subtest Scale. This pre and posttest was conducted to determine the telephone volunteers retention of empathy over time.

Hypothesis I

A T-test analysis was run to determine if there were a
significant difference between means of pre and posttest scores. Subsequent data yielded a significant positive level of difference between the two tests. Table 1 depicts these results. The table shows that the volunteers' empathic skills, as measured by the CPI Empathy Subscale increased at a significant level from the pre to the posttests. (Significant at < .001 level with 51 degrees of freedom).

**Hypothesis II**

These volunteers, also after one year of volunteer service on the telephones, received a "fake" telephone call. All volunteers heard the same problem from the same caller and each call was taped while the interactions were in process. Three trained observers rated the first four minutes of each call for over-all level of empathy. The observers rated the volunteers on Carkhuff's Empathy Rating Scale. Table 2 shows the correlation between the observers. Significance was at the .901 level indicating a high correlation between all three observer's rating scores.

Posttest CPI Empathy Subscale results were compared to the Empathy Behavior Ratings through a linear correlation analysis. Additional demographic data of age and education were also compared to the posttest CPI Empathy Subscale. Table 3 depicts the linear correlation of the posttest with behavior, age, and education. Results demonstrated that behavior correlated significantly with the posttest (S = .001). Volunteers rating high on empathy also had a high behavior rating.
Table 1

T-Test on Pre and Post CPI Empathy Subscale

Tests for Volunteer Telephone Workers

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Mean</th>
<th>S.D.</th>
<th>S.E.</th>
<th>T-Value</th>
<th>Df</th>
<th>P</th>
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<tr>
<td>Pre-Test</td>
<td>52</td>
<td>18.1731</td>
<td>3.434</td>
<td>.476</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Posttest</td>
<td>52</td>
<td>18.9038</td>
<td>3.466</td>
<td>.481</td>
<td>2.04</td>
<td>51</td>
<td>.047*</td>
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</tbody>
</table>

*Significant at .001
Table 2

Correlation Coefficient of Evaluation

<table>
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<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>1.000</td>
<td>.9414</td>
<td>.9512</td>
</tr>
<tr>
<td></td>
<td>$S = .001$</td>
<td>$S = .001$</td>
<td>$S = .001$</td>
</tr>
<tr>
<td>B</td>
<td>.9414</td>
<td>1.0</td>
<td>.9289</td>
</tr>
<tr>
<td></td>
<td>$S = .001$</td>
<td>$S = .001$</td>
<td>$S = .001$</td>
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<tr>
<td>C</td>
<td>.9512</td>
<td>.9289</td>
<td>1.0</td>
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<tr>
<td></td>
<td>$S = .001$</td>
<td>$S = .001$</td>
<td>$S = .001$</td>
</tr>
</tbody>
</table>
Table 3
Pearson Correlation Coefficients of CPI Empathy Subscale Posttests correlated with Behavior, Age, and Education of Volunteer Telephone Workers

<table>
<thead>
<tr>
<th></th>
<th>Behavior</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttest</td>
<td>.4260</td>
<td>-.3562</td>
<td>.2524</td>
</tr>
<tr>
<td></td>
<td>s = .001</td>
<td>s = .005</td>
<td>s = .036</td>
</tr>
</tbody>
</table>
When the CPI Empathy Subscale Test was compared to the age of the volunteer, it depicted a negative correlation, significant at .005. The younger person tended to have the higher empathy behavior rating. Education of volunteers showed a positive correlation with a significance of .041 when compared to the CPI Empathy Subtest Scale. The higher the education, the higher the score on the CPI Empathy posttest.

Because partial correlation coefficients show relationship between two variables while adjusting for the effects of one or more additional variables, they were used to obtain a more complete breakdown of the data. Table 4 shows partial correlation coefficients with posttest behavior, age, and education. CPI Empathy Subscale posttest correlated significantly with behavior ($r = .4260, p < .001$). CPI Empathy Subscale posttests showed a negative correlation when compared to age ($r = -.3562, p < .005$). CPI Empathy Subscale posttests correlated significantly with education level of volunteers ($r = -.5160, p = .001$). Behavior also correlated significantly with the educational level of volunteers ($r = .5532, p = .001$). Age showed a negative correlation to education ($r = -.2107, p = .067$). Table 5 shows the correlation of the pretest with age, education, and behavior.

Hypothesis III

It was important to determine if the CPI Empathy Subscale could be used as a predictor of behavior. A multiple regression analysis
### Table 4

Partial Correlation Coefficient of CPI Empathy Subscale Posttests with Behavior, Age, and Education of Volunteer Telephone Workers

<table>
<thead>
<tr>
<th></th>
<th>Posttest</th>
<th>Behavior</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttest</td>
<td>1.000</td>
<td>.4260</td>
<td>-.3562</td>
<td>.2524</td>
</tr>
<tr>
<td></td>
<td>s = .001</td>
<td>s = .001</td>
<td>s = .005</td>
<td>s = .036</td>
</tr>
<tr>
<td>Behavior</td>
<td>.4260</td>
<td>1.000</td>
<td>-.5160</td>
<td>.5532</td>
</tr>
<tr>
<td></td>
<td>s = .001</td>
<td>s = .001</td>
<td>s = .001</td>
<td>s = .001</td>
</tr>
<tr>
<td>Age</td>
<td>-.3562</td>
<td>-.5160</td>
<td>1.000</td>
<td>-.2107</td>
</tr>
<tr>
<td></td>
<td>s = .005</td>
<td>s = .001</td>
<td>s = .001</td>
<td>s = .067</td>
</tr>
<tr>
<td>Education</td>
<td>.2524</td>
<td>.5532</td>
<td>-.2107</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>s = .036</td>
<td>s = .001</td>
<td>s = .067</td>
<td>s = .001</td>
</tr>
</tbody>
</table>
Table 5

Pretest and Posttest Correlations Coefficients
of Behavior, Age and Education

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
<th>BEH</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>1.0000</td>
<td>0.7198</td>
<td>0.3040</td>
<td>-0.1615</td>
<td>0.3262</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
</tr>
<tr>
<td></td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.014</td>
<td>s = 0.126</td>
<td>s = 0.009</td>
</tr>
<tr>
<td>Posttest</td>
<td>0.7198</td>
<td>1.0000</td>
<td>0.4260</td>
<td>-0.3562</td>
<td>0.2524</td>
</tr>
<tr>
<td></td>
<td>(52)</td>
<td>(0)</td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
</tr>
<tr>
<td></td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.005</td>
<td>s = 0.036</td>
</tr>
<tr>
<td>BEH</td>
<td>0.3040</td>
<td>0.4260</td>
<td>1.0000</td>
<td>-0.5160</td>
<td>0.5532</td>
</tr>
<tr>
<td></td>
<td>(52)</td>
<td>(52)</td>
<td>(0)</td>
<td>(52)</td>
<td>(52)</td>
</tr>
<tr>
<td></td>
<td>s = 0.014</td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.001</td>
</tr>
<tr>
<td>Age</td>
<td>-0.1615</td>
<td>-0.3562</td>
<td>-0.5160</td>
<td>1.0000</td>
<td>-0.2107</td>
</tr>
<tr>
<td></td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
<td>(0)</td>
<td>(52)</td>
</tr>
<tr>
<td></td>
<td>s = 0.126</td>
<td>s = 0.005</td>
<td>s = 0.001</td>
<td>s = 0.001</td>
<td>s = 0.067</td>
</tr>
<tr>
<td>Education</td>
<td>0.3262</td>
<td>0.2524</td>
<td>0.5532</td>
<td>-0.2107</td>
<td>1.0000</td>
</tr>
<tr>
<td></td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
<td>(52)</td>
<td>(0)</td>
</tr>
<tr>
<td></td>
<td>s = 0.009</td>
<td>s = 0.036</td>
<td>s = 0.001</td>
<td>s = 0.067</td>
<td>s = 0.001</td>
</tr>
</tbody>
</table>
was performed to determine a regression equation and the value of the CPI Empathy Subscale pretest as a predictor of empathic skills. The prediction equation \( y' = .4856 + .1302 \) (pretest score on CPI Empathy Subscale) has a 1.12238 standard error. Behavior, as rated by Carkhuff's Empathy Scale, can be predicted by the equation with a +1.1 error. For example, if the equation predicts a person will score a 3 on CES, he could, in fact, score anywhere from 1.9 to 4.1. Therefore, it can be concluded that the CPI Empathy Subscale as a pretest measure cannot be used as the sole predictor of behavior. Table 6 depicts the results.

In order to further understand the data, a discriminant analysis was run. Discriminant analysis distinguishes between two or more groups of cases by forming one or more linear combinations of discriminating variables. The functions are formed in such a way as to maximize separation of the groups. The 52 volunteers were divided into three groups depending upon their score on the behavioral ratings. Group 1 with 14 subjects, scored less than 2.1; group 2 with 19 subjects, scored less than 3.6 and greater than 2.0; group 3 with 19 subjects, scored greater than 3.5. Table 7 shows the means and standard deviation of each group on pretest, posttest, age, and education.

Group 1 showed mean scores on pretest of 16.0, posttest 16.1, with a mean age of 48.07 and mean educational level of 13.07. Group 2 showed mean scores on pretest of 18.68, posttest 19.58 with a
### Table 6

**Multiple Regression Analysis of Behavior**

with CPI Subscale Pretest Scores

<table>
<thead>
<tr>
<th>Multiple R</th>
<th>.34774</th>
</tr>
</thead>
<tbody>
<tr>
<td>R Square</td>
<td>.12092</td>
</tr>
<tr>
<td>Adjusted R Square</td>
<td>.08576</td>
</tr>
<tr>
<td>Standard Error</td>
<td>1.12238</td>
</tr>
</tbody>
</table>

**Analysis of Variance**

<table>
<thead>
<tr>
<th></th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>1</td>
<td>4.33200</td>
<td>4.33200</td>
<td>3.438</td>
</tr>
<tr>
<td>Residual</td>
<td>25</td>
<td>31.49319</td>
<td>1.25973</td>
<td></td>
</tr>
</tbody>
</table>

**Variables in Equation**

<table>
<thead>
<tr>
<th>Variable</th>
<th>( B )</th>
<th>( \beta )</th>
<th>Standard Error ( B )</th>
<th>( F )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>.1302</td>
<td>.34774</td>
<td>.07023</td>
<td>3.439</td>
</tr>
<tr>
<td>Constant</td>
<td>.4856</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prediction Equation**

\[ y' = .4856 + .1302 \text{ (pretest)} \]
Table 7

Discriminant Analysis on Groups 1, 2, 3;
Means and Standard Deviations of
pretest, posttest, age and education

<table>
<thead>
<tr>
<th></th>
<th>Group 1 Mean</th>
<th>S.D.</th>
<th>Group 2 Mean</th>
<th>S.D.</th>
<th>Group 3 Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>16.0</td>
<td>2.57</td>
<td>18.68</td>
<td>3.25</td>
<td>19.26</td>
<td>3.59</td>
</tr>
<tr>
<td>Posttest</td>
<td>16.1</td>
<td>2.31</td>
<td>19.58</td>
<td>3.45</td>
<td>20.26</td>
<td>3.14</td>
</tr>
<tr>
<td>Age</td>
<td>48.07</td>
<td>11.78</td>
<td>36.95</td>
<td>11.54</td>
<td>33.05</td>
<td>4.84</td>
</tr>
<tr>
<td>Education</td>
<td>13.07</td>
<td>1.27</td>
<td>14.79</td>
<td>1.93</td>
<td>16.21</td>
<td>1.75</td>
</tr>
</tbody>
</table>
mean age of 36.95 and a mean educational level of 14.79. Group 3 showed mean scores on pretest of 19.26, posttest 20.26 with a mean age of 33.05 and an educational level of 16.21.

In an effort to break down the data further, a Wilk's Lambda was computed. This statistic takes all the factors which make up function and breaks down all factors in order to understand what factor or factors discriminate between the groups. This particular statistic will show the discriminating power of variables which haven't been removed by discriminate functions. The larger the \( \Lambda \), the less chance there is that the function will affect it.

The Wilk's Lambda and Univariate F-ratio with 2 and 49 df shows a significant difference between group 1 and group 3 with age and education demonstrating the highest discriminating power. Table 8 depicts these results.

Multiple regression analysis of behavior with CPI Subscale pretest scores and the regression equation have shown that the pretest has some power for prediction but additional data shows that there are other factors important for the selection process.

In an attempt to define the importance of these factors, additional discriminant analysis was run to determine the function with the most weight. Function 1 contains age and education. These two factors make up 95% of the differences between the three groups. The standardized discriminant function coefficients under Function 1 show pretest = .0319; posttest = .274; age = -.501; and
Table 8
Wilk's Lambda (U-statistic) and Univariate F-ratio with 2 and 49 degrees of freedom
Discriminating factors of pretest, posttest, age and education of Groups 1, 2, and 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>Wilk's Lambda</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>.8443</td>
<td>4.52*</td>
</tr>
<tr>
<td>Posttest</td>
<td>.7543</td>
<td>7.98**</td>
</tr>
<tr>
<td>Age</td>
<td>.7095</td>
<td>10.03**</td>
</tr>
<tr>
<td>Education</td>
<td>.6430</td>
<td>13.60**</td>
</tr>
</tbody>
</table>

* significant at 5% level of confidence
** significant at 1% level of confidence
education = .620. Table 9 shows the statistics and Table 10 shows the coefficients in Function 1.

Group 1 was comprised of 14 subjects scoring less than 2.1 on the behavior rating of Carkhuff's Empathy Scale. Of these 14, 11 fell within the same age and education level. Three subjects fell within the age and education level normal for group 2 (less than 3.6 and greater than 200 on Carkhuff's Empathy Scale). Group 2 had 19 members with 10 falling into the same age and education level. Three members fell into the norm established for group 1 and six fell into the norm established for group 3 (greater than 3.5 on Carkhuff's Empathy Scale). Group 3 had 19 members with 13 falling into the same age and education level. Six fell into the group 2 norm for age and education.

For prediction purposes, one can predict by age and education that a person will be in Group 1, Group 2, or Group 3. For Group 1, the percentage of accuracy is 78.6% for Group 2, 52.6%; and for Group 3, 68.4%. Table 11.

Hypothesis I

Pre and posttest CPI Empathy Subscale will demonstrate maintenance or increase of empathic skills over time.

The Hypothesis was accepted.

A significant difference was found between the pre and posttest. The volunteer's empathic skills increased significantly (\(< .001\)) over time.

Hypothesis II
### Table 9

**Discriminant Analysis of Groups 1, 2, 3**

**Determining Primary Factors of Selection**

<table>
<thead>
<tr>
<th>Discriminant Function</th>
<th>Eigen Value</th>
<th>Relative Percentage</th>
<th>Canonical Correlation</th>
<th>Functions Derived</th>
<th>Wilk's Lambda</th>
<th>Chi-Square</th>
<th>DF</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.45870</td>
<td>95.39</td>
<td>.770</td>
<td>0</td>
<td>.3799</td>
<td>44.52</td>
<td>14</td>
<td>.000</td>
</tr>
<tr>
<td>2</td>
<td>.07050</td>
<td>4.61</td>
<td>.257</td>
<td>1</td>
<td>.9341</td>
<td>3.13</td>
<td>6</td>
<td>.792</td>
</tr>
</tbody>
</table>
Table 10

Standardized Discriminant Function Coefficients
of Groups 1, 2, and 3

<table>
<thead>
<tr>
<th>Function 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>.0319</td>
</tr>
<tr>
<td>Posttest</td>
<td>.275</td>
</tr>
<tr>
<td>Age</td>
<td>-.501</td>
</tr>
<tr>
<td>Education</td>
<td>.620</td>
</tr>
</tbody>
</table>
Table 11

Prediction Results of the Discriminate Function: Age/Education
for Group 1, 2, and 3 Membership

Predicted Group Membership

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>11</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>78.6%</td>
<td>21.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>3</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15.8%</td>
<td>52.6%</td>
<td>31.6%</td>
</tr>
<tr>
<td>3</td>
<td>19</td>
<td>0</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.0%</td>
<td>31.6%</td>
<td>68.4%</td>
</tr>
</tbody>
</table>
The telephone behavior will correlate significantly with the posttest on CPI's Empathy Subscale.

The Hypothesis was accepted.

A linear correlation analysis demonstrated that behavior does correlate significantly with the posttest \( (s = .001) \). A volunteer who scores high (18.5 or above) on the Empathy posttest will also score high (3.0 or above) on the behavior rating.

**Hypothesis III**

The pretest on CPI's Empathy Subscale will prove valuable as a prediction of telephone behavior, i.e., subjects scoring 18.5 or above will be rated as having appropriate telephone behavior (3 or above on Carlhuff's Empathy Scale).

A multiple regression analysis gave the following prediction equation: \( y' = 0.4856 + 0.1302 \) (pretest score) with a 1.12236 standard error. Predicted behavior score derived from the equation will have an error of ±1.1.

The Hypothesis was rejected. The standard error ±1.1 was so great when used with the 5 point behavior rating scale that prediction could only be made on extreme cases.
Chapter 6

Summary

Twenty-four hour hotlines have multiplied rapidly as the need for such services has intensified. Research indicating that the majority of calls come from lonely people and those having relationship problems (Haughton, 1968; Farberow, 1968), has resulted in new trends in training of the volunteer phone workers. This shifting in emphasis has encouraged the enhancement of a helping relationship characterized by an empathic atmosphere.

This, in turn, has led to a need for improved selection procedures of potential volunteers with goals being (a) the volunteer who will show the most potential for training and (b) the volunteer who will best retain the necessary ingredient of empathy training over time. This study is designed to evaluate the effectiveness of CPI Empathy Subscale and demographic data as a predictor of potential volunteers. It will also evaluate the retention of empathic skills over time.

Data was gathered on 52 volunteers during February, 1976 and May, 1977. The pretest was given in September, 1976 and the posttest and telephone call in May, 1977, one year after they finished training. The pre and posttest were scored, and the telephone behavior was rated by three independent judges.

Conclusions and Recommendations

The following conclusions appear warranted in light of the data.
generated by this study.

**Hypothesis I**

The pre and posttest CPI Empathy Subscale demonstrates an increase in empathic skills over time. Since telephone centers generally keep the same workers for a number of years, it is important to note that their skills are maintained. Whether the skills are sustained because of telephone experience or other life experiences is unknown. Further evaluation should be considered in an attempt to determine the variables instrumental in empathy enhancement over time. Studies should also be conducted at both shorter and longer intervals to determine (1) if the enhancement is a steady increase or sporadic, (2) for what period of time beyond a year does improvement continue, (3) if there is a leveling off or decline in empathic skills with time.

Because of all the unknown elements in empathy retention, telephone centers might consider controlling for the retention factor by requiring in-service training in listening skills. To insure that callers receive the best care, mandatory retraining seems advisable.

**Hypothesis II**

The telephone behavior does correlate significantly with the posttest on CPI Empathy Subscale.

The research indicates that the posttest is truly measuring behavior and that both the behavior and the posttest appear to be tapping into the same aspects of empathy.
Since the CPI Empathy Subscale appears to be measuring the same aspect of empathy as the behavioral ratings, it would seem that the subscale could be further refined to have less standard error. If this could be accomplished, then the subscale could be used as a screening device as well as a measure of behavior for supervision purposes.

**Hypothesis III.**

The pretest on CPI's Empathy Subscale is not valuable as a predictor of telephone behavior.

The standard error (1.1) is too great to enable the pretest to be used as a screening device. If the prediction equation predicts the telephone behavior to be a four, the person could score a 2.9 - 5. That range is acceptable but if the equation predicts the telephone behavior to be a 2.4, the person could range from 1.4 - 3.6. The lower limit is unacceptable while the upper limit is acceptable, thus prediction is left to chance.

There is entirely too much error to make the pretest useful for screening. This is not to say that prescreening for empathy is not important but that the CPI Empathy Subscale is not valuable as a predictor, especially in the middle ranges of CPI scores.

**Demographic Data**

The factors which have the most promise in terms of selection are age and education. Both age and education correlated significantly with the posttest score. The higher the education and the lower the age, the higher the posttest scores.
In grouping the volunteers according to behavior ratings (G1 less than 2.1; G2 less than 3.6 but greater than 2.0; G3 greater than 3.5), the Means Chart (Table 7) shows that no one over 37 or under 28 years of age will be in G3. The Means Chart also shows that one in G3 will have 15+ years in school.

It seems that telephone centers should consider looking at the age and education of their volunteers as these factors make up 95% of the differences between the groups.

Also, based on age and education, one can predict accurately for G1 78.6% of the time; G2 52.6% and G3 68.4%.

While it appears that age and education are crucial factors, they are not definitive. Further research needs to be conducted to determine which attributes correspond to the various age groups. Isolating these factors can enhance selection techniques. The educational variable also needs further investigation, to determine if there is a minimum education level at which empathy is high and whether specific areas of educational concentration correlate with empathic skills. The combined factors of age and education should be studied as they relate to each other and as they relate to other variables.

Until further research is done in the area of prescreening based on tests and/or demographic data, centers will continue to select because of need or one's performance during the entire training course. It is hoped that this research will motivate
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others interested in the quality of hotlines to explore methods of selection in order to assure that callers receive high performance listeners.
Appendix I

Empathic Understanding in Interpersonal Processes. II

A Scale for Measurement

Robert R. Carkhuff

State University of New York at Buffalo

Level 1

The verbal and behavioral expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.

Example: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

In summary, the first person does everything but express that he is listening, understanding or being sensitive to even the feelings of the other person in such a way as to detract significantly from the communications of the second person.

Level 2

While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he subtracts
noticeable affect from the communication of the second person.

Example: The first person may communicate some awareness of obvious surface feelings of the second person but his communications drain off a level of the affect and distort the level of meaning. The first person may communicate his own ideas of what may be going on but these are not congruent with the expressions of the second person.

In summary, the first person tends to respond to other than what the second person is expressing or indicating.

Level 3

The expressions of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.

Example: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

In summary, the first person is responding so as to neither subtract from nor add to the expressions of the second person; but he does not respond accurately to how that person really feels beneath the surface feelings. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The responses of the first person add noticeably to the expressions
of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.

Example: The facilitator communicates his understanding of the expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings which he was unable to express previously.

In summary, the facilitator's responses add deeper feeling and meaning to the expressions of the second person.

Level 5
The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (1) accurately express feelings levels below what the person himself was able to express or (2) in the event of ongoing deep self-exploration on the second person's part to be fully with him in his deepest moments.

Example: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wavelength. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

In summary, the facilitator is responding with a full awareness of who the other person is and a comprehensive and accurate
empathic understanding of his most deep feelings.

The present scale "Empathic Understanding in Interpersonal Processes" has been derived in part from "A scale for the measurement of accurate empathy (Truax, 1961)" which has been validated in extensive process and outcome research on counseling and psychotherapy (Bergin & Soloman, 1963; Carkhuff & Truax, 1965, 1965a, 1965b; Rogers, 1962; Truax, 1963; Truax & Carkhuff, 1963, 1964, 1965) and in part from "Empathic Understanding in Interpersonal Processes (Berenson, Carkhuff & Southworth, 1964); which has been validated in extensive process and outcome research on counseling and psychotherapy (Berenson, Carkhuff & Myrus, 1966; Pagell, Carkhuff & Berenson, 1966; Pierce, Carkhuff & Berenson, 1966). In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy (Barrett-Lennard, 1962; Demos, 1964; Halkides, 1938; Truax, 1961) and education (Aspy, 1965). The present scales were written to apply to all interpersonal processes and represent a systematic attempt to reduce the ambiguity and increase the reliability of the scale. In the process many important delineations and additions have been made, including in particular the change to a systematic focus upon the additive, subtractive or interchangeable aspects of the levels of communication of understanding. For comparative purposes, Level 1 of the present scale is approximately correspondent; Level 2 and Stages 2 and 3 of the earlier version; Level 3 and Stages 4 and 5; Level 4 and Stages 6 and 7;
Level 5 and Stages 8 and 9. The levels of the present scale are approximately equal to the levels of the earlier version of this scale.
Appendix II

EMPATHY: TUNE IN

Donald A. Tubesing and Nancy L. Tubesing

Section I: Introduction

Listening Group Creed

Introduction to TUNE IN

Discussion Guidelines

Contract

Suggestions for getting the most out of this experience

Section II: Empathy

What empathy is and is not

The process of empathy

Empathy in the helping relationship

Diagram of empathy process

Section III: Workbook

How to use this workbook

Expectations inventory

Session 1: Getting in touch

Session 2: Feelings at war

Session 3: Expressing feelings

Session 4: Total listening

Session 5: Art of paraphrase

Session 6: Modes of Response

Session 7: Levels of empathy

Session 8: Putting it all together
Bibliography


Aspy, D., & Roebuck, F. From humane ideas to humane technology and back again, many times. Education, 1975, 95 (3).


Betz, B.J. Differential success rates of psychotherapists with "process" and "non-process" schizophrenic patients. 

Brockopp, G.W. The differentiation of a telephone service. 
Crisis Intervention, 1967, 2, 41-42.


Carkhuff, R.R., & Truax, C.B. Lay Mental Health Counseling.


Harvey, L.V. The use of nonprofessional auxiliary counselors in staffing a counseling service. *Journal of Counseling Psychology, 1964, 11, 348-351.*


Knickerbocker, D.A. Lay volunteers and professional trainee therapeutic functioning and outcomes in a suicide and


Lipps, T. *Psychological studies*. Baltimore: Williams & Wilkins, 1926.


McGee, R.K. *Crisis Intervention in the Community*. Baltimore:
University Park Press, 1974.


Rudow, E. The training of paraprofessionals. Paper presented


Truax, C.B., Altman, H., & Willis, W.A., Jr. Therapeutic


ABSTRACT

The primary purpose of the study was to assess volunteers' maintenance of empathic skills over time and to determine if Hogan's Empathy Scale could be used as a screening instrument.

Fifty-two volunteers were given the CPI before training, trained for ten weeks, manned the hotline telephones for a year, given the CPI again, and were rated for empathy (Carkhuff's Empathy Scale) on a telephone interaction.

A T-test analysis found that volunteer's empathic skills, on the pre and posttest of the CPI Empathy Subscale, increased after one year. A linear correlation found that the posttest CPI Empathy Subscale correlated significantly with the behavioral ratings. In addition, demographic data was compared with the posttest. The findings suggest that the younger, educated person will have a high level retention of empathy.

It was found that the CPI Empathy Subscale is not valuable as the sole predictor of behavior. Behavior, as rated by Carkhuff's Empathy Scale, can be predicted by an equation with ± 1.1 error.

It was concluded that: (1) telephone volunteers do maintain or increase empathic skills over time; (2) behavioral ratings and CPI Empathy Subscale appear to be tapping into the same aspects of empathy; (3) the CPI Empathy Subscale cannot be used as the sole predictor of retention of empathic skills; (4) demographic data (age and education) are important considerations in screening of volunteers.
VITA

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