NONPROFESSIONALS AS PSYCHOTHERAPEUTIC AGENTS: A CRITICAL REVIEW

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This essay is my own work. All sources used have been acknowledged.

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Chapter 1

INTRODUCTION

The nonprofessional mental health worker is a person who, while directly engaged in the provision of mental health services to the public, does not hold an accepted professional degree in mental health. Nonprofessionals have also been named "paraprofessionals", "subprofessionals", "lay helpers", "auxiliary helpers", "ancillary helpers", "new mental health workers", "community mental health workers", and "community workers". While "nonprofessional" is the most popular of the terms, all are used essentially interchangeably. Nonprofessionals may be paid or unpaid volunteers, or employed members of staff.

The nonprofessional movement is still in an early stage of development but, since its beginning in the mid 1950's with a few pioneering programmes using student volunteers in mental hospitals, it has grown sufficiently rapidly to be described by one writer (Sobey,1970) as the "nonprofessional revolution". Gottesfeld, Rhee, and Parker (1970) estimate that an average of 42% of the staff of community mental health centres consists of nonprofessionals, and the percentage is increasing. Some indication of the extent and diversity of the nonprofessional movement can be gained from a listing of the major groups of persons who have been used as nonprofessionals: college and high school students, mature housewives, indigenous neighbourhood workers, hospital attendants, grandparents and retired persons, teachers, ex-offenders and delinquents,

welfare and enforcement officers, and parents (as therapeutic agents for their own children). Clearly, nonprofessionals have varied markedly on such variables as age, socioeconomic status, education and race, as well as on prior background and experience, and level of training.

The diversity of helper groups utilized as nonprofessionals is matched by the diversity both of target groups with whom they work, and of specific functions which they may perform. Many of the nonprofessionals' clients are inner-city residents or mental hospital patients, but such groups as troubled schoolchildren, clinic outpatients, drug addicts, distressed college students, alcoholics, welfare and court clientele, prisoners, and mentally retarded persons, are being seen with increasing frequency. From her survey of 185 nonprofessional programmes, Sobey (1970) concluded that the functions performed by nonprofessionals could be grouped into 3 major categories and 5 minor ones. The major functions of nonprofessionals are described by Sobey as "therapeutic", which includes individual and group counselling and therapy, "special skill training" (tutoring, special training or retraining), and "community adjustment", which involves such tasks as job and home finding, home visiting, and facilitating access to community services. The minor functions listed are case finding, reception and orientation to services, screening (assessment of suitability for the services offered), caretaking, and community improvement. It is clear that nonprofessionals have not only performed most of the traditional functions of the mental health professional - they are also engaged in a number of new functions not previously considered as part of mental health services. Sobey reports that of all the functions the therapeutic is the most

frequent (noted in 87% of the 185 programmes), this being often in the form of "social relationship therapy", which is conducted by nonprofessionals much more frequently than by professionals. The popularity of social relationship therapy is indicative of the considerable influence of a client-centred philosophy on many of the nonprofessional programmes. A client-centred approach would seem to be especially suited to these programmes since its application does not require an extensive understanding of psychopathology or psychodiagnostics.

The rather sudden development of the nonprofessional movement appears to have been motivated primarily by a shortage of mental health manpower. It was Albee's (1959, 1967, 1968) continuing investigations which revealed that, in the four core mental health professions of psychiatry, clinical psychology, social work, and psychiatric nursing, manpower shortages run from 25% to 75% below the standards necessary for "minimal care". Extrapolations suggest that this disparity will become more severe in the future, given a continuation of present methods and conceptual models in the mental health field. Albee criticizes the medical model for its dependence on scarce and expensive manpower, but in fact the emergence of the community mental health movement seems to have accentuated the manpower problem by attempting to cater for a much broader target population. The undertaking of innovative new roles by nonprofessionals, not previously conducted by mental health services, also contributes to the manpower shortage. In economic terms the problem here is one of Parkinsonian inflation: nonprofessionals may be "cheaper" than professionals, but expanded services are likely to create an expanded demand.

This essay will focus on the substantive therapeutic activities of the nonprofessional. The term "psychotherapeutic agent" is used to indicate that the range of activities being considered is rather broader than that encompassed by most definitions of psychotherapy, and may frequently extend beyond an office-bound, verbal-expressive procedure. In many programmes, nonprofessionals are quite deliberately not carefully instructed on precise modes of behaviour with their patients, but are simply asked to attempt to establish a meaningful relationship. The behaviour of nonprofessionals can be expected to vary greatly between both programmes and individuals, and cannot be summarily defined. Behaviour modification programmes employing nonprofessionals will not be discussed in this essay; such programmes typically give brief training to the nonprofessional (usually a parent, teacher, or peer) in the management of specific behaviours (see Guerney, 1969a). The "ex-movement", as represented by the ex-drug addicts of Synanon, the ex-alcoholics of Alcoholics Anonymous, and the ex-mental patients of Recovery Incorporated, is also not specifically considered, as these groups constitute a rather special and distinctive example of the use of nonprofessionals as psychotherapeutic agents.

While the literature on the nonprofessional movement is expanding rapidly, it has to date consisted very largely of detailed project descriptions and discussion of plans for action. Cowen (1973, p.444) has commented on the notable lack of careful evaluation: "the great strength of the movement lies in the new roles and expanding horizons that it opens for helping services; its gravest weakness is that it has grown more through evangelistic fervour than through critical research scrutiny". The continuing emphasis on exploration rather

than research has resulted in a failure to adequately answer questions concerning whether, when, and why nonprofessional programmes work. In this essay an attempt will be made to consider these neglected yet central issues fairly thoroughly. Hopefully, the review may serve as a corrective to earlier work which has failed to give sufficient attention to the difficulties and complexities associated with the use of nonprofessionals.

Chapter 2

TYPES AND FUNCTIONS OF NONPROFESSIONALS

Programmes utilizing nonprofessionals as psychotherapeutic agents may be divided into two major groups: those using students, housewives, and other citizens as nonprofessionals, and those which employ "indigenous" nonprofessionals. The indigenous nonprofessional is a person who has been recruited from the population to be served; the term is most frequently applied to persons recruited from the inner city to work with the poor (Reiff and Riessman, 1965). Indigenous workers form the largest single group of employed nonprofessionals. They are typically lower class, nondegreed, and employed in community mental health centres. In this chapter the functions of these two broad categories of nonprofessionals will be considered separately, with special attention being given to indigenous nonprofessionals because of the existence of a distinctive rationale for their use.

1. Student And Housewife-Citizen Nonprofessional Programmes

Since a variety of programmes of this kind will be outlined in some detail in chapter 4, which reviews the research literature, only a brief indication of their scope will be given in this section.

College students have been a major source of nonprofessional manpower. Students are frequently used as "companions" to patients in mental hospitals, usually on a once-a -week basis over a period of one academic year. The first companion programme, and indeed one

of the very first of all nonprofessional programmes, was initiated in 1954 at the Metropolitan State Hospital in Boston. As described by Umbarger, Dalsiner, Morrison, and Breggin (1962), this ambitious project brought more than 2,000 student volunteers into contact with mental patients during its first 7 years of operation. Goodman (1972a) estimates that there are now over 600 companion programmes of various kinds underway. Goodman's own intensive study of college students as companion-counsellors for emotionally disturbed 5th and 6th grade schoolboys is discussed in detail in chapter 4. Students have also been used as therapeutic agents with hospitalized children (Reinherz,1963), with children in outpatient and clinic settings (Brennan,1967), and with institutionalized delinquents (Gorlich,1967). They have acted as play therapists (Stollak,1969; Linden and Stollak,1969), and as counsellors for other college students (Zunker and Brown,1966).

Housewives have similarly been employed in a wide variety of therapeutic roles. As described in chapter 4, Rioch (1966) systematically trained mature housewives to function, in effect, as traditional psychotherapists in school, hospital, and outpatient settings. Other functions performed by housewives include acting as help-agents for hospitalized chronic mental patients, in both companion and more traditional therapeutic roles (Carletti,1964; Cain and Epstein,1967); as counsellors on the problems of youth (Cooper,1967); as therapeutic agents in suicide prevention centres (Heilig, Farberow, Litman, and Schneiderman,1968); and as child-aides or help-agents in the schools with children experiencing problems of varying degrees of severity (Cowen,1969).

Two further programmes of interest involve the training of parents to work as therapists with their own children (Stover and Guerney,1967; Guerney,1969b), and the utilization of retired persons as child-aides for maladjusted children (Cowen, Leibowitz, and Leibowitz,1968).

2. The Indigenous Nonprofessional

Much of the motivation for the large-scale employment of indigenous nonprofessionals has derived from a growing realization of the existence of social class inequities in the mental health delivery system. In addition to the general category of "the poor", relatively neglected groups include alcoholics, drug addicts, juvenile delinquents, geriatrics, the mentally retarded, and various social minorities. The failure of these groups to receive adequate treatment is not attributable solely to either professional manpower shortages or to economic factors. Gruver (1971) suggests that professionals have had little success with target populations of this kind, and prefer to work with persons showing more rapid and dramatic change. Professional agencies may be reticent to accept urban poor as clientele because they are regarded as difficult to work with, as having poor prognoses, as demanding of time and effort, and, in some cases, because the agency is concerned about a possible loss of status if it accepts such clients (Reiff,1966).

Social class selectivity for mental health services was first revealed by Hollingshead and Redlich (1958). They found that lower class patients were less likely to be accepted for treatment. If they were accepted, moreover, their treatment was more likely to be of a nonpsychotherapeutic nature, and frequently consisted of

ECT or, simply, "custodial care". Meltzoff and Kornreich (1970,p.244) note that the more prestigious therapies tend to be received by patients of higher status: "If psychotherapies are placed in a hierarchy, there is then a tendency for the more intensive, individual, dynamically oriented therapies to be applied to those of higher class status. It is not simply that these therapies cost more and are not available to individuals of lower socioeconomic status, for the pattern was present in studies in which the fee was held constant or no fee was charged. It is also not just a function of different distributions of diagnoses in different class groups, for the finding is obtained within single diagnostic groups". Lower class patients are more likely to receive treatment from staff persons of less status, training, and experience (Hollingshead and Redlich,1958).

This uneven social distribution of professional mental health manpower is frequently "justified" by the assertion that psychotherapy is inappropriate to, and ineffective with, lower class individuals. Individual psychotherapy, it is argued, is ill-adapted to the capacities and orientation of these persons, who are said to lack ability to verbalize and "psychological mindedness" as well as financial resources, and to attach less value to self-understanding. Redlich, Hollingshead, and Bellis (1955) investigated the attitudes of 17 therapists working with lower class patients, and recorded expressions of frustration which were attributed by the therapists to an inability to do insight therapy, and to the handicap of having to work against difficult environmental conditions. The therapists expressed liking for 62% of their middle class patients, but for only 17% of their lower class patients. Quite possibly professional therapists, who are predominantly of middle class status, feel uneasy

with lower class patients and have difficulty in understanding and empathizing with them as a consequence of discrepancies in values, cultural background, language, intelligence, education, and the like. The lower class patient may be unable to conceptualize in the manner and at the level that some therapies require. Therapist-patient discrepancies in expectations and goals may also occur: lower class patients are said to expect and to prefer a more authoritarian, advice-giving, "medical" therapeutic approach, and to be primarily seeking symptom relief, with an immediate and concrete solution to their problems. Zax and Cowen (1972,p.401), for example, maintain that "whereas the mental health professional has traditionally emphasized the subtlety of human dysfunction, intrapsychic processes, and intricate psychodynamic formulations, the needs of the poor and the interventions they can most readily accept as relevant to their needs pertain much more to the visible, palpable problems of everyday living (housing,jobs, food)".

The relevance of these hypotheses to the present review lies in the fact that, in addition to serving as a justification for the shortage of professional psychotherapeutic services for lower class persons, the hypotheses form the basis of the rationale for the use of indigenous nonprofessionals with this group. Thus the indigenous nonprofessional typically shares a common language, background, ethnic origin, life style, interests, and value system with the target population that he serves. According to Reiff and Riessman (1965), this should endow the indigenous nonprofessional with a variety of distinctive advantages. He is more familiar with the problems of his patients than is the professional, and might be expected to be able to more realistically assess possible solutions to them. A tendency

to view problems in a manner similar to that of his patients - which would usually refer to a concrete, active approach which externalizes causes rather than searching for intrapsychic ones - is said to be advantageous. The indigenous nonprofessional would also appear to have some potential to function as a "bridge" between the professional and the target population, acting as a two-way communication channel by virtue of his anticipated interclass communication and mediation skills (Pearl and Riessman,1965; Reiff,1966). Furthermore, it is hoped that the employment of indigenous nonprofessionals will reduce the impersonality of an agency, facilitating client identification with and acceptance of the services provided. In general, then, the advocates of the indigenous nonprofessional claim that he can, more readily than the professional, enter the milieu of, empathize with, and take an active part in, the distressed person's total life situation.

Two key assumptions would seem to underlie this discussion: first, that it is difficult if not impossible for a professional psychotherapist to effectively treat a person of lower class background, and second, that similarity of the therapist to his patient is a basic ingredient of successful therapy. These assumptions are examined critically in chapter 4, where the research data relevant to each is briefly outlined and discussed.

Chapter 3

THE "HELPER THERAPY PRINCIPLE"

Riessman (1965) maintained that being genuinely helpful to a distressed person was a highly therapeutic experience for the helper, and coined the term "helper therapy principle" to describe this process. Since 1965, sufficient adequately controlled research has been conducted to enable one to conclude that nonprofessionals do frequently derive significant gains from their experience as therapeutic agents. Most of this research, however, has utilized college students as nonprofessionals, so that caution should be exercised in generalizing the results to other nonprofessional groups. College students may well be particularly open to change as their identity, goals, and interests are likely to be in the process of crystallization.

A variety of gains have been reported for college student nonprofessionals. Holzberg, Gewirtz, and Ebner(1964) found that student companions to patients in a mental hospital demonstrated a significant increase in self-acceptance, and a significant decrease in the severity of moral judgements relating to sexual and aggressive behaviours, by comparison to a control group of nonparticipant students. Evidence of improved self-understanding among student nonprofessionals is presented by Umbarger, Dalsiner, Morrison, and Breggin (1962), and Stollak (1969). In a study of student companionships with mental patients by Rappaport, Chinsky, and Cowen (1971), described in detail in chapter 4, the self-description of the students changed in the direction of greater surgency, confidence, self-control, nurturance, and general adjustment (see also Chinsky and Rappaport,

1970). These investigators, like Scheibe (1965), also noted a shift in the attitude of the student volunteers towards more acceptance of mentally disturbed persons, relative to a matched control group of nonvolunteers. Two further consistent findings are an increased knowledge of mental illness following participation in a nonprofessional programme (Holzberg and Gewirtz,1963), and a crystallization of career goals in a direction favourable to mental health (Scheibe,1965; Goodman,1972a).

Patterns of gains might be expected to vary with the particular characteristics of the nonprofessional, but Goodman (1972a) appears to be the only researcher to have explored this possibility. Dividing his sample of companion-counsellors to emotionally disturbed schoolboys into "quiet" and "outgoing" counsellors (see chapter 4), he found that it was the quiet counsellors who gained most in openness and assertion, while the outgoing counsellors became more interested in person-oriented careers and more favourable in their judgements of the trustworthiness of others. Goodman (1972a,pp.217-218) comments that "Quiets seemed to reverse their reserved interpersonal style, while outgoings appeared to become even more of what they were".

The changes which occur in nonprofessionals may be attributable to several factors. It is not suprising that college students uniformly report satisfaction with their experience as nonprofessionals, for they are provided with an opportunity to effect real and meaningful changes in their environment, to make a fairly realistic assessment of their personal suitability for work in the mental health field, and to establish and experience a relatively intimate interpersonal relationship. Nonprofessional programmes can thus assist in the

resolution of the identity and career problems of the adolescent or young adult. The indigenous nonprofessional, on the other hand, may directly increase his status and prestige, as well as his general self-esteem, as a consequence of his engagement in productive full-time employment, and acquisition of new skills. The reasoning that "I must be O.K. if I can help others in need" should strengthen the self-esteem of all groups of nonprofessionals. Finally, being placed in a helper role may divert the attention and involvement of the nonprofessional away from his own problems and self-concern.

Nonprofessional programmes are of particular value where the helper group is itself characterized by attributes which are a source of social concern. This would apply, for example, not only to the many college students who feel a lack of meaning and significance in their lives, but also to retired and aged persons, to that large group of housewives which suffers from feelings of emptiness and malaise, and to more extreme groups such as ex-delinquents. Any personal or educational development resulting from the participation of such persons in nonprofessional programmes will be of substantial social value, perhaps especially so in the case of those college students who subsequently achieve positions of status and influence in society. In a more general sense, by involving the local community meaningfully in its own mental health services, nonprofessional programmes can function as a means of public health education.

An interesting objection to any attempt to apply the helper therapy principle on a large scale has, however, been stated by Riessman (1965,pp.31-32): "Much of the intrinsic value of the technique may depend on it operating in a relatively subconscious

fashion. Once people know they are being placed in certain helping roles in order to be helped themselves, some of the power of the principle deriving from feelings of self-importance and the like may be reduced". This is an important hypothesis which is clearly deserving of empirical investigation.

While gains to the helper group are important, they must properly be regarded as secondary or even incidental to the effects which nonprofessionals have on their patients in their role as psychotherapeutic agents. It is with this key issue that the following two chapters are primarily concerned.

Chapter 4

REVIEW OF THE RESEARCH LITERATURE

It is perhaps suprising, and certainly unfortunate, that the widespread utilization of nonprofessionals in mental health settings has proceeded far in advance of the state of research knowledge. The small number of research studies which have been conducted can, moreover, be generally characterized as lacking in methodological sophistication. This chapter is devoted to a detailed critique of the most widely quoted and the most sophisticated of the studies, together with a presentation of the main research findings and some suggestions for future research. The emphasis of the chapter, consistent with that of the research literature itself, will be on investigations of the effectiveness of nonprofessionals. Individual consideration of the major studies will be followed by an overall appraisal of the state of research, and finally by a discussion of the research data relevant to the special rationale for the use of indigenous nonprofessionals.

1. Studies Using Relatively Untrained Nonprofessionals

Most of the research studies using nonprofessionals with little or no prior training have utilized college students as the psychotherapeutic agents, often as companions to mentally disturbed persons. The Metropolitan State project (see chapter 2) included a "case-aide" programme in which unpaid student volunteers worked in a one-to-one relationship with chronic psychotics. Beck, Kantor, and Gelineau (1963) attempted to evaluate the efficacy of this programme. 120 patients, predominantly chronic schizophrenics, were seen individually by students for an hour a week over a period of one

academic year. They were untrained, but given hour-for-hour supervision in groups of 8 to 10 by a psychiatric social worker, as well as biweekly individual supervision. Companionships did not follow a stereotyped pattern, but included activities of various kinds and verbal interaction, as well as the students' direct participation with families when patients attempted to leave the hospital. Two outcome criteria were used: number of case-aide patients dismissed from the hospital, and ratings of the patients in the categories "sick as ever", "marginal adjustment", "considerably improved", and "comparatively well". Ratings were based on an examination of student records and a follow-up telephone interview with the relatives of patients who had left hospital.

The results of this study indicated that 31% (37) of the patients had left the hospital while being seen by the students, and 28 of these were still out at the time of the follow-up, an average of 3.4 years after discharge. The other 9 patients stayed out for an average of 1.4 years. An additional 7 patients left hospital a few months after their case-aide work terminated, and all 7 were out at the follow-up (an average of 1.2 years each). Of the 35 patients still out at follow-up, 2 were rated as sick as ever, 10 as marginal, 18 as considerably improved, and 5 as apparently well.

Beck, Kantor, and Gelineau's study is one of the earliest conducted, and it suffers from many methodological inadequacies. The major inadequacy is the absence of any control group: a no-special treatment control group should have been used, possibly supplemented by a comparison group of patients seen by professional staff. Discharge criteria, which are subject to bias, are not discussed. Gross ratings of data obtained from relatives and collected unsystematically from

telephone interviews are questionable, particularly since there is no mention of any efforts to avoid rater bias. No ratings were made of the clinical status of the 69% of patients who were not discharged. Clearly, then, this study possesses too many defects to justify any definite conclusions concerning the efficacy of nonprofessionals.

An adequately controlled study of a companionship programme has, however, recently been completed in Australia by Stevenson and Viney (1973). Patients were drawn from the back wards of two large Sydney mental hospitals, and consisted of 100 chronic psychotics who had experienced no contact with anyone other than hospital staff for a period of at least 6 months. A no-treatment control group was formed by matching 50 pairs of patients on age, suspected organic involvement, pretreatment degree of withdrawal, ward placement, and degree of institutionalization. The 50 nonprofessional volunteers, of whom 42 were females and 8 males, had an average age of 47 years. 28 of the volunteers had previous contact with mental illness, mostly during the course of earlier volunteer work. Each nonprofessional established a one-to-one relationship with a patient for a period of 12 weeks, meeting with their patients for 1 to 3 hours a week. The structure of the companionships is not described in detail. The outcome criteria consisted of pre- and post-treatment ratings of the patients' behaviour, made by junior psychiatric nurses using the Lorr Psychotic Reaction Profile. This instrument yielded scores on four scales: thinking disorganization, withdrawal, paranoid belligerence, and agitated depression.

The major finding of Stevenson and Viney's study was that companionship patients did not change significantly more positively than their matched controls on any of the four scales. The authors'

suggest three reasons for their failure to obtain positive results: the chronicity of the patients, whose average length of stay in hospital was 21 years, and who, they claim, "were undeniably uncommunicative, unattractive and, in many senses, hopeless" (p.45); the possibility that ward staff attempted to compensate control patients for their having been denied a companionship; and the possibility of aggressive obstruction on the part of professional staff, who may have felt threatened by the volunteers. All three suggestions are plausible, but no tangible support for their validity is presented.

Partitioning the patient sample according to length of hospitalization did, however, yield some significant findings, as summarized by Stevenson and Viney (p.44): "Therapy by nonprofessionals appears to be most effective for paranoid belligerence in short stay patients, withdrawal in medium stay patients, and for thinking disorientation and agitated depression for those with the longest records of hospitalization". The obtaining of significant results from a partitioned sample would seem to be important in two respects: first it suggests the beginning of a rationale for the successful placement of nonprofessional volunteers with particular patients, and second, it raises the possibility that patterns of gains for particular subsamples may counteract, and so be masked by, negative findings for the total sample. Goodman's (1972a) study of companionship therapy with emotionally disturbed schoolboys, discussed in detail later in this section, also revealed a pattern of significant subsample effects embedded within nonsignificant total sample findings.

A widely quoted, controlled study by Poser (1966) used college students as "group therapists" for chronic patients. The

patients were 343 male chronic schizophrenics, hospitalized for at least 3 continuous years, and with a median length of hospitalization of 14 years. 11 young female college students, with no prior psychological training or experience in a mental hospital, served as paid volunteer nonprofessionals. 15 experienced professional therapists, consisting of 7 psychiatrists, 6 psychiatric social workers, and 2 occupational therapists, were used as a comparison-treatment control group. The patients were divided into 34 groups of 10, the groups being matched for age, severity of illness, and length of hospitalization. 26 of these 34 groups were randomly assigned to the nonprofessional and professional therapists, with the remaining groups serving as no-special-treatment controls. Each treatment group met with its therapist for 1 hour a day, 5 days a week, over a period of 5 months. Therapists were left free to conduct their sessions as they wished. A pre-post battery of 2 perceptual, 2 psychomotor, and 2 verbal psychometric tests constituted the major outcome criteria of this study. Tests of tapping rate, visual reaction time, verbal fluency, digit symbol, and the Stroop Colour Word Test were used.

The results were favourable to the nonprofessional therapists: by comparison with the no-treatment controls, the patients treated by nonprofessionals performed significantly better on 4 of the 6 tests, and on 3 of the 6 tests by comparison with the professional therapists. The nonprofessionals' patients also exceeded the test performance of the no-treatment controls at a follow-up conducted 3 years later. However, there was no significant difference in discharge rates for the control patients and those treated by nonprofessionals during the 3 year period.

Two major criticisms can be made of Poser's study. First, the use of tests as the basic outcome criteria: while Poser points out that the tests used have been demonstrated to distinguish between schizophrenics and normals, what has not been established is whether they can differentiate levels of adjustment within a population of chronic schizophrenics. Thus it is not clear how changes in test scores are related to changes in adjustment. In fact, the only relatively direct measure of adjustment that was used, namely discharge rates, did not yield significant results. The second criticism of Poser's study concerns the dropout of 48 patients who failed to attend two thirds of their sessions. Dropout rates for the nonprofessionals were much higher: 33% of their patients were lost, whereas the professionals' dropout rate was less than 4%. The two treatment groups were therefore no longer strictly comparable, since it is quite possible that the more highly motivated patients excessively weighted the groups of the nonprofessional therapists. The implication of these two criticisms is that Poser's results cannot be regarded as convincing "proof" of the effectiveness of nonprofessional therapists, and it is certainly unfortunate that sweeping generalizations have so frequently been drawn from the results of this single study.

The remainder of this section is devoted to a fairly detailed consideration of what appear to be the two most methodologically sophisticated research studies conducted to date. These are Goodman's (1972a) study of college students as companion-counsellors for emotionally troubled schoolboys, and Rappaport, Chinsky and Cowen's (1971) investigation of college students as group therapists for chronic psychotics. The latter study, which is similar in some respects to Poser's, is considered first.

Rappaport, Chinsky, and Cowen used as patients 320 chronic schizophrenics, half male and half female, with a mean length of hospitalization of 13 years. 32 college student volunteers, also divided equally by sex, and all with some prior academic background in psychology, served as nonprofessional therapists. 40 groups of 8 patients each were formed by matching on age, level of education, marital status, length of hospitalization, and psychiatric diagnosis (paranoid vs nonparanoid). Half of the groups were all-male, and the other half all-female. 8 groups (4 male, 4 female) were used as no-treatment controls, while the others were randomly assigned to student group leaders. Students met with their groups for 1 hour a week during the first 2 months of contact, and for 2 1-hour meetings a week for the remaining 3½ months. They were not specifically instructed on how to conduct their groups, but were given only the general orientation of fostering social and verbal interaction. Relatively unstructured supervision was, however, provided in the form of groups of 7 to 8 students meeting each week with a professional, to exchange ideas and discuss problems.

Like Poser (1966), Rappaport, Chinsky, and Cowen utilized as outcome criteria, in a pre-post design, a number of psychometric tests which had demonstrated ability to discriminate between schizophrenics and normals: reaction time, tapping speed, digit symbol, verbal fluency, the Stroop Colour Word Test, and an embedded figures test. The use of these tests is thus subject to the same criticism regarding validity discussed in relation to Poser's study. Two kinds of pre-post behaviour ratings were, however, employed as additional outcome criteria. Ward attendants rated

all patients on the Ellsworth MACC Behavioural Adjustment Scale, which yielded scores on 4 factors (mood, cooperation, communication, and social contact) as well as a total adjustment score. Ward personnel also rated each patient's overall behaviour on a 5 -point scale ranging from "rarely good" to "almost always good"; unfortunately these ratings are weakened by the absence of clearly defined reference points. Ratings of the group behaviour of the patients were obtained from the student leaders, using an adaption of the Ellsworth scale and an overall 5-point adjustment scale. A final and particularly interesting criterion of change was the "Patient Expectations and Perceptions Scale", a measure of the patients' perception of the students. Devised by the authors, this scale consists of 25 statements such as "he admires you", "he is critical", "he senses your feelings", which are read aloud to the patient, who indicates whether they best describe a doctor or a college student. The items are divided, apparently on an "a priori" basis, into 3 subscales: therapist perceived as nurturant, as a model, and as a critic.

Measures of group process, giving some indication of the nature and frequency of interactions within the groups, were obtained by having the students complete a specially devised "Group Activities Form" after each 10 sessions. Each student also kept a log of his impressions, and tape-recorded one or more group sessions, which were rated by judges on the Truax dimensions of accurate empathy, nonpossessive warmth, and congruence. "GAIT" sessions were held shortly before the programme began, as a further measure of student therapeutic talent. GAIT is a behaviour-sampling technique, developed by Goodman and described below in the discussion of his study. Finally, a variety of personality and attitude measures were

also administered to the students.

Rappaport, Chinsky, and Cowen succeeded in obtaining overall positive results from their study. The students' patients improved significantly on 8 out of 10 test measures, whereas control patients improved on only 3. They remained essentially unchanged in ward behaviour, however, but did improve significantly in group behaviour (in group cooperation, communication, social contact, and total adjustment), as rated by the students. The authors believe that the latter finding reflects a real change rather than rater bias, and describe an apparent contrast between ward and group behaviour: "If there is one clinical observation that stood out above all others, it was the dramatic, sometimes instantaneous regression of patients to sadness and listlessness as group meetings ended and they marched back to the ward" (p.184). Quite possibly the gains generated in the groups did not easily generalize back to the wards of a hospital characterized by a stable custodial orientation.

A particularly striking finding of this study was that the male patient-female student combination was the only one to consistently demonstrate greater improvement than the controls. This combination undoubtedly contributed heavily to the significant overall findings. Poser's (1966) results had, of course, been obtained using the male patient-female student combination alone. Perhaps the attractive, young female group leaders succeeded in rekindling the interest of male patients in the opposite sex, despite the patients' long histories of withdrawal, isolation and apathy. Rappaport, Chinsky, and Cowen comment (p.102) that "some male patients who, before the program, were the epitome of poor grooming, soon began to show up for their

female student leaders, clean shaven with shined shoes, and wearing ties".

Another interesting finding was that it was the more severely disturbed patients who improved the most. This is in contrast to the oft-mentioned tendency, based however mainly on studies of less chronic patients, for better adjusted patients to profit most from therapy, as normally conducted by professionals (see Luborsky and Strupp,1962; Garfield,1971).

Only a few significant relationships were found between student characteristics and patient improvement. Scores on the Truax dimensions did not consistently predict outcome, but GAIT ratings of student warmth, understanding, and overall therapeutic talent showed a small but significant correlation with improvement in ward behaviour. Student scores on the battery of personality and attitude measures were factor analyzed, but the number of significant correlations between factor scores and the outcome measures failed to exceed chance expectancy. The failure of student characteristics to consistently predict outcome may be partly attributable to the smallness of the sample of students (30) and to the use of a group approach, which possibly had the effect of diluting the student's personal impact.

Results from the process measures revealed that time spent talking in the groups was related to patient improvement on several test criteria, while time spent listening (including such activities as listening to television or radio) related <u>negatively</u> to improvement on some indices. Talking, especially with a person from outside of

the hospital, would probably constitute a pleasant departure from the typically dull hospital routine, and reflect good group rapport, whereas listening is already a part of the patients' routine.

Findings on the Patient Expectations and Perceptions Scale were highly significant. Initial patient attitudes towards the students were unfavourable: on only 2 of 25 items were students preferred to doctors. The posttest analysis, however, clearly demonstrated that the students' patients had developed markedly more favourable attitudes towards college students, both absolutely and in relation to doctors. In fact, the patients now preferred students to doctors on 18 of the 25 items. In terms of the subscale clusters of items, there was a significant increase in the patients' perception of the students as nurturant, but not in their perception of students as critics or as a model. These results can be interpreted as supporting the view that many patients find it easier to relate to college students than to professionals.

A follow-up study was conducted by Rappaport, Chinsky, and Cowen about one year after the project had ended. Some 300 of the original 320 patients were located. They were rated on a 7-point scale of "current status", which ranged from "patient has become worse" (-1) through to "sufficiently improved to be placed on convalescent or family care" (+4) and "discharged" (+5). Ratings were based primarily on such change-in-status indices, obtained from file data, as ward reassignment, assignment to rehabilitation, assignment to convalescent or family care, physician's progress notes, changes in medication, and job status. Using these relatively objective change criteria, the patients seen by students were shown to have improved

significantly more than the control patients, although in absolute terms the improvement was only slight: less than 10% of the students' patients achieved the status indicated by +4 or +5 ratings.

Goodman's (1972a) study of "companionship therapy" with troubled schoolboys is similar to that of Rappaport, Chinsky, and Cowen in the mixture of positive and negative results which it yielded, as well as in the relative methodological sophistication of its design. Goodman used paid volunteer college students as companions ("counsellors") to 10-11 year old, 5th and 6th grade, troubled schoolboys. A representative sample of emotionally troubled schoolboys was selected on the basis of sociometric ratings by teachers and classmates, and parent descriptions. In global terms, Goodman characterizes them as an emotionally and interpersonally vulnerable group, who tend to be socially isolated and to experience low self-regard. Following selection, the boys were sorted into pairs matched on age, socioeconomic status, neighbourhood, intactness of home, race, grade, birth order, and problem characteristics ("quiet" problems, such as withdrawal and depression, or "outgoing" problems, such as aggressiveness and attention-seeking). The pairs were then split and randomly assigned to either control or participants status, with the final sample consisting of 74 controls and 88 participants. About $\frac{3}{4}$ of the boys were white, and ¼ black.

The student volunteers were selected throughthe use of the GAIT ("Group Assessment of Interpersonal Traits") procedure. Described briefly, GAIT involves a structured, small-group situation (7-8 persons) in which applicants are asked,individually and in turn, to disclose a personal problem. Each group member is also required

to attempt to understand, and to respond to, the problem posed by another applicant. At the conclusion of a session, which typically takes about 1½ hours, ratings of each participant are made by all group members, and by more experienced observers, on these dimensions: acceptance-warmth, depression, quietness, openness, understanding, rigidity, and degree of tension. An overall rating of "best counsellor" is also obtained. The openness, understanding, and acceptance-warmth scales are combined into a general measure of therapeutic talent. This promising new selection procedure, which has clearly been strongly influenced by client-centred theory, will be discussed further in chapter 6, where the selection of nonprofessionals is considered in more detail. Goodman rejected 31% of his student volunteers as a result of their failure to meet specified GAIT standards.

Counsellors met with their boys for 1 to 4 hours a visit, 2 to 3 times a week; on the average, pairs met twice a week for 3 hour visits over a period of 8 months. The counsellors were denied diagnostic information about their boys, and advice about companionship activities was kept to a minimum. A 3 to 4 hour programmed instruction course on interpersonal relations, involving dyadic role-playing and other exercises in empathy and openness was, however, administered to all counsellors at the beginning of the programme. Additionally, to allow study of training effects, half of the counsellors attended weekly small-group training sessions. These groups were essentially unstructured, following a sensitivity-training format. The groups met for 25 to 29 sessions, each lasting about 90 minutes.

A notable feature of Goodman's study was the collection of detailed process data from "Structured Visit Reports", which were completed by counsellors after each visit. These reports indicated that boys and counsellors frequently collaborated in making decisions about activities: about half of the decisions were made jointly, with most of the remaining decisions being made by the boys. Typically there were 2 to 3 distinct activities per visit, usually involving active sports or lengthy visits to the boy's home. Walks, talking, sharing meals, sightseeing, hobbies, television, music, going for a ride, and visiting the counsellor's home were also common. Personal communication tended to take about 2 to 3 months to become a habit; after this time there was more discussion of personality and behaviour, and of the feelings of the counsellor and boy towards each other.

Change criteria were obtained from parents, counsellors, teachers, classmates, and from the boys themselves. Parents provided observations and ratings before, during, at the end of, and 1 year after the companionships, using an adjective checklist filled out to describe their children, and a Problem List for Elementary School Boys. Pre-post sociometric ratings on Wiggins and Winder's Peer Nominations Inventory were obtained from teachers and classmates; teachers also provided structured retrospective descriptions of change. Counsellors' views were obtained only after completion of the programme. The boys provided self-descriptions in the form of structured interviews based on a story-completion device.

Unlike Rappaport, Chinsky, and Cowen (1971), Goodman was unable to present evidence demonstrating the overall effectiveness of the companionships. 180 separate comparisons of participants and

controls yielded only 8 significant differences, a number which fails to exceed chance expectancy (although Goodman does not point this out). Several factors could have contributed to this failure to achieve significant overall results: parents of control boys may have sought alternative forms of therapy (there was in fact, a slight reduction in problems for the controls over time); control parents' reports of gains may have been linked to feelings that their boys were denied a companionship; and masking effects could have resulted from the existence of subgroups with differing change patterns.

The validity of this latter factor is suggested by the emergence of a number of interesting findings once the total sample was partitioned into various subgroups. Four separate counsellor-boy combinations had been incorporated in the experimental design by dividing the counsellors as well as the boys into "quiet" and "outgoing" types. The classification of counsellors was based on GAIT "quiet" scores and counsellor self-descriptions. Goodman found that boys with outgoing counsellors improved more than those with quiet counsellors. A quiet counsellor-quiet boy combination was, in fact, the best negative predictor of outcome; such pairs seemed unwilling to take initiatives, and more likely to conceal disappointments from each other. These findings were unexpected, since quieter applicants were thought to better fit the stereotype of the traditional nondirective therapist, but it is important to note that assertive and emotionally expressive students were accepted as counsellors only when their scores on GAIT understanding, acceptance-warmth, and openness were also relatively high. Thus it may be that it is a particular combination of qualities which is important, rather than "outgoingness" alone. Outgoing counsellors tended to be more

person-oriented, self-disclosed and assertive, and less depressed than their "quiet" peers.

Black boys, all of whom were paired with white counsellors, demonstrated marked gains. Comparison with their controls revealed a substantial reduction in phobias, timidity, and solitary play, improved attitudes towards school, and increased independence and self-esteem. The particular attention which these cross-race companionships attracted may perhaps have encouraged extended efforts at mutual understanding. This view is supported by the finding that black boys rated themselves as receiving more understanding, as disclosing more feelings, and as having and giving more fun in their companionships, than their white peers.

Consistent with the results of Rappaport, Chinsky, and Cowen (1971),and again contrary to normal expectations, Goodman noted a tendency for more severely disturbed persons to improve the most. Most of the more severely troubled boys had problems of a "quiet" nature (passivity, withdrawal, depression), but following their companionships they became more dominant and assertive, less self-abasing, and more popular at school. Practice of interpersonal skills may have been the major facilitative factor for these boys: "We suspect that extremely withdrawn boys were able to practice assertive and even dominant behaviours in the safely egalitarian companionships that were structured to demand collaboration" (Goodman,1972a,p.249).

The final major positive finding was that boys in companionships with longer visits,or with less frequent visits,

improved more. Longer visits allowed a wider range of activities and seemed to provide greater fun and interest. Counsellors who visited their boys less frequently were found to be more disclosing and more autonomous, but otherwise the reasons for this finding remain unclear.

Only minor gains were associated with group training: group-trained counsellors showed a greater increase in assertiveness, and were rated higher by their boys on measures of empathy, openness, and control. The latter finding is probably a consequence of attempts to employ therapeutic "gimmicks" suggested by fellow group members. Training effects were poorly tested in Goodman's study, however, primarily because the supposedly "untrained" control group had in fact been allowed easy access to professional consultants, and had taken a programmed course on interpersonal relations.

It is perhaps dangerous to generalize from such a small group of studies as those which have been reviewed in this section, especially since many of them have suffered from important defects in methodology. Nevertheless the studies do suggest that relatively untrained nonprofessionals can be used effectively, within the context of a particular programme, provided that their apparently "therapeutic" characteristics are first identified, and that they are subsequently matched with those particular groups of patients who are most likely to benefit from contact with these characteristics. Such combinations as female college students with male schizophrenic patients (Poser,1966; Rappaport, Chinsky, and Cowen,1971) and "outgoing" student companion-counsellors with "quiet" troubled schoolboys (Goodman,1972a) appear to be particularly promising, and certainly deserve a thorough testing in practice as well as in

research.

2. Studies Using Systematically Trained Nonprofessionals

Nonprofessionals have usually been given systematic training when they are to function in "traditional" psychotherapeutic roles. There are relatively few research studies using such nonprofessionals, however, and those which have been conducted suffer from methodological inadequacies.

Rioch's study (Rioch, Elkes, Flint, Usdansky, Newman, and Silber, 1963; Rioch, 1966) is probably the single most widely quoted of all research studies of nonprofessionals. This project, which began in 1960, was undertaken to determine whether carefully selected, mature women could be trained to become effective psychotherapists. 8 housewives were selected from 80 applicants, using interviews, tests, written autobiographies, and observation of participation in group interaction. The trainees were selected for their intelligence, perceptiveness, integrity, and emotional maturity. All were mothers with professional or executive husbands, and all were at least college graduates. 6 had held professional jobs in other fields, and 4 had been psychoanalyzed. Eclectic professionals gave these women a training in psychotherapy which was so thorough that it differed little from the practical training that a professional psychotherapist might receive. The training programme was a full 2 years in duration, and contained much on-the-job practical experience, with intensive professional support and supervision. Training in individual, group, and family therapy was given, with trainees working in a variety of agencies such as courts, clinics, and counselling centres. Theoretical material was covered in courses on personality development, adolescence,

family dynamics, and psychopathology, and in special lectures.

After completion of the training programme, the trainees treated 49 patients, most of whom were college students, and 69% of whom were judged as being difficult or very difficult to treat. On average, each trainee saw 7 patients once a week for 10 weeks. 4 outside experts made blind ratings of taped interviews of these sessions, and also of the trainees' "autocriticism" of their own interviews. Interview performance was rated on 5-point scales which ranged from "excellent" (5) to "poor" (1). Trainees were rated on such interview variables as respect for, interest in, and understanding of the patient, skill in drawing out affect, in starting and ending the interview, and in using patient cues, and professional attitude.

Rioch found that the ratings of trainees on interview variables ranged from 2.7 to 4.0, and on autocriticism from 3.6 to 4.0. Patients were rated as being 6% markedly improved, 20% moderately improved, 35% slightly improved, and 39% no change. These findings have frequently been interpreted as providing strong support for the efficacy of trained nonprofessional therapists. In fact, however, Rioch's study is too defective methodologically to warrant such a conclusion. The major limitation is the absence of any "external" criterion of outcome. In using professionals' ratings as the only outcome criterion, all that Rioch has really succeeded in demonstrating is that highly trained women can be trained to act as psychotherapists in a way that mimics, and is approved of, by their professional mentors. Even these rating scales were weak in that their points were not clearly defined. Furthermore, Rioch failed to use a no-treatment control group, which is essential if any conclusions

concerning the absolute effectiveness of nonprofessionals are to be drawn. The results obtained do not, in any case, seem to be particularly striking: only ¼ of the patients showed improvement judged as clear-cut, while the study failed to include a rating category for "patient has become worse".

Carkhuff and Truax are strong advocates of the nonprofessional movement, and in 1965 they presented evidence from two studies to support their views. The first of these (Carkhuff and Truax, 1965a) sought to demonstrate that the Rogerian-based therapeutic conditions of unconditional positive regard, therapist self-congruence, and empathic understanding can be quickly taught to nonprofessionals. 12 graduate students and, separately, 5 lay hospital personnel, received training of about 6 hours a week for 16 weeks. Carkhuff and Truax claim, perhaps not unreasonably, that most psychotherapy training programmes have concentrated overly much on theory and patient psychodynamics, and have given little attention to the actual practice of psychotherapy, and in particular to the methods of establishing a facilitative relationship with the patient. In this study they employed a "didactic-experiential" approach to training, which did not provide any specific instruction in psychotherapy theory, psychopathology, or personality dynamics, but concentrated instead on instructing the trainees in the provision of the Rogerian therapeutic conditions, using such exercises as role-playing and listening to tapes of therapy interviews.

At the conclusion of the training programme, trainees interviewed one schizophrenic patient each. Undergraduates trained to acceptable levels of judgement reliability rated these interviews on the dimensions of accurate empathy, unconditional positive regard,

therapist self-congruence, and patient's depth of self-exploration. Samples of the interviews of 11 experienced staff therapists were also rated. The results of this study indicated that while the ordering of ratings was, generally, experienced therapists, followed by graduate students, and finally lay personnel, nevertheless the only significant difference was that between experienced therapists and lay personnel on therapist self-congruence (on which the experienced therapists scored higher). Carkhuff and Truax interpret these results as implying that, given brief but appropriate training, nonprofessionals can quickly master the process of psychotherapy. This is certainly too general and too optimistic a conclusion. Training had been conducted essentially in one type of interview, for one interview only: the nonprofessional had knowledge only of a single technique. Inter-rater reliability was not high, ranging from 0.4 to 0.6. And no outcome measures were employed, so that the relationship of the ratings to outcome remained uncertain.

Carkhuff and Truax's second study (1956b) did make use of outcome criteria. The aim of the study was to demonstrate the effectiveness of didactic-experiential training for nonprofessional group therapists. 5 volunteer nonprofessionals were used, consisting of 3 hospital aides, a volunteer worker, and an industrial therapist, of whom only the latter was college educated. The 80 treatment patients and 70 controls were mostly chronic schizophrenics; they were randomly assigned to treatment and control groups. Following didactic-experiential training, which was again completed in less than 100 hours, 3 of the nonprofessionals were assigned to 2 groups of 10 patients each, while the other 2 nonprofessional therapists each had 1 group. Groups met twice a week for a total of 24 sessions over a

3 month period. Outcome criteria were as follows: discharge rates; pre- and posttherapy ratings of ward behaviour by nurses and ward attendants, made on three 9-point rating scales (for degree of psychological disturbance, of constructive interpersonal concern, and of constructive intrapersonal concern); and posttherapy ratings of the degree of overall improvement. Data for each variable were analyzed by 2x3 chi-squares comparing treatment and control groups on the categories "improved", "unchanged", and "deteriorated". Significant chi-squares were obtained for ratings of overall improvement, psychological disturbance, and intrapersonal and interpersonal concerns. Carkhuff and Truax claim that these results provide proof for the success not only of the nonprofessional therapists, but also of the didactic-experiential programme by which they were trained.

Again, however, the presence of inadequacies in the experimental design raises doubts about the validity of these conclusions. No validity checks of the ratings, or information on the rating scheme or judge reliability are presented. The ratings of overall improvement are particularly dubious since they are dependent on a global, memory-based impression of how the patient was 3 months ago. The dropout of 6 patients from the treatment groups would have reduced the comparability of these groups with the control groups. Especially significant is Carkhuff and Truax's apparent failure to notice that for all 3 ward behaviour rating scales there was a significantly greater deterioration rate among patients treated by nonprofessionals than among the controls. Finally, no conclusions can be made about the efficiency of the particular type of training given, since there was no control group of nonprofessionals receiving either no training or different training.

It is not possible at this stage to draw any definite conclusions regarding the effectiveness of systematically trained nonprofessionals. While it would be suprising if they proved to be less effective than relatively untrained nonprofessionals, it is important to recognize that their functions have tended to be rather different. Whereas untrained nonprofessionals have most typically been used as companion-counsellors, nonprofessionals receiving systematic training are frequently employed in roles very similar to those of professional psychotherapists. The effectiveness of the trained nonprofessional might also be expected to be dependent on the type of training received; appropriate methods for training nonprofessionals will be discussed in chapter 6.

3. An Appraisal Of The State Of Research

As the preceding review will have made apparent, almost all research studies of nonprofessionals suffer from methodological inadequacies of some kind. The most frequent inadequacies seem to be: too small samples of patients or therapists; failure to use at least a matched no-treatment control group, and preferably also a comparison control group of patients treated by professional therapists; failure to describe methods of selection and training of the nonprofessionals; sampling biases; and unsatisfactory outcome criteria. Expanding upon the last-mentioned inadequacy, studies of nonprofessionals frequently fail to use both pre- and posttreatment measures, or place excessive reliance on subjective reports of change. Ratings of change by the nonprofessional himself, or by his patients, are insufficient since they are subject to bias. If ratings are used, they should be preferably be blind ratings made by impartial outside observers, using rating scales in which the criteria are made quite explicit.

More objective and behaviourally based outcome criteria, for example such change-in-status indices as discharge rates and ward reassignments, would seem to be the best, although even these are not exempt from bias. When test measures are employed, evidence for their validity as indices of adjustment must be presented. The "sampling biases" inadequacy listed above refers especially to a tendency, in some studies comparing nonprofessionals and professionals, for easier cases to be assigned to the nonprofessionals.

Apart from these methodological flaws, an impartial evaluation of the effectiveness of nonprofessionals is made difficult by the still-gathering momentum and enthusiasm of the nonprofessional movement. Associated with this may well be a bias towards the reporting only of studies with positive results. Moreover, those research studies which have been reported are both too few and too diverse to allow sweeping generalizations to be safely drawn. Variability between studies is noted on many variables: in types of nonprofessionals, of patients, and of treatment; in the nature and degree of the selection and training of the nonprofessionals; in the duration and frequency of contact with the patients; in the outcome criteria employed; and in the motivation of the nonprofessionals - who may receive money, academic credit, or no extrinsic rewards, or be full-time employees. These variables must be adequately controlled, and their separate and interactive effects carefully studied.

A review of the existing research literature, despite the smallness and inadequacies of this literature, does at least serve the purpose of pointing up some of the areas in which there is a particular need for further research. The research suggestions made

below, together with suggestions drawn from other chapters of this essay, will also be summarized and listed in chapter 7.

A very important possibility, and one which does not seem to have been specifically investigated at all, is that higher patient deterioration rates may be associated with the use of nonprofessional therapists. Some indication of this was evident in the data from Carkhuff and Truax's (1965b) study, although it was not commented upon by these researchers. The dropout rates for nonprofessionals may also prove to be greater than those for professionals; an infrequently noticed finding of Poser's (1966) study was that the nonprofessional group therapists lost 33% of their patients, whereas the professionals' dropout rate was only 4%. Evidence that less experienced therapists tend to have higher dropout rates (see Meltzoff and Kornreich,1970) is also consistent with this suggestion, since nonprofessionals frequently have had little previous experience in a therapeutic role. The presence of greater dropout and deterioration rates would not necessarily imply that nonprofessionals are ineffective as therapists but rather, perhaps, simply that they do not "work" for all patients, and that more attention should be given to the important issue of the "matching" of nonprofessionals with their patients. A good illustration of the importance of this issue is Rappaport, Chinsky, and Cowen's (1971) finding that the particular combination of female student group therapists with male schizophrenic patients was the only one to prove consistently efficacious. While it is probable that some kinds of nonprofessionals will be more effective than others with a particular patient group, it would also be worthwhile, conversely, to determine which <u>patients</u> are most likely to take to, stay with, and benefit from, programmes staffed by nonprofessionals. For example, two studies (Rappaport, Chinsky, and

Cowen,1971; Goodman,1972) have noted a rather suprising tendency for more severely disturbed patients to improve the most from contact with nonprofessionals. The careful placement of nonprofessional manpower should substantially increase the cost-effectiveness of nonprofessional programmes.

Very noticeable is the scarcity of research on process and on relationships between process and outcome. What do nonprofessional actually do in their contacts with patients, which activities are most helpful to patients, and does the pattern of activities change over time? These are important yet neglected questions. Identification of those activities which contribute to, or detract from, the efficacy of nonprofessionals, is particularly necessary for the design of effective nonprofessional programmes.

4. The Indigenous Nonprofessional: A Special Case

There are two reasons for devoting a special section of this research review to the indigenous nonprofessional. First, a distinctive rationale is associated with the use of indigenous nonprofessionals. This rationale was outlined in chapter 2, and research data relevant to it will be discussed below. The second reason is the virtual absence of research studies using indigenous nonprofessionals. Much of the following discussion will consequently necessarily consist of extrapolations based upon studies of professional therapists. The lack of research studies of indigenous nonprofessionals is suprising, for these workers are employed in large numbers in community mental health centres.

From chapter 2 it may be recalled that two basic assumptions appear to underlie the use of indigenous nonprofessionals: first, that

professional psychotherapists have great difficulty in effectively treating lower class persons, and second, that therapist-patient similarity is a central component of successful therapy.

In support of the first assumption, it is often said that lower class persons expect and prefer a more authoritarian, advice-giving, "medical" type of treatment approach, with less emphasis on self-understanding than is typically the case in psychotherapy. Available research data suggests, however, that while social class differences in therapy expectations and preferences do exist, they are nevertheless not this clearly marked. Goin, Yamamoto, and Silverman (1965), for example, were suprised to find that as many as 52% of a sample of 250 lower class psychiatric outpatients indicated a desire to solve their problems by talking about their feelings. These 250 patients were subsequently assigned to insight-oriented psychotherapy, with half of them additionally receiving direct advice about their problems. Again contrary to expectations, no significant differences were found between patients receiving advice and those not receiving advice in both improvement as judged by therapist ratings, and in expressed client satisfaction with the treatment outcome. Aronson and Overall (1966) similarly failed to find any difference between middle and lower class patients in the degree to which they expected the therapist to focus on emotional and dynamic material, although lower class patients did expect more action and support from their therapist.

Research on the relationship between social class and therapy outcome has yielded only an inconsistent set of results, probably as a consequence of failure to control for such variables as selection of patients, diagnosis, therapist assignment, and type and duration of therapy. In those studies where a relationship is found, however,

it almost always favours the upper classes (see Meltzoff and Kornreich, 1970; Cobb,1972). Nevertheless, several studies present evidence which appears to indicate that lower class patients can be successfully treated by professional psychotherapists. Thus Albronda, Dean, and Starkwather (1964) report that while, during the first few weeks of psychotherapy (type unspecified), upper class patients improved significantly more than those from the lower class, yet as therapy continued the proportions of upper and lower class patients considered as significantly improved became similar. Positive findings have also been presented by Lerner (1972). In this study 15 professional therapists, including 9 social workers, gave psychotherapy to a heterogenous group of 45 predominantly lower class patients, 23 of whom were black and 22 white. The therapists had had considerable experience working with lower class persons, and were an unusually highly motivated and optimistic group. Lerner was able to demonstrate significant improvement for 23 of the 30 patients who completed treatment. She suggests that the attitudes of the therapists towards lower class patients were of major importance: "most of the therapists in this study ...clung...to a basic respect for even the most confused and needy clients' capacity to make choices and take responsibility for their own behaviour, and this appears to be the crucial reason for the unusually good results achieved with such clients in the present study" (p.141). Such a view is clearly quite different from the belief that therapists treating lower class patients should assume the role of an authoritarian advice-giver. The importance of therapist attitudes is also suggested by Mitchell and Namenek's (1970) finding that therapists of lower class backgrounds are more likely than those of upper class backgrounds to accept lower class persons for psychotherapy.

It is possible, then, that the difficulties which professional therapists may experience in treating lower class patients derive at least in part from a self-fulfilling prophecy, the therapists approaching such patients with a bias or negative set which anticipates failure from the start. If further research verifies the existence of therapist attitudes of this kind, attention could be given to discovering methods of modifying them. Perhaps this might be achieved through a change in training programmes for professional therapists, which could for example be expanded so that the family structure and dynamics, education systems, housing and living conditions, and employment opportunities of lower class persons are specifically considered. Research which establishes the most relevant and effective therapeutic methods for lower class individuals would also do much to modify therapist attitudes; unfortunately there is currently " a near absence in the literature of studies designed to assess the relative effectiveness of different approaches to serving lower socioeconomic class patients" (Cobb,1972, p.413). Indigenous nonprofessionals can, at present, be expected to have more knowledge of the problems of lower class patients than professional therapists, and perhaps also more appropriate and optimistic attitudes towards such patients, although whether this is so has yet to be tested empirically.

The second major assumption underlying the use of nonprofessionals is that similarity between the therapist and his patient both facilitates the process of psychotherapy and improves the likelihood of a favourable outcome. Research has been conducted on this issue of therapist-patient similarity, but suprisingly this does not seem to have been referred to in the literature on indigenous nonprofessionals. One study by Carkhuff and Pierce (1967), for

example, is of direct relevance since it examined the effect of similarity in social class and in race. The therapists used in this study consisted of an upper class Negro, a lower class Negro, an upper class white, and a lower class white, matched for training and experience. Each therapist gave an initial interview to 4 hospitalized mental patients, whose race and social class varied in the same way as those of the therapists. Taped segments of these interviews were rated on depth of patient self-exploration. Carkhuff and Pierce found that self-exploration was greatest for patients working with therapists of similar social class and race. The results of this study are, however, limited by its dependence on small samples, on initial interviews only, and on self-exploration rather than actual treatment outcome.

The findings of research studies of therapist-patient similarity have not been unequivocally positive. Indeed, after a thorough review of relevant studies, Meltzoff and Kornreich (1970,p.325) conclude that "we can find no solid evidence that therapist-patient similarity or dissimilarity either aids, abets, or hampers effectiveness". But they also note that "If there are any trends in these data, they suggest that curvilinearity, with a medium degree of patient-therapist similarity on selected and as yet not clearly defined or explored ... variables ... is conducive to somewhat better results" (p.320). Support for a curvilinearity hypothesis has been obtained in studies by Gerler (1958), Mendelsohn and Geller (1965), and Cook (1966), each of which examined the effects of similarities between college students and their counsellors. Therapy was found to be most effective with medium therapist-patient similarity on a variety of personality variables in the first two studies, and with medium similarity of values on the Allport-Vernon-Lindzey Study of Values in Cook's (1966) study. Perhaps, then, it is

possible for a therapist to be too similar to his patients. While, as the advocates of indigenous nonprofessionals maintain, shared characteristics can facilitate empathy and understanding, it is also conceivable that they might actually interfere with the process of therapy by making detachment and "distancing" from the patient more difficult. Excessive identification and involvement with the patient may reduce the likelihood of his being helped to cope more effectively with his problems, for the therapist's capacity to provide new perspectives on these problems is important in the formulation of new solutions.

Even this analysis, however, is probably an oversimplification of what may well prove to be an issue of considerable complexity. Therapist-patient similarity is possible on many variables; while successful psychotherapy may involve similarity on some of these, it may also involve dissimilarity on others. For example, similarity in many emotional states would be expected to facilitate the therapeutic process, but similarity in dominance or in nurturance could actually inhibit the development of a helping relationship. It would seem desirable that the therapist-patient similarity hypothesis be investigated in terms of specific personality or other variables, both singly and in combination as "personality types": some types of patients may succeed only with similar therapists, whereas other patient types will succeed only with dissimilar therapists. Previous research has typically merely examined global similarity averaged over groups of therapists and patients - a procedure which could easily fail to yield significant results due to the operation of counteracting subsample effects.

Existing research data suggests, then, that the rationale for the use of indigenous nonprofessionals can best be characterized as an oversimplification. The purported "untreatability" of lower class persons by professional therapists has yet to be convincingly demonstrated. Even if it were, research on the issue of therapist-patient similarity would still seem to indicate that the best therapist for a lower class person is not necessarily always an indigenous nonprofessional. Nevertheless, it does remain likely that indigenous nonprofessionals are effective for some patients, and further research is clearly needed to determine to what extent, and with which patients, this is true.

Chapter 5

THEORETICAL ISSUES

With the possible exception of the indigenous nonprofessional, suprisingly little consideration has been given to the development of a coherent theoretical rationale for the use of nonprofessional psychotherapeutic agents. In this chapter an attempt will be made to outline some of the mechanisms which may underlie the successful use of nonprofessionals. Many of the factors to be discussed must properly be regarded as "two-edged swords": they have the potential to detract from the effectiveness of the nonprofessional as well as to contribute to it.

In general terms, it seems possible to distinguish between two major grouping of factors. The first and larger of these involves the various distinctive qualities of the nonprofessional, particularly as these are perceived by the patient. The other major grouping of factors centres on the nonprofessional's freedom from certain constraints, such as in time and flexibility, associated with a professional role. Factors from these two groupings will be considered in turn.

One quality of many nonprofessionals, namely shared experiences and similarities with their patients, has already been commented upon in relation to the indigenous nonprofessional, to whom it is obviously particularly relevant. This quality may also apply to other nonprofessionals, however. For example the college student nonprofessional may, like his patient, be struggling with his identity, uncertain of his financial and employment security, and perhaps

experiencing feelings of alienation from society. The professional therapist, by contrast, is likely to at least appear to have achieved identity, security, and social acceptance. The apparent success of college students in working with children (see Gruver,1971) in particular, may be related to some similarity in problems, especially those concerning maturation and identity. Perhaps because he is not yet irrevocably committed to the adult world, the college student may have a special talent for understanding and responding to children. This suggestion is consistent with Goodman's (1972a) finding that the companionships of atypically old (23-35 years) college students with troubled schoolboys were less effective; empathy and the establishment of an egalitarian relationship is possibly more difficult with such an age disparity. As previously discussed in the sections on the indigenous nonprofessional, therapist-patient similarity can build rapport, and facilitate empathy and understanding. But it must again be emphasized that the presence of similarities between therapist and patient is not necessarily advantageous, and may in fact create problems in detachment and in the formulation of new perspectives on the patient's problems.

Not unrelated to this issue is what might be called the "social distance hypothesis". Central to this hypothesis is the existence of individual differences among patients: while some patients seem to be best helped by a professional therapist of status and authority, others may well find it easier to interact with nonprofessionals, who they perceive as being closer to them in a social status hierarchy. As Rappaport, Chinsky, and Cowen (1971,p.25) comment: "The position occupied by the professional has potential advantages and disadvantages. The advantages lie in the wisdom and

authority often imputed to the expert, and in the fact that many individuals who require help feel considerable need to be seen by a person with high status and regard. Conversely, there are other individuals experiencing interpersonal distress for whom the status, authority, and style of the expert are inhibiting or distasteful-sufficiently, in some cases, to thwart establishing an effective relationship and to impair meaningful communication". Some patients will be hostile to the mental health system, perhaps seeing themselves as victims. These patients may interact most meaningfully with nonprofessionals, who are less likely to be closely identified with the mental health system than are professionals. The therapist-patient similarity issue is relevant here in that those nonprofessionals whom patients perceive as being "like them" would probably be regarded as being outside of, or at least not centrally involved in, the mental health system. The fact that nonprofessionals, particularly those in institutions, have less control over their patients' environment than do professionals, may also encourage some patients to become less defensive and concerned with impression management.

Pentony (1972), in a paper entitled "The authority of the therapist", has argued that in order to be immune to the patient's attempts to manipulate or hurt him, the therapist must achieve a position of power or security in the therapeutic relationship. This process is facilitated by the existence of socially defined roles of "therapist" and "patient", the therapist being accorded a higher status by society at large and being essentially in a giving role, whereas the patient is in a receiving one. The extent of the discrepancy in status, Pentony suggests, is also dependent on the professional standing and orientation of the therapist, as viewed and esteemed by

the patient, on the use of various therapeutic strategies, and on the level of maladjustment attributed to the patient. Where, then, does the nonprofessional stand in relation to status and authority? With many patients he may well be in a disadvantageous position for, with his lack of credentials, experience, expertise in authority-enhancing tactics and so on, treatment by nonprofessionals could easily be regarded by them as "second rate", and even resented. These patients would probably be more willing to accept nonprofessionals if they were known to have been carefully selected, trained, and sanctioned by professionals. Such a procedure could be doubly advantageous for, in addition to raising the expectations of these patients of being helped, it should strengthen the nonprofessional's own sense of security and confidence, and so further inspire the patient's faith in his competence.

But other patients may perceive the nonprofessional quite differently. For those patients with negative attitudes towards professionals, close professional supervision and training could well have the effect of lowering the status and authority of the nonprofessional, in the patient's eyes, and reducing his expectations of being helped. Should the nonprofessional demonstrate a special facility at empathic understanding, accurate evaluative judgement, or concrete help-giving he may, however, be able to raise his attributed status and authority. Attempts to manipulate the perceived status of the nonprofessional might allow an empirical test of these hypotheses. This could be done, for example, by introducing the nonprofessional to the patient as a "professional colleague", or simply by refusing to reveal the status of the therapist, be he professional or nonprofessional, while controlling for such possible cues to professional identity as age, wearing a white coat, and so on.

The distinctive qualities of the nonprofessional may make him a more appropriate and viable role model of competent social behaviour than is the professional therapist. This would seem to apply particularly to the indigenous nonprofessional, who may be perceived by the patient as a person of similar background who has achieved a position of some status and success. Provided that the nonprofessional is still relatively acceptant of, and respectful to, his origins (see chapter 6), a process of positive identification is quite likely to take place. Positive identification is also more likely to occur in relatively evenly balanced power situations (see Pentony,1972), which is more frequently the case when the therapist is a nonprofessional rather than a professional. Furthermore, the greater length of time which nonprofessionals commonly spend with their patients, and the usually greater possibility of "in vivo" modelling of behaviour in real life situations, should facilitate the patient's learning of more appropriate social skills. The building of a long-term relationship with a nonprofessional is itself educational: an exercise in collaboration, and in the learning (or relearning) of interpersonal skills.

Factors of this kind may be of special value for those patients, such as chronic schizophrenics, in whom withdrawal from social relationships is particularly marked. With these patients the aim of therapy is to inhibit feelings of not belonging, of low self-esteem, of powerlessness and helplessness, and to encourage feelings of independence, responsibility, and self-expression. The development of social activity, cooperation with others, and generally of role behaviour consonant with the demands and realities of community living is of major importance. Interestingly, conventional "insight" approaches tend to be ineffective with chronic schizophrenics,

both in individual and in group form (Meltzoff and Kornreich,1970). Patients other than chronic schizophrenics may also benefit from therapies which emphasize social relationships. Christmas (1969),for example, advocates group approaches with disadvantaged persons: "The democratic and cooperative aspects of groups prove useful to persons who have had disturbing life experiences with authority and who may perceive the therapist in a one-to-one relationship as an inevitably malevolent authority figure" (p.167). Nonprofessionals frequently seem to be in an advantageous position, relative to professionals, in terms not only of their capacity to function as viable role models, establish meaningful social relationships with patients,and encourage the learning of social skills, but also, as therapy group leaders, to provide a nondefensive group atmosphere which facilitates patient-to-patient interaction.

Qualities such as enthusiasm, involvement, and dedication are often described as being characteristic of nonprofessionals. Goodman (1972a), for example, made a content analysis of the expressed motives of his student "companions", and reported that: "Most of all, they wanted to develop better interpersonal skills, to take action in giving to someone as opposed to their more passive and taking student roles, to clarify career goals. Some joined the project in search of academic relief, autonomy, or a new adventure. One theme threaded its way through most of their expressed motives: the need for converting pent-up ideals into some humanitarian action" (p.255). In writing of the Metropolitan State companion programme, Umbarger, Dalsiner, Morrison, and Breggin (1962) also note that students seem to have an especially strong sense of personal conviction in their work as nonprofessionals, feeling that they are crusaders working for a

worthwhile cause, or even revolutionaries engaged in a struggle against mental illness. For patients long exposed to institutional settings characterized by pessimism, static defeatism, and a management-custodial orientation, qualities of this kind may be of particular value. As Zax and Cowen (1972,p.490) remark, "the vibrance and enthusiasm of the nonprofessional serves both as a model for the patient and as a link to a different, more exciting world that he may have forgotten. The nonprofessional becomes ... a breath of fresh air in an otherwise stagnant atmosphere". In such settings the nonprofessional's expectancies of patient change are likely to be more optimistic than those of the professional. Zax and Cowen (1972,p.490) comment that: "They may ... in naive simplicity see mental hospital patients as people rather than as incurably sick individuals, and may anticipate that they will be responded to when they speak to a patient". This raises the possibility that a self-fulfilling prophecy will occur.

Two further factors involve the patient's perception of the nonprofessional. The first of these is, quite simply, that the nonprofessional is more likely than the professional to be perceived by the patient as having a genuine human interest in him. This would seem to apply particularly to the unpaid volunteer, whose interest in the patient can scarcely be said to be motivated by money or job demands. Secondly, the use of nonprofessionals may result in a reduction of the stigma associated with receiving treatment from mental health services, and so be less injurious to the patient's self-esteem. It is, in fact, quite plausible that situations will exist in which receiving help from a nonprofessional actually raises the status of a patient among his peer group, and increases his self-esteem. This seems to occur, for example, when chronic male patients

gain the attention of an attractive female college student, or when troubled Negro boys successfully establish close, long-term relationships with white student companions. This possibility would not apply, however, to those patients who are inclined to view nonprofessionals as "second rate" therapists.

The second major grouping of possible factors underlying the successful use of nonprofessionals centres on the nonprofessional's relative freedom from constraints. Most nonprofessional programmes are characterized by an absence of rigid therapist and patient role definitions. A wide range of behaviours is regarded as acceptable for, and even appropriate to,the nonprofessional. He will be less bound than the professional by fixed rules of interaction and standard ideas about the ways in which distressed persons are helped. Gruver (1971) points out that in his experimentation with treatment approaches the nonprofessional may uncover new ones considered too inappropriate or too illogical to be attempted by professional therapists. The nonprofessional is able to relate to the patient in new and possibly more meaningful ways than is the professional, and can become sufficiently involved to play an active part in the life of the patient. As Zax and Cowen (1972,p.490) comment: "A housewife-aide... feels entirely free to sew a button on a school child's shirt; an indigenous nonprofessional freely engages his charge on the street, in his home, a coffee shop, or a bar. Such contacts might be regarded a priori, by the professional as implausible, unsophisticated, or without precedent".

Thus the therapeutic activities of the nonprofessional need not be confined to the consulting room. Many patients may find it

easier to talk nondefensively about their difficulties in the context of a more familiar environment. The greater flexibility of the nonprofessional's therapeutic relationships should encourage the emergence of material not normally forthcoming in the more highly structured relationships of the professional. Exposure to the patient's environment will itself give the nonprofessional an opportunity to collect valuable information. On the other hand, the lack of structuring could result in uncertainty and confusion, with exploratory approaches to treatment giving rise to errors and problems. This practical difficulty will be discussed in detail in chapter 6.

Related to flexibility is the fact that nonprofessionals can usually spend more time with their patients, and concentrate more attention and effort on them, than can the professional, who is likely to be faced with a heavy case load. In fact, many volunteer nonprofessionals have only one patient, and are able to devote their time and attention exclusively to him. The effort and motivation which characterizes many nonprofessionals'therapeutic relationships will be further accentuated by the anxiety of the nonprofessional, particularly if he is considering a career in mental health, to prove to his own satisfaction that he <u>is</u> capable of helping another person.

This discussion of the kinds of mechanisms underlying the successful use of nonprofessionals suggests the importance which nonprofessional programmes implicitly attach to the therapeutic relationship. The distinctive personal qualities of the nonprofessional, and his relative freedom from constraints, should both have the general effect of facilitating the establishment of a genuine helping relationship. Of central importance in this process is the

patient's perception of the nonprofessional. Lacking a clearly defined social role, it is probable that patient attitudes and responses to nonprofessionals are not primarily determined by the socially validated roles of "therapist" and "patient". Evidently patients do not often view nonprofessionals as their "therapists". Instead they may be perceived and responded to as, for example, persons sharing a similar background and interests, as persons not associated with the mental health hierarchy or bound by inflexible rules of behaviour, and as persons who are prepared to enthusiastically and optimistically devote much time and attention to individual patients. To the institutionalized patient the nonprofessional may be perceived as an "outsider", to use Goffman's (1961) term. Goffman's analysis of the relationship between mental patients and outsiders deserves quotation: "Concern for interaction with outsiders seemed to be related to the caste-like position of patients in the hospital and to myths associated with the stigma label of insanity... outsiders were less likely to be as offensive as staff members about patient status; outsiders did not know how lowly the position of the patient was... a few patients claimed to be very tired of talking about their incarceration and their case with fellow patients and looked to conversation with outsiders as a means of forgetting about the culture of the patient. Association with outsiders could confirm a sense of not being a mental patient" (pp.195-196). The emphasis in this quotation is clearly on such factors as the perceived (low) social distance of the nonprofessional or "outsider", and his apparent separateness from the formal hospital setting and hierarchy.

The particular advantages of the nonprofessional can be expected to vary somewhat with differences in both the nonprofessional

group utilized, and in the target group of patients. Nonprofessional groups will differ in the pre-eminence of various qualities. College students generally seem to be particularly suited to the role of psychotherapeutic agent. As well as being easily accessible and forming a very large manpower pool, they appear to possess to a high degree many of the characteristics discussed in this chapter: dissociation from the mental health system; sufficient intelligence and ability to be able to exploit a flexible role; much enthusiasm, dedication and optimism; a typically genuine interest in the patient; and increased sensitivity to certain problems as a consequence of their own experience of problems of identity, career, and the like. But it is unlikely that students can work effectively with all patient groups. With some patients, for example, they may lack the similarities in background and experience which an indigenous nonprofessional could provide. The significance of variations in the target group of patients can be illustrated by comparing institutionalized and noninstitutionalized patients. Factors of primary importance to the institutionalized patient would probably include social distance and separateness from the institutional setting and hierarchy, as well as concentrated attention, enthusiasm, optimism, genuine interest in the patient, and perhaps - not forgetting the findings of Rappaport, Chinsky, and Cowen (1971) - sex. With noninstitutionalized patients, on the other hand, the specific personality characteristics of the nonprofessional may take on larger significance.

Virtually all of the discussion in this chapter must properly be regarded as speculation awaiting confirmation by research; nevertheless, it may at least help to guide this research into issues which are of practical importance as well as theoretical significance.

Chapter 6

PRACTICAL ISSUES

This chapter is divided into two sections. The first section consists of some comments of a general nature on the selection and training of nonprofessionals, while the second section will consider the organizational and other practical difficulties associated with nonprofessional programmes.

1. General Comments On The Selection And Training Of Nonprofessionals

Nonprofessionals can be highly selected, since there is usually a large pool of applicants from whom to choose, even when unpaid volunteers are utilized. The development of reliable selection procedures will be of particular importance when training is minimal, which is of course often the case with nonprofessionals. Unfortunately, however, little is known concerning the adequacy of selection criteria for therapeutic roles. The effectiveness of interviews, application forms and the like is rarely studied. Academic-achievement criteria appear to be of definitely limited usefulness (Goodman,1972a).

Currently used procedures for selecting nonprofessionals are generally rather unsystematic. According to Sobey (1970), paid nonprofessionals are most often recruited from advertisements in news media, recommendations from project staff, and from employment agencies, while unpaid volunteers are most frequently recruited through talks to community and other voluntary groups. Recruitment practices and standards vary widely; frequently there is no formal specification of the qualities sought. Gottesfeld, Rhee, and Parker (1970) claim that

the choice of nonprofessionals is made primarily on the basis of global impressions of such qualities as "healthy emotional make-up", "warmth", and "ability to work with people". The emphasis does generally seem to be on selection for personal qualities and life experience.

The most promising, systematic selection procedure is GAIT, devised by Goodman (1972a,1972b) and briefly described in chapter 4. GAIT directly samples interpersonal behaviour in a quasi-therapeutic situation. Early evidence on reliability and validity is presented by Goodman. GAIT appears to be more reliable and bias-free than interviews, and has the additional advantages of being relatively quick (about 1½ hours per session), inexpensive, and easy to score. A selection device of this kind could also be used as a complement to academic-achievement criteria in selecting persons to enter professional training courses in psychotherapy. GAIT is not problem-free, however. Variability in interpersonal style over time and situation, with changes in the composition and size of the assessment group, will reduce predictability; research support for GAIT is not yet substantial, although it is growing quite rapidly.

Procedures for training nonprofessionals have also tended to be rather haphazard and unsystematic. Little research has been done on optimum training procedures. The duration of training ranges from none to several years of fairly intensive training, as for example in Rioch's study (see chapter 4). An "on the job" type of training is the most common; the exact nature of a training programme is dependent on such factors as the conceptual biases of the trainers, the nonprofessional's future role, and the perceived needs of the agency and of the target population to be served. Training programmes may also

vary according to the nature of the group being utilized as nonprofessionals. An overly academic approach, for example, would be unsuitable in programmes using indigenous nonprofessionals.

Nonprofessional training programmes should benefit from a careful consideration of the following suggestions. First, in view of the nonprofessional's lack of prior training and experience, close supervision from either professionals or experienced nonprofessionals should be readily available. This supervision must be of high quality, since it is likely that the supervisors will serve as models for their trainees. Second, the utilization of group training with group discussion of problems, strategies, and so on, may be desirable. Advantages of group training include the development of a sense of identity and support among nonprofessionals, reduction in trainee dropouts, establishment of a source of critique and new ideas, and the probable strengthening of the nonprofessional's sense of responsibility for constructive patient change. A third consideration is the provision of frequent opportunities for frank discussion of programme and role difficulties. This is most easily and efficiently done in the context of a warm and acceptant supervisory relationship. Finally, it is desirable that the trainees are supplied with feedback on both their level of interpersonal skills and on the outcome of their work with patients. Feedback of the latter kind is rarely provided even during the training of professional therapists. Careful consideration of these four suggestions should do much to maintain the enthusiasm of the nonprofessionals, and will encourage the development of a sense of commitment and dedication.

If nonprofessionals, with little or no training, can be shown to be as effective as professional therapists, then doubts as to the efficacy of current procedures for training professional psychotherapists are certain to arise. In fact, as Meltzoff and Kornreich (1970,p.288) note, "We do not know if the rigorous pre - and post-doctoral training requirements really make people better psychotherapists in terms of outcome rather than merely more skillful in the application of techniques". The effective use of nonprofessionals would seem to imply that mastery of a complex theoretical scheme is not essential for successful practice as a psychotherapist. If personal qualities and interpersonal skills prove to be of greater importance, then more emphasis should be given to the selection of therapists, be they professionals or nonprofessionals, and to practical training in relationship skills.

The task of designing a relevant and effective training programme is greatly complicated by the continuing lack of knowledge of the critical components of successful psychotherapy. Empirical support for any of the hypotheses discussed in chapter 5 concerning the mechanisms underlying the success of nonprofessionals, where they are successful, could well have an impact on professional as well as on nonprofessional training programmes. Thus, for example, supporting evidence for the importance of shared background and experience would indicate the need for special training if professional therapists are to work more successfully with patients from different cultural and social backgrounds. Such training might involve learning about the particular language and customs of these patients, including perhaps some first-hand experience of the patients' environment, which would allow the therapist to become more familiar with their problems and way of life.

Recently established courses for the training of community psychologists have, in fact, begun to employ training experiences of this general nature (see Iscoe and Spielberger,1970).

2. Practical Difficulties In The Utilization Of Nonprofessionals

Particular emphasis will be given in this section to practical difficulties of a broadly "organizational" nature. These must be considered carefully if the nonprofessional is to be smoothly integrated into a mental health organization, without any loss in either his own effectiveness or in that of the organization.

A major problem for both the nonprofessional and the organization of which he is a part is the absence of a clear role definition. As Riessman (1969,p.154) points out,"'Nonprofessional' describes what he is not, but does not clearly indicate what he is". This difficulty of clearly delineating the role of the nonprofessional is not suprising in view of the recency of the nonprofessional movement, which is still experimenting with possible roles, and has yet to decide on which functions nonprofessionals can and should perform. The problem is accentuated by the uncertainty of goals which characterizes the rapidly expanding field of community mental health. In some instances the nonprofessional is assigned to perform only the more trivial and tedious tasks of the professional. Such a policy is likely to cause considerable dissatisfaction, since the nonprofessional will normally desire a dignified role with status and prestige.

A related difficulty, specific to the employed nonprofessional, is the lack of well-defined advancement opportunities and career ladders.

In most nonprofessional jobs there is little or no possibilty of advancement. And since the nonprofessional does not have a degree in mental health, it is argued that he cannot expect to receive the salary and status of a professional. Limitations of this nature must be expected to lead to much dissatisfaction among nonprofessionals, particularly where, like the professional, they too are working in a directly therapeutic capacity. Possible ways of avoiding this dissatisfaction, such as the promotion of experienced nonprofessionals to positions involving the training of new nonprofessionals, and allowance for time off so that the nonprofessional can further his formal education, must be explored thoroughly.

Professional antagonism to the nonprofessional is often a very real problem. Part of the source of this antagonism is evident in a quotation from Rioch (1966,p.291), made in reference to Poser's (1966) study: "If we have invested long years of hard work in achieving a high professional status, including many courses that were dull and many examinations that were nerve wracking, and we are told that some young bit of a girl with no training can do the job as well as or better than we can, it is natural that we should try to find some objections". Professionals are most likely to be resentful of the nonprofessional where he is performing a direct service function for which the professional was prepared by years of education. In such cases there is a danger that nonprofessionals will be viewed as "scab labour"- as low cost replacements - by the professional. Moreover, the use of nonprofessionals is frequently associated with a changing emphasis, for the professional, away from the direct practice of psychotherapy, and towards such new roles as the selection, supervision and training of nonprofessionals, consultation, administration, planning,

evaluation, and systems analysis. These are complex and responsible roles for which many professionals have virtually no training or experience, and which many may find less rewarding than direct therapeutic work with patients. The general point,then, is that the use of nonprofessionals can throw the professionals' own role into doubt and confusion. The development of professional training programmes in community mental health will eventually help to overcome some of these difficulties but, as Zax and Cowen (1972,p.492) point out, "the process of bringing about massive functional changes in professional roles will be a slow and difficult one".

Nevertheless there are some relatively simple practical steps which can assist the integration of the nonprofessional into a mental health team. As far as is possible the nonprofessional's role should be carefully planned and developed, and explained in detail to the nonprofessional himself, as well as to all relevant staff members. Staff members should be given an opportunity to discuss and perhaps assist in the planning of the nonprofessional's role, and to relate it to their own functioning. In this way, the importance of the new role will hopefully be recognized and accepted by the staff, and achieve a degree of permanance. Careful specification of the nonprofessional's role will reduce the role ambiguity of the professional as well as of the nonprofessional, and will also facilitate the process of designing an appropriate training programme. It is important that ward and other relevant regular staff be included in the planning and discussion since otherwise they may, like the professional, be antagonistic to the use of nonprofessionals. Umbarger, Dalsiner, Morrison, and Breggin (1962) attribute much of this antagonism to jealousy of the time and opportunity which the

nonprofessional usually has for personal contact with patients. Regular staff may also fear accusations of incompetence from "outsiders" who do not understand the complexities of their work, and the possible creation of additional work resulting from the disruption of well-established routines. The involvement of regular staff in the planning and implementation of nonprofessional programmes can do much to allay these fears.

Retention of commitment to the community is a practical issue of particular relevance to the indigenous nonprofessional. There is a possibility that this commitment will be lost fairly rapidly following employment as a nonprofessional and association with professionals. Meyer (1969,p.45) claims that "If the professional controls as well as supervises the nonprofessional, we may expect the nonprofessional to be socialized toward professional orientations and norms, to be rewarded in terms of his adaption to them, and in this manner to become 'professionalized' at the expense of the very qualities that are supposed to represent his major source of effectiveness". Thus a shift in reference group could occur, with the indigenous nonprofessional now identifying with professionals rather than with persons of his own background. Goldberg (1969) even suggests that the indigenous nonprofessional will develop negative attitudes towards the poor, regarding them disdainfully as persons unable to cope as well as they. Riessman (1969,p.163), on the other hand, remains optimistic: "Actually, it generally takes people a long time to lose their knowledge and understanding of the ways, traditions, style, and language of their origin. And if they initially have some commitment, this concern will not fall away over night. Thus, the commitment and knowledge can remain even if immediate identification diminishes. Moreover, commitment

can be maintained by the reinforcement of it by the agency and the training staff... the agency... can reinforce and reward at every turn the nonprofessional's concern for his neighbourhood and the poor". As Riessman notes, commitment to the poor does not of necessity involve the complete retention of identification with the poor, and in fact, as was suggested in the discussion of the therapist-patient similarity issue (chapter 4), overidentification with the patient may interfere with the therapy process. Whether or not the indigenous nonprofessional loses his commitment to the poor is a matter which can only be decided by research. It is certain, however, that the position of the indigenous nonprofessional is frequently quite marginal: removed from the community and yet not a professional, if he attempts to serve community and agency simultaneously there will be times when the demands of two do not coincide, and he will experience role conflict.

The lack of psychological "sophistication" of many nonprofessionals is a further difficulty. The relatively untrained nonprofessional may feel inadequate and fail to inspire the confidence of his patient if he is asked to cope with particularly complex and demanding problems. He may be more prone than the professional to project his own difficulties on to the patient, to be excessively dependent, to panic at crucial moments, and to burden the patient with his own personal problems. The nonprofessional's attempts at therapy may at times seem superficial. Rioch, for example, comments that her housewife nonprofessionals frequently gave the impression of being either unable or unwilling to confront their patients. They tended to "pleasantly reassure, protect, and sympathize when it would be better to question more deeply and seriously... to try to deal on a surface, commonsense level with problems that are soluble only by

eliciting unconscious conflicts" (Rioch, Elkes, Flint, Usdansky, Newman, and Silber, 1963,p.688). To a degree it should be possible to counter this problem by utilizing careful selection and training procedures, but difficulties regarding psychological sophistication must realistically be expected in nonprofessional programmes. It is primarily for this reason that the ready availability of qualified supervision is desirable.

Problems involving sophistication and responsibility are likely to be particularly marked in programmes utilizing short-term volunteers or indigenous nonprofessionals. Short-term volunteers, with no future responsibility for the patient and no job or status to lose, will perhaps have a greater tendency to exploit their position to satisfy their own needs rather than those of the patient. Employed indigenous nonprofessionals, on the other hand, do have both a new job and new status, but they may nevertheless retain some of the problems associated with their background. Christmas, Wallace, and Edwards (1970,p.1482) comment on this possibility: "Life experiences of staff from the ghetto may lead to sears as well as strengths, evidenced at times... by a facade of indifference, hostility, and dependency or by absenteeism and 'beating the system'. In addition there are the realities of disruptive home life, frequent needs to attend to personal business during working hours, problems with child care, and personal bouts with alcoholism, family conflicts and financial stress". Again, while careful selection and training procedures should diminish problems of this kind, it is unlikely that they can ever be eliminated.

A final possible practical difficulty concerns the duration of peak effectiveness of the nonprofessional. If it is true that such qualities as enthusiasm, invovement, and positive expectancy are

essentially only initial responses to a challenging new life situation, then there is a danger that the effectiveness of the nonprofessional will decline as the novelty and challenge of his new role diminishes. Such a decline might be expected to be particularly rapid where the nonprofessional is exposed to a pessimistic institutional atmosphere. It would also be most marked for nonprofessionals utilized on a continuous full-time basis, such as indigenous nonprofessionals, and may have relatively little effect on short-term volunteers. To some extent it may be possible to sustain enthusiasm and involvement by continuing to engage the nonprofessional in new activities and experiences, as well as by ensuring that adequate professional and peer support is available to the nonprofessional. Clearly, this is an important issue deserving of careful research: does the effectiveness of nonprofessionals decline with time and, if so, when and by how much?

Chapter 7

CONCLUSION

To conclude the essay, an attempt is made at an overall evaluation of the value of the nonprofessional, followed by a summary listing of suggestions for future research.

1. The Value Of The Nonprofessional

It is difficult, at this early stage, to draw any definite conclusions regarding the value of the nonprofessional as a psychotherapeutic agent. But it can be safely said that nonprofessionals will not be a panacea. The limitations of nonprofessionals are likely to be especially apparent when they are used in institutional settings characterized by a custodial orientation, in which they may be little more than "a momentary breath of fresh air". Significant progress in such settings may well require a comprehensive, systematic therapeutic approach, with the goals of all staff members shifting from custodial to active patient-helping. The success of nonprofessional programmes is also endangered by the organizational and other practical difficulties discussed in the previous chapter. Careful consideration of these problems is essential if widespread feelings of discontent among nonprofessionals and professionals alike are to be avoided.

Nevertheless, when systematically selected and trained, and appropriately supervised, nonprofessionals should generally prove to be of substantial value as an addition to a mental health team. Some patients who have not responded well to professional treatment may react more favourably to contact with a nonprofessional. Nonprofessionals

typically provide a rather different kind of treatment, so that much of their value may come from their utilization as therapeutic agents complementary to the professional psychotherapist. In addition to the direct gains of the patient, a successful nonprofessional programme has much to offer to both the nonprofessionals themselves, and to professional staff. Nonprofessionals almost always enjoy and value their experience, and may well receive benefits of a more tangible nature through the operation of the "helper therapy principle". Possible gains to professional staff are illustrated by a quotation from Panzetta (1971,p.56), which refers particularly to the indigenous nonprofessional: "The introduction of the indigenous worker into the organizational life of a mental health centre carries with it the chance that the cultural ethos of that organization can be influenced. The chance may never be actualized if the indigenous person is placed in too peripheral a role. But given an important role, that person can bring the elements of the so-called culture of poverty into the organization's awareness". As well as sensitizing professional staff to the problems and expectations of the patient population, nonprofessionals may effectively improve staff morale, should their own characteristic enthusiasm and optimism be infectious. Thus the utilization of nonprofessionals can bring new perspectives and ideas to a therapy programme; it may involve a re-examination of the role of the professional, but this can be productive as well as painful.

2. Suggestions For Future Research

During the course of this essay a number of research suggestions have been made. These are now collected together and listed below.

The "helper therapy principle" (chapter 3)

(1) Are the results obtained with college students generalizable to other nonprofessional groups? (p.12).

(2) Are there varying patterns of gains among nonprofessionals? (p.13).

(3) Investigation of Riessman's (1965) claim that the helper therapy principle will be less effective once the helper realizes that he is being placed in a helping role in order to be helped himself (pp.14-15).

Review of the research literature (chapter 4)

(4) Research on the "matching" of patients and nonprofessionals, including further study of such combinations as male patients with young female nonprofessionals, and black emotionally disturbed boys with white companion-counsellors (pp.24-25,30-31,40,58).

(5) Are there differences in the characteristics of patients improving following contact with nonprofessionals and those improving after contact with professional therapists? Two studies noted a tendency, contrary to normal expectations with professionals, for more severely disturbed patients to improve the most from contact with nonprofessionals (pp. 25,31,40-41).

(6) Scarcity of process research: what do nonprofessionals actually do in their relationships with patients, which activities are the most helpful to patients, and does the pattern of activities change over time? (pp.31-32,41).

(7) Effects of variations in the motivation of nonprofessionals, for example of whether they receive money, academic credit, no extrinsic rewards, or are full-time employees (p.39).

(8) Do the patients of nonprofessionals have higher deterioration rates? (p.40).

(9) Do the patients of nonprofessionals have greater dropout rates? (p.40).

The indigenous nonprofessional (chapters 2,4, and 6)

(10) Do professional therapists approach the treatment of lower class patients with negative, pessimistic attitudes? Does the presence of such attitudes in itself affect treatment outcome? How might such attitudes be modified? (pp.43-44).

(11) Are indigenous nonprofessionals as effective as professionals, or as other nonprofessionals, with lower class patients? (pp.44-47).

(12) Does the indigenous nonprofessional lose his identification with, or commitment to, his community following employment as a nonprofessional and association with professionals? (pp.66-67).

(13) A more detailed and sophisticated investigation of the therapist-patient similarity issue (p.46).

Theoretical issues (chapter 5)

(14) Systematic investigation of patient perceptions of nonprofessionals. Rappaport, Chinsky, and Cowen's (1971) "Patient Expectations and Perceptions" scale is a beginning in this direction. Research on the "social" distance hypothesis" would involve a comparison of patient perceptions of professionals and of nonprofessionals, particularly in terms of their attributed authority and status. One method of doing this is to attempt to manipulate the perceived status of the nonprofessional (pp.23,26,49-51,56-57).

(15) Are patients more likely to identify with nonprofessionals than with professionals? Is this most likely to occur with certain kinds of patients, or of nonprofessionals? (p.52).

(16) Do patients perceive nonprofessionals as having a genuine, human interest in them? (p.54).

(17) Effects of the nonprofessional's freedom from the constraints of a professional role: these could be investigated by, for example, using professionals in a nonprofessional role (pp.55-56).

(18) Do the particular advantages of the nonprofessional vary with the patient group? Do they differ between institutionalized and noninstitutionalized patients? (pp.57-58).

The selection and training of nonprofessionals (chapter 6)

(19) More extensive research on the value of GAIT as a selection procedure for nonprofessionals (pp.27-28,60).

(20) Investigation of the effectiveness of various training programmes for both nonprofessionals and professionals. What kind and amount of training is desirable? How important are theoretical knowledge, personal qualities, and interpersonal skills to successful practice as a psychotherapist? (pp.60-62).

Practical difficulties (chapter 6)

(21) Detailed study of the "errors" made by nonprofessionals when acting as psychotherapeutic agents. Is responsibility a special problem with short-term volunteers? Do indigenous nonprofessionals retain problems associated with their background? (pp.67-68).

(22) Does the effectiveness of the nonprofessional diminish with time, as the challenge and novelty of the new role wears off? If so, when and by how much? (pp.68-69).

Research on these issues, if carefully conducted, would do much to rectify the current "evangelistic" character of the nonprofessional movement, and should enable nonprofessionals to be used more rationally and more effectively.

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