

Communicative Empathy in Paraprofessionals
Working in Telephone Crisis Intervention

by

Andrew A. Lubusko

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A thesis

presented to the University of Manitoba

in partial fulfilment of

the requirements for the degree of

Masters of Arts

in

Department of Psychology



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COMMUNICATIVE EMPATHY IN PARAPROFESSIONALS
WORKING IN TELEPHONE CRISIS INTERVENTION

BY

ANDREW A. LUBUSKO

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

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ABSTRACT

Therapeutic empathy is a multidimensional intra- and interpersonal construct believed to be highly important in therapy, counselling, and helping relationships. The present study was a preliminary investigation of the factors that predict communicative empathy (i.e., empathic responding) in paraprofessionals working in telephone crisis intervention. Factors such as telephone crisis intervention training, degree of crisis line experience, previous counselling experience and training, dispositional empathy (i.e., perspective taking, empathic concern, personal distress, and fantasy), and altruistic motivation were hypothesized to influence communicative empathy. Demographic factors (e.g., age, gender, and education) and social desirability (e.g., enhancement, denial, and impression management) were also hypothesized to be relevant predictors of communicative empathy. The present study employed a quasi-experimental design and compared 41 trained and 32 untrained crisis line paraprofessionals on communicative empathy. Trained paraprofessionals scored significantly higher than untrained subjects; however, the effect was small. Preliminary qualitative analyses suggest that trained and untrained subjects had different patterns of responses -- with untrained subjects giving more advice and reassurance, and trained subjects being more empathic, doing more problem-solving, and asking more questions. Significant predictors of communicative empathy included crisis training, studying/working in a counselling/health field, previous counselling training, age, enhancement, and altruistic motivation.

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INTRODUCTION

Empathy is a multidimensional construct that has been used to explain how a person understands and reacts to the emotional experiencing of another (Davis, 1994; Williams, 1990). The empathy construct embodies the characteristics of caring and understanding that are at the heart of altruism and human helping relationships. Empathy or "therapeutic" empathy is seen as a crucial variable in medicine, psychotherapy, counselling, and telephone crisis intervention (Burns & Nolen-Hoeksema, 1992; Davis, 1994; Everstine & Everstine, 1983; Horvath & Luborsky, 1993; Rogers, 1951, 1957). Therapeutic empathy is particularly important in telephone crisis intervention or crisis line counselling: The person who is in crisis or distress needs to feel "understood" or at least that the helper "is willing to try to understand his or her view of reality" (Everstine & Everstine, 1983, p. 30). The caller's most immediate need is often to talk with someone who cares and understands.

Therapeutic empathy is generally defined as the willingness and ability of the therapist (or counsellor) to understand -- cognitively and emotionally -- the psychological experiencing of the client and the ability of the therapist to communicate this understanding back to the client (Barrett-Lennard, 1962, 1981; Carkhuff, 1969; Martin, 1983; Rogers, 1951, 1957; Szalita, 1981; Truax, 1967; Truax & Carkhuff, 1967; Williams, 1990). Some definitions of therapeutic empathy also emphasize the willingness and ability of the client to receive that communication (e.g., Barrett-Lennard, 1962, 1981). These latter definitions view therapeutic empathy as a relational variable -- that is, as an important aspect of the therapist-client relationship.

Communicative empathy refers specifically to the therapist's demonstrated ability to communicate his or her understanding of the client's stated psychological experiencing back to the client (Barrett-Lennard, 1981; Szalita, 1981; Williams, 1990). The therapist

communicates this understanding through an empathic response which attends to both the cognitive and affective aspects of the client's statements. The empathic response can be viewed as an objective "interpersonal outcome" of therapeutic empathy (Davis, 1994). The formation of an empathic response is determined by a number of factors: the therapist's dispositional empathy, perspective-taking abilities and ability to "understand" the client's experiencing (i.e., interpersonal accuracy; attributional judgements), affective reactions towards the client's experiencing (i.e., compassion; sympathy), altruistic motivation, personal experience, and cultural background; the characteristics of the client, and the context of therapeutic situation (Carkhuff, 1967; Davis, 1994; Rogers, 1951, 1957; Szalita, 1981; Williams, 1990). In other words, communicative empathy is a measurable clinical skill which is influenced by a number of factors.

The present study represents a preliminary investigation of the relationships among the factors predictive of communicative empathy in paraprofessionals working in telephone crisis intervention. Factors hypothesized to predict communicative empathy include crisis intervention training, degree of crisis line experience, dispositional empathy, and altruistic motivation (Clary & Orenstein, 1991; Davis, 1983, 1994; Jimenez & Jimenez, 1990; Miller, Hedrick, & Orlofsky, 1991; Williams, 1990). Demographic factors such as age, gender, education, and previous training and social desirability (i.e., self-enhancement, denial, and impression management) may also be relevant predictors of communicative empathy (Jenkins, Stephens, Chew, & Downs, 1992; Lyons & Zingle, 1990; Paulhus & Reid, 1991; Rushton, Fulker, Neale, Nias, & Eysenck, 1986, 1989).

As background to this study, the history and a conceptual overview of the empathy construct will be reviewed, particularly as they relate to therapy and counselling. Davis' (1994) "organizational model" of empathy will be presented and emphasized as a useful

conceptual framework for the study of therapeutic and communicative empathy. Finally, empathy research relating to the training and selection of paraprofessionals working in telephone crisis intervention will be reviewed in the context of the organizational framework. The central theme of this introduction is that therapeutic empathy is a multidimensional construct that is important in the selection and training of crisis line volunteers and that communicative empathy represents an objective, measurable aspect of therapeutic empathy. Furthermore, communicative empathy is a teachable communications skill and is influenced by a number of factors.

THERAPEUTIC EMPATHY: HISTORICAL AND CONCEPTUAL BACKGROUND

Empathy is a multidimensional construct that has been used to explain how a person understands and responds to the emotional experiencing of another (Davis, 1994; Gladstein, 1984; Williams, 1990). Research on empathy has historically lacked a clear conceptual framework and has been confounded by several factors: oscillation between affective and cognitive conceptions of empathy, semantic and theoretical confusion between the terms "empathy" and "sympathy," and conceptual confusion between "process" and "outcome" measures of empathy (Davis, 1994; Eisenberg & Miller, 1987b; Gladstein, 1984; Gruen & Mendolsohn, 1986; Moore, 1990; Szalita, 1981; Williams, 1990; Wispé, 1987). Therapeutic empathy has been variously defined as a dispositional trait or attitude of the therapist, a cognitive process, an affective outcome, a communications skill, and a relationship variable (Barrett-Lennard, 1981; Carkhuff, 1969; Dryden & Ellis, 1988; Gladstein, 1984; Marcia, 1987; Rogers, 1957; Truax & Carkhuff, 1967; Williams, 1990).

The roots of the empathy construct lie in Ancient Greece and more recently in 19th century German aesthetic philosophy, constructivism, and hermeneutics (Davis, 1994; Gladstein, 1984; Mahoney, 1991; Meen, 1986). In Ancient Greece the term empathia referred to "an affective state encompassing qualities of affection, passion and suffering, and [also] a process of feeling-into another [italics added for emphasis]" (Meen, 1986, p. 9). Moreover, Aristotle stressed the importance of both logic (logos) and passion (pathos) -- cognition and emotion -- in human understanding and communication (Mahoney, 1991).

The term "empathy" was introduced into the English language in 1909 by Titchener who modeled it on the older conceptually different but related term, "sympathy" (see below; Davis, 1994; Gladstein, 1984). The word empathy was a direct translation of the German word Einführung, coined in 1885 by a contemporary of Freud's, Theodor Lipps (Gladstein,

1984; Szalita, 1981). In German aesthetic philosophy, empathy represented a theory of how people understood art (Gladstein, 1984). Lipps specified a psychological theory based on the premise that "every aesthetic object represents a living being and that, in contemplating a work of art, a person projects himself into that object and experiences a specific state of mind" (Szalita, 1981, pp. 3-4). Modern views of therapeutic empathy have also viewed it as "imaginatively placing oneself in the shoes of another person in such a way as permits sympathetic understanding of his mental life" (McKellar, cited in Szalita, 1981, p. 5).

Affective and Cognitive Conceptualizations

Conceptualizations of empathy have historically oscillated between affective and cognitive dimensions (Davis, 1994). For Lipps and Titchener empathy was an affective state in which the observer experienced -- in an attenuated form -- the affective state of the other (i.e., another person or artistic object) (Davis, 1994; Gladstein, 1984). Early views of empathy concentrated on the matching of affect between observer and observed through unconscious automatic mechanisms such as inner imitation and motor mimicry (Davis, 1994; Meen, 1986). Later views began to emphasize one's "understanding" and "active interpretation" of another's experience over the sharing of affective experience (Davis, 1994; Mahoney, 1991).

The conceptualization that "understanding" requires "active interpretation" was first stressed by William Dilthey in 1883, one of the founders of hermeneutics (Mahoney, 1991). Hermeneutics is based on the notion "that there are implicit meanings in the messages exchanged among humans" (p. 91). In order to "understand" human communication one has to "actively interpret" those messages (Gadamer, cited in Mahoney, 1991, p. 92). Hermeneutics stresses the importance of historical context and personal history in interpretation and understanding. A therapeutic interaction takes place in a specific historical

and cultural context; a therapist brings his or her personal history, learning experiences, and expectations into that therapeutic interaction.

Further cognitive conceptualizations of empathy were added through the independent but parallel works of developmental theorist Jean Piaget and sociologist George Herbert Mead (Davis, 1994; Gladstein, 1984; Meen, 1986). Mead stressed the individual's role-taking or perspective-taking ability -- the "capacity to take on the role of other persons as a means of understanding how they view the world" (Davis, 1994, p. 6). He considered perspective-taking ability to be crucial to the development of meaningful social organization (Davis, 1994; Gladstein, 1984). Piaget focused on the development of the ability to decentre in children -- that is, to differentiate between their own experiences and the experiences of others (Davis, 1994; Gladstein, 1984). Both constructs -- perspective taking and decentring -- emphasize cognitive processes in which people suppress their egocentric perspectives and imagine how the world appears to others.

The importance of the role-taking aspect of therapeutic empathy was stressed by Carl Rogers (1959). According to Rogers, therapeutic empathy involves the therapist's ability "to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition" (p. 210). Rogers was one of the strongest proponents of therapeutic empathy and viewed it as one of the necessary and sufficient conditions for successful psychotherapy and counselling (1951, 1957).

The "as if" quality of empathy distinguishes empathy from more passive and unconscious constructs such as identification and projection (Meen, 1986). The active "as if" notion of cognitive metarepresentation was first proposed by the philosopher Hans Vaihinger in 1911 (cited in Mahoney, 1991). Vaihinger stated that human consciousness is not a

"passive mirror," but an active, purposive, constructive process which moulds and transforms "external information" in order to more easily understand reality (pp. 98-99).

In recent years, affective definitions of empathy have again been emphasized (Davis, 1994; Eisenberg & Strayer, 1987; Gladstein, 1984; Gruen & Mendolsohn, 1986). These definitions of stress view empathy as an affective state of the observer that is congruent with the affective state of the other. Stotland, for example, defines empathy as "an observer's reacting emotionally because he perceives that another is experiencing or is about to experience an emotion" (cited in Davis, 1994, p. 7). Hoffman (1987) defines empathy "as an affective response that is more appropriate to another's situation than to one's own" (p. 53). Batson and his colleagues (e.g., Batson, Fultz, & Schoenrade, 1987) define empathy simply as "other-oriented feelings" of compassion in response to seeing the suffering of another person (p. 181). These definitions ignore the cognitive perspective-taking aspects of empathy and confound empathy with the term "sympathy" (Davis, 1994; Gruen & Mendolsohn, 1986).

Empathy and Sympathy

Historically, empathy has been often confused with the older, conceptually different but related term, "sympathy" (Davis, 1994; Gladstein, 1984; Gruen & Mendelsohn, 1986). Although most theorists tend to view the constructs as separate and different, the distinction has been difficult to maintain in the literature. The confusion stems from the fact that both of the terms carry overlapping meanings of other-oriented understanding and affective reactivity to another's emotional experiencing (Davis, 1994).

The original German definition of empathy or Einfühlung means "feeling into" (Szalita, 1981, p. 3) and refers to an active process of "knowing" another (Davis, 1994; Wispé, 1987). Empathy is conceptualized as a process that involves some cognitive effort on the observer's part (e.g., imagination, interpretation, or perspective-taking). Empathy is

the observer's attempt "to comprehend unjudgementally the [other's] positive and negative experiences" (Wispé, 1987, p. 18).

On the other hand, the original German definition of sympathy (Mitfuhlung) is "feeling with" (Szalita, 1981, p. 3). Sympathy is often viewed as a more passive process -- an almost automatic response of compassion to another's distress (Davis, 1994; Wispé, 1987). Wispé (1987) defines sympathy as an "awareness of the suffering of another person as something [negative that needs] to be alleviated" (p. 18). Sympathy is a feeling of compassion in the observer that stems from the observer's awareness or understanding of the other's distress (see next section; Davis, 1994).

Most theorists have viewed empathy and sympathy as separate but related constructs (Davis, 1994; Gruen & Mendolsohn, 1986). McKellar states that one can understand the other's emotions without "siding with" them (cited in Szalita, p. 12). Truax (1967) states that it is unnecessary that the therapist feel the emotions as the client feels them. He defines "accurate empathy" as involving "an appreciation of" and a "sensitivity to" the client's feelings and the ability to communicate that understanding back to the client in a language attuned to the client's feelings" (p. 555).

However, as indicated above, the distinction between empathy and sympathy has been difficult to maintain in the literature (Davis, 1994; Gruen & Mendolsohn, 1986; Wispé, 1987). Some researchers define empathy so broadly that it encompasses all human understanding and responses to the emotional experiencing of the other (Davis, 1994; Gruen & Mendolsohn, 1986). Others combine definitions of empathy and sympathy and refer to potentially confusing constructs such as "sympathetic understanding" (McKellar, cited in Szalita, 1981) and "empathic concern" (Davis, 1983, 1994). Batson and his colleagues (e.g., Batson et al., 1987) do not distinguish between empathy and sympathy and regard both terms as referring

to "other-oriented feelings of concern, compassion, and tenderness experienced as a result of witnessing another person's suffering" (p. 181).

As indicated above, empathy and sympathy are conceptually linked and carry overlapping meanings (Davis, 1994). Furthermore, empathy and sympathy are usually studied in the context of negative emotions -- in situations which likely to arouse feelings of compassion or distress in the observer (Davis, 1994; Batson et al., 1987; Gruen & Mendolsohn, 1986). Moreover, in the therapeutic setting (e.g., in-person psychotherapy or counselling; telephone crisis counselling), the client is almost always undergoing some form of emotional distress. An empathic therapist is expected to understand the client's experiencing and also to feel at least some compassion or tenderness towards the client (Rogers, 1951, 1957).

Process and Outcome Conceptualizations

The confusion between the constructs of empathy and sympathy highlights a much larger issue: confusion between "process" and "outcome" conceptualizations of empathy (Davis, 1994). According to Davis, the term "empathy" has historically been used to refer to two separate phenomena, cognitive perspective taking and affective reactivity to others. Definitions of empathy which focus on the "attempt to understand" another's cognitive or affective perspective (e.g., motor mimicry, perspective taking) are process-oriented definitions. Definitions of empathy and sympathy that stress affective reactions (e.g., compassion or personal distress) are outcome-oriented:

part of the definitional confusion regarding empathy results from the fact that theorists and researchers, while all studying "empathy," are in fact frequently addressing quite different parts of a larger phenomenon. . . . [F]ailing to distinguish between process and outcome . . . contributes to the ongoing confusion regarding the "true" nature of

empathy. (Davis, 1994, p. 11)

According to Davis, most researchers and theorists continue to mix cognitive and affective constructs in definitions of empathy and sympathy. He argues that sympathy ("empathic concern") is an outcome of process-empathy (i.e., affective perspective-taking processes) and involves "understanding" and compassion. Similarly, "understanding" another's thoughts (e.g., interpersonal accuracy; attributional judgements) is an outcome of cognitive perspective-taking processes (i.e., the "attempt" to understand).

Summary

Davis (1994) likens empathy research to the parable of the blind men studying an elephant: Each man is convinced that the part he is holding defines the "true" nature of the creature (p. 12). Empathy theorists have studied the same subject yet have reached "dramatically different conclusions" concerning the nature of empathy. Davis argues that the confusion regarding the "true" nature of empathy stems from the fragmented style in which the constructs of empathy and sympathy have been studied. Different traditions have focused on specific aspects of empathy (e.g., motor mimicry, cognitive perspective taking, cognitive understanding of others, affective reactivity to the emotions of others, altruism, etc.), have labelled those aspects "empathy" or "sympathy," and have ignored other conceptualizations. In other words, empathy research has lacked a clear organizational framework. Davis' "organizational" framework for the study of empathy is presented in the next section. Barrett-Lennard's (1981) model of therapeutic or relational empathy -- which complements the Davis model -- is also outlined.

EMPATHY: ORGANIZATIONAL MODELS

This section outlines two conceptual models that have been used in the study of empathy: Davis' (1994) "organizational" model of empathy and Barrett-Lennard's (1981) "empathy cycle" model of therapeutic or relational empathy. The organizational model outlined by Davis (1994) brings together the disparate fragments of empathy theory and research and creates a broad and well-defined conceptual framework for empathy research. Even though Davis limits his discussion of empathy to developmental and social psychology, the organizational model offers a useful framework for the study of therapeutic empathy and the study of the factors that predict communicative empathy.

Barrett-Lennard's (1962, 1981) empathy cycle has been one of the most extensive and well-researched models in clinical and counselling psychology (Horvath & Luborsky, 1993; Ivey, 1988; Martin, 1983; Orlinsky & Howard, 1986). As will be seen shortly, the Barrett-Lennard model complements and is congruent with the Davis model. Both models provide a framework for the study of communicative empathy.

Davis' (1994) Organizational Model

Davis (1994, pp. 12-21) outlines an organizational framework that synthesizes and organizes empathy theory and research into a logical, multidimensional, conceptual framework. Unlike the fragmented approaches that have characterized empathy theory and research, the organizational model emphasizes the "connectedness" of the constructs related to the study of empathy (Davis, 1994). Consequently, Davis defines "empathy" broadly:

. . . as a set of constructs having to do with the responses of one individual to the experiences of another. These constructs specifically include the processes taking place within the observer and the affective and non-affective outcomes which result from those processes. (p. 12)

Davis (1994) focuses on what he calls a typical empathy "episode" which consists "of an observer being exposed in some way to a target, after which some response on the part of the observer, cognitive, affective, and/or behavioral occurs" (p. 12). This prototypical episode consists of four constructs: antecedents, processes, intrapersonal outcomes, and interpersonal outcomes.

Antecedents

Antecedents are the "characteristics" of the observer (e.g., therapist or counsellor), target (e.g., client), or the situation that may potentially "influence both processes and outcomes" (e.g., communicative empathy) of the empathy episode (Davis, 1994, p. 12). Davis identifies two broad categories of antecedents: person variables and situation variables.

Person variables. Person variables include characteristics such as the observer's capacity for empathy (e.g., perspective-taking ability; affective reactivity capacity), previous learning history (e.g., "socialization of empathy-related values and behaviours" and cultural background), and individual differences in the tendency to engage in empathy-related processes [e.g., perspective taking] or to experience empathic outcomes [e.g., empathic concern, personal distress]" (Davis, 1994, p. 14). According to the philosopher Hans-Georg Gadamer (cited in Mahoney, 1991, p. 92), "understanding" arises from the interaction of the target's message (i.e., the text) with the personal history and experience (Erfahrung) of the observer.

Several individual difference measures of empathy have been developed (e.g., Davis, 1980, 1983; Hogan, 1969; Mehrabian & Epstein, 1972). These measures assess stable individual characteristics "which influence the likelihood of engaging in empathy-related processes or experiencing an empathy-related outcome during any particular empathy episode" (Davis, 1994, p. 14). Measures of dispositional empathy will be reviewed in the next section.

Situation variables. According to Davis (1994) every empathy episode occurs in a "specific situational context" (e.g., a face-to-face encounter, a telephone encounter, watching the target on television, or reading about the target in the newspaper). These specific situations vary along two dimensions: strength of the situation (e.g., a strong display of negative emotion by a weak or helpless target) and the degree of similarity between the target and the observer (pp. 14-15). Greater observer-target similarity is associated with increased affective and nonaffective empathic responding in observers (Staub, 1987). Furthermore, certain target characteristics are associated with poor therapeutic empathy (Horvath & Luborsky, 1993). These include difficulty maintaining social and family relationships, extreme hopelessness, poor object relations, defensiveness, and lack of psychological mindedness. Symptom severity however seems to have little "impact on the ability to develop a good therapeutic relationship" (p. 567).

Processes

Processes are the "mechanisms" that generate empathic outcomes in the observer (Davis, 1994, p. 12). Davis identifies three broad classes of empathy-related processes, differentiated by the level of cognitive ability and sophistication required for their operation: noncognitive, simple cognitive, and advanced cognitive processes.

Noncognitive processes include primary circular reactions (e.g., the tendency of newborn babies "to cry in response to hearing other infants cry") and motor mimicry (i.e., the tendency for observers to automatically and unconsciously imitate the facial and body cues of the target) (Davis, 1994, p. 15). Lipps and Titchener believed that motor mimicry leads to shared affect between the observer and the target (Davis, 1994; Gladstein, 1984; Hoffman, 1987, 1990).

Simple cognitive processes require at least some cognitive ability on the part of the

observer (Davis, 1994). These include classical conditioning and direct association (i.e., previous experience with a given stimulus may evoke emotional states in the observer); and labelling (i.e., "the observer uses simple cues to infer something about the target's experience") (Davis, 1994, p. 16). An example of labelling is the simple association that the presence of tears usually means that the target is experiencing sadness.

Finally, advanced cognitive processes include language mediated association and perspective taking (Davis, 1994; Hoffman, 1987). In language mediated association, the observer's reaction to the target's situation is produced by an activation of the observer's "language-based cognitive networks which trigger associations with the observer's own feelings or experiences" (Davis, 1994, p. 16). For example, a client who says "I've lost my job" may not exhibit any obvious signs of distress (e.g., facial or vocal cues). Nevertheless, an "observer may respond empathically because personal relevant memories are activated by the target's words" (p. 16). This process is cognitively more complex than direct association or labelling. According to Hoffman (1987):

Empathy aroused by nonverbal and situational cues can be mediated by largely involuntary, cognitively shallow processing modes (mimicry; conditioning). Empathy aroused by verbal messages from the victim or by one's knowledge about the victim requires more complex processing, such as language-mediated association or putting oneself in the other's place. (p. 52)

The most complex cognitive process is perspective taking, in which the observer tries to "understand another by imagining the other's perspective" (Davis, 1994, p. 17). Perspective-taking ability is comprised of three dimensions: perceptual, the ability to imagine the literal visual perspective of another; cognitive, the ability to imagine the thoughts and motives of another; and affective, the ability to infer the emotions of another (Davis, 1994,

p. 7). Cognitive and affective perspective-taking abilities are important elements of therapeutic empathy: effective communicative empathy attends to both the client's thoughts and emotions (Carkhuff, 1969; Dryden & Ellis, 1988; Martin, 1983; Rogers, 1951, 1957; Truax, 1967).

Intrapersonal Outcomes

Intrapersonal outcomes are "the cognitive and affective responses produced in the observer which are not manifested in overt behavior toward the target" (Davis, 1994, p. 12). Davis identifies two categories of intrapersonal outcomes: affective and non-affective.

Affective outcomes are "the emotional reactions experienced by an observer in response to the observed experiences of the target" (Davis, 1994, p. 17). These affective outcomes are subdivided into two categories: parallel and reactive outcomes.

Parallel affective outcomes are the affective reactions of the observer that are "congruent, but not necessarily the same as, that of the target" (Davis, 1994, p. 18). Reactive affective outcomes are affective reactions of the observer that "differ from the observed affect" of the target (p. 18). Reactive outcomes are "empathic reactions to another's state" and include reactions such as sympathy, feelings of compassion, or empathic concern. Feelings of anger and distress are also included in this category. Empathic anger refers to the anger that observers sometimes experience in response to witnessing another being maltreated. Personal distress refers to "the tendency to feel discomfort and anxiety in response to needy targets" (p. 18).

Parallel outcomes usually result from simpler cognitive processes such as motor mimicry and tend to be self-centred in nature (e.g., distress) (Davis, 1994, p. 19). Reactive outcomes require "some higher order processing to recognize and interpret the target's cues" and tend to be other-oriented (e.g., sympathy or empathic anger) (p. 19).

Non-affective outcomes are primarily cognitive phenomena such as interpersonal accuracy -- "the successful estimation of" the target's "thoughts, feelings, and characteristics," usually resulting from cognitive and affective perspective-taking processes; and attributional judgements or explanations for the target's behaviour (Davis, 1994, p. 19).

Interpersonal Outcomes

Interpersonal outcomes are "defined as behaviours directed towards a target which result from prior exposure to that target" (Davis, 1994, p. 19). The three areas which have attracted the most attention from empathy theorists and researchers are helping behaviour (i.e., how "cognitive and affective facets of empathy" contribute "to the likelihood of observers offering help to needy targets"), aggressive behaviour (i.e., the negative association between "empathy-related processes and dispositions" with aggressive actions) and the role of empathy in social relationships (i.e., the association between empathy-related processes and dispositions with relationship-enhancing behaviours) (p. 19). As has been indicated previously, communicative empathy is an interpersonal outcome of the therapeutic relationship, a communication skill that is influenced by the factors that make up the construct of therapeutic empathy.

Summary

The need for a multidimensional approach to the study of empathy has been advocated by many empathy researchers and theorists over the years (Barrett-Lennard, 1981; Davis, 1980, 1983, 1994; Eisenberg & Fabes, 1990; Eisenberg & Miller, 1987a, 1987b; Hoffman, 1987; Williams, 1990). Until recently, the area has lacked a clear conceptual framework by which to tackle this issue (Davis, 1994; Williams, 1990). The Davis organizational model offers a logical, conceptual framework for the study of empathy in a number of contexts and through a multidimensional approach.

The Empathy Cycle, the Organizational Model, and Communicative Empathy

Barrett-Lennard (1981) identified a 5-stage model of the empathy process in the therapeutic and counselling situation. The five steps of the empathy cycle of therapeutic or relational empathy include: an empathic attentional set, empathic resonance, expressed empathy, received empathy, and feedback. Barrett-Lennard's model is discussed in the context of Davis' (1994) organizational model and communicative empathy.

Empathic attentional set. The first of the five steps of Barrett-Lennard's (1981, p. 90) empathy cycle involves the manifestation of an "empathic attentional set" -- an openness to the psychological experience of another's reality -- which creates the "possibility" of an empathic process. The therapist's attentional set refers to the antecedent variables outlined in Davis's (1994) model such as the therapist's dispositional empathy, altruistic motivation, personal history, learning experiences, cultural background, and expectations. In hermeneutic terms, the therapist brings all of these elements into the empathy episode in order in order to interpret the client's experience (Gadamer, cited in Mahoney, 1991; Szalita, 1981).

The situation (i.e., the therapeutic setting), situational variables (e.g., therapist fatigue or anxiety), and the characteristics of the client (e.g., similarity to the therapist) will all affect the therapist's empathic set (Davis, 1994; Szalita, 1981; Williams, 1990).

Empathic resonance. Phase 1 empathy -- "empathic resonance" -- occurs when the helper "reads or resonates to" the client such that the client's directly or indirectly conveyed experience becomes "experientially alive, vivid, and known to" the helper (Barrett-Lennard, 1981, p. 90). Empathic resonance for the most part refers to the processes aimed at understanding the client's experience (i.e., direct association, labelling, and perspective taking). The therapist actively interprets the client's message (Mahoney, 1990; Szalita, 1981; Williams, 1990).

The "empathic resonance" construct also encompasses the cognitive and affective intrapersonal outcomes associated with empathy, such as understanding and affective reactivity (e.g., feelings of compassion) (Davis, 1994). The therapist uses these intrapersonal outcomes to generate an empathic response to the client.

Expressed empathy. Phase 2 -- "expressed empathy" -- occurs when the helper communicates in some manner a "quality of felt awareness" of the client's experience (Barrett-Lennard, 1981, p. 90). Barrett-Lennard's "expressed empathy" is congruent with communicative empathy as defined in the present study and refers to an interpersonal outcome of empathy. Communicative empathy involves "the ability to translate into meaningful verbal and nonverbal language a conceptualization of the [client's] experience" (Williams's, 1990, p. 167). The formation of this empathic response depends on the therapist's having available a variety of life experiences (see above), perspective-taking abilities, interpersonal accuracy, and attributional judgements (Barrett-Lennard, 1978; Szalita, 1981; Williams, 1990).

Empathic responsiveness seems to depend upon the availability and variety of our own experiences, which facilitate the emergence of images. . . . Empathy also depends on the degree of precision of perception, which determines the selection of a response or idea that is appropriate to the immediate situation. (Szalita, 1981, p. 12)

Furthermore, in order to select an empathic response and also to express it appropriately, the therapist needs to be "free of anxiety" or at least "able to tolerate whatever anxiety he [or she] is experiencing" (Szalita, 1981, p. 12). As indicated above, personal distress is one of several intrapersonal outcomes associated with empathy (Davis, 1994). Freedom from anxiety or distress allows the therapist to decentre, to separate his or her own feelings from those of the client, and to attend to the client's experiencing more objectively (Szalita, 1981).

Received empathy. Phase 3 of the empathy cycle -- "received empathy" -- refers to the step in the empathy cycle in which the client attends sufficiently to the helper's response to perceive the degree of the helper's understanding (Barrett-Lennard, 1981, p. 90). The client's perception of the therapist's empathy has been found to be one of the strongest predictors of therapy outcome (Gurman, 1977; Martin, 1983). The most commonly used instrument to measure client perceptions is Barrett-Lennard's Relationship Inventory (RI) (1962, 1978). The RI includes items that reflect critical client perceptions of the therapist's empathy. Examples of RI items include: "He may understand my words but he does not see the way I feel" and "He realizes what I mean even when I have difficulty in saying it" (Barrett-Lennard, 1978).

Therapist empathy, especially as perceived by the client, is strongly related to the therapeutic alliance, the collaborative working relationship between the therapist and client (Burns & Noel-Hoeksema, 1992; Horvath & Luborsky, 1993; Orlinsky & Howard, 1986). The alliance is a general relationship factor believed to be responsible for therapeutic change across all forms of therapy. According to Horvath and Luborsky (1993), empathy appears to be primarily associated with the early stages of the alliance which require the development of "collaboration and trust" (p. 567). In this phase, "the client needs to join the therapist as a participant in the therapeutic journey, agree on what needs to be accomplished, and develop faith in the procedures that provide the framework of the therapy" (p. 567). Early alliance measures are significantly correlated with measures of empathy as well as outcome (Burns & Noel-Hoeksema, 1992; Horvath & Luborsky, 1993; Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990).

As indicated above, some characteristics of the client -- for example, difficulty with social relationships, a lack of psychological mindedness, and defensiveness -- may interfere

with the client's responsiveness to therapeutic empathy and empathic communication (Horvath & Luborsky, 1993).

Feedback, fresh expression, and resonation. The final step in the cycle involves the continuation of the client's self-expression. The client provides the helper with feedback which confirms or corrects the helper's view of the client's experience (Barrett-Lennard, 1981, p. 90). Assuming that the helper's empathic set is sustained, the cycle then returns to the second step with expanded or new content. Consequently, the fifth step is referred to as "feedback, fresh expression, and resonation."

The empathy cycle is similar to the hermeneutic circle identified by Gadamer (cited in Mahoney, 1991). The client's new statements add to the therapist's ongoing understanding and interpretation of the client's experiencing; the therapist communicates that ongoing understanding to client; and the client confirms or corrects that expression.

Summary

Barrett-Lennard's (1981) empathy cycle is congruent with the organizational framework outlined by Davis (1994). Both models provide a conceptual framework for the study of therapeutic empathy. The empathy cycle emphasizes the relational nature of therapeutic empathy and the importance of the client's perceptions of the therapist's empathic communication. The empathy cycle expands on the interpersonal dimension of the Davis model and provides a dynamic conceptualization of the therapeutic (communicative) empathy process. The Davis model clearly delineates the antecedents, processes, and outcomes associated with the empathy construct. These factors all influence communicative empathy. Therapeutic empathy is primarily an interpersonal relationship variable; communicative empathy is an interpersonal outcome of therapeutic empathy. Communicative empathy is also an objective, measurable communications skill which can be taught through didactic and

experiential means (Martin, 1983).

Both Davis and Barrett-Lennard emphasize the need for a systematic approach to empathy research (Barrett-Lennard, 1981; Davis, 1994). Like Davis, Barrett-Lennard argues that each phase of the empathy cycle requires its own unique measurement and research. The next section will review the research on empathy, its development, relationship with helping behaviour, measurement, relationship between therapy and counselling outcome, and training (i.e., communicative empathy). The following section will focus on research related to the study of empathy, paraprofessionals, and telephone crisis intervention.

EMPATHY RESEARCH, MEASUREMENT, AND TRAINING

The primary areas which have investigated empathy are developmental psychology, social and personality psychology, and clinical and counselling psychology (Davis, 1994; Gladstein, 1984; Eisenberg & Strayer, 1987; Williams, 1990; Wispé, 1987). The present section briefly reviews the research on the development of empathy, the relationship between empathy and altruism and helping behaviour, the relationship between empathy and therapy and counselling, the measurement of empathy, and on the training of communicative empathy.

The Development of Empathy

Human developmental psychology research on empathy has focused on how humans' capacity to react emotionally to others interacts with their developing cognitive abilities to produce empathic responses such as concern for others and perspective taking and how these empathic responses change over the lifespan (Barnett, 1987; Davis, 1994; Gladstein, 1984; Hoffman, 1987, 1990; Zahn-Waxler & Radke-Yarrow, 1990).

Hoffman (1987, 1990) has outlined an extensive, research-based theory on the development of empathy. According to Hoffman, children progress through several stages of empathic behaviour. Initially children are more self-centred and their empathic abilities are limited to basic processes (e.g., primary circular reactions, motor mimicry, classical conditioning, and direct association). Due to a lack of self-other differentiation, very young children experience distress when they witness others who are distressed. Sympathetic distress develops around age 2 years when children begin to have a clear self-other distinction. They make attempts to engage in helping behaviour, but these efforts are usually inappropriate due to a lack of role-taking abilities. After about age 3, children develop simple language-mediated association and role-taking abilities -- and appropriate helping behaviour begins to develop. Children's cognitive and affective perspective-taking abilities become

more sophisticated as children mature into adolescence and adulthood. According to Hoffman (1987), the adult can "look beyond situational cues to life conditions" and "can empathize with abstract categories" (p. 54).

The development of perspective-taking abilities is associated with feelings of warmth and compassion and negatively associated with personal distress when witnessing a distressed other (Davis, 1994).

Empathy and Altruism

Considerable research in social psychology has investigated the role of empathy in altruistic motivation and helping behaviour (Davis, 1994; Eisenberg & Miller, 1987a, 1987b; Gladstein, 1984; Staub, 1987). Empathy is seen as a relatively stable personality trait (e.g., empathic concern) that mediates altruistic motivation and helping behaviour (Davis, 1994; Clary & Orenstein, 1991). How empathy mediates helping, however, remains controversial. For some researchers empathy is linked to an "altruistic personality" trait; for others empathy mediates altruistic or egoistic motivation to help.

Altruistic personality. Consistent research findings suggest that individual differences in helping exist (Davis, 1994). These differences are not completely explained by differences in empathy and point to the existence of an "altruistic personality" trait (Batson et al., 1986; Bierhoff et al., 1991; Oliner & Oliner, 1988; Rushton et al., 1986, 1989). Early evidence for the relationship between personality factors and helping came from a study by Staub (1974) which recorded the helping or nonhelping behaviour of observers who had completed a series of personality measures. Helpfulness was positively associated with social responsibility and moral judgement and negatively with Machiavellianism (i.e., attitudes and tendency to exploit others for personal gain). More recent research suggests that the altruistic person believes in a just world, is socially responsible, internally oriented, and empathic (Bierhoff et al., 1991;

Oliner & Oliner, 1988).

Empathy and altruism. Research and meta-analyses show a positive relationship between empathy (i.e., perspective taking and empathic concern) and helping behaviour (Batson, Bolen, Cross, & Neuringer-Benefiel, 1986; Bierhoff, Klein, & Kramp, 1991; Clary & Orenstein, 1991; Davis, 1994; Eisenberg & Miller, 1987a, 1987b). Nevertheless, the mechanism by which empathy and helping are linked is poorly understood. Perspective-taking ability is seen as a necessary but insufficient factor for helping (Clary & Orenstein, 1991). Current research suggests that empathy facilitates helping behaviour through affective reactivity (i.e., empathic concern and personal distress) (Clary & Orenstein, 1991; Davis, 1994; Eisenberg & Fabes, 1990; Eisenberg & Miller, 1987a). Empathic concern has been linked to both altruistic motivation (Clary & Orenstein, 1991) and egoistic motivation (Batson et al., 1986). In altruistic motivation, people help because they feel sympathy or compassion for the other's distress. They may also help because they believe (or want to believe) that they are caring, helpful individuals. In egoistic motivation, people help others because they feel distressed by the other's distress or because they feel guilty about not helping. They help in order to alleviate their own distress. Potential "distressed" helpers are less likely engage in helping if they view that the target's neediness results from factors under the target's control (i.e., blaming the victim). Egoistic helpers may also help if there are extrinsic rewards for helping (e.g., being seen by others as helpful).

The Measurement of Empathy: Dispositional Empathy and Altruistic Motivation

People obviously differ in their capacities for perspective taking and affective reactivity (Davis, 1983, 1994; Hoffman, 1987, 1990) and in their motivation (altruistic or egoistic) to help others (Clary & Orenstein, 1991; Davis, 1994). A number of measures assessing dispositional empathy and altruistic motivation have been developed.

Dispositional Empathy

The measures of dispositional empathy that have been developed reflect different views of empathy (e.g., cognitive, affective, or both). In this section, three self-report measures of dispositional empathy are reviewed. Measures of altruistic motivation, the role of demographic factors, and a measure of socially desirable responding are also examined.

Hogan Empathy Scale. The Hogan Empathy Scale (HES; 1969) is a cognitive measure of empathy. Hogan views empathy as "the intellectual or imaginative apprehension of another's condition or state of mind without actually experiencing that person's feelings. Empathy refers only to the act of constructing for oneself another person's mental state [italics added for emphasis]" (p. 308). The HES contains 64 items mostly derived from the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943) and the California Psychological Inventory (CPI; Gough, 1964). Although the HES has relatively good reliability and validity its use has not been widespread (Davis, 1994; Eisenberg & Miller, 1987a).

Emotional Empathy Scale. The Emotional Empathy Scale (EES) developed by Mehrabian and Epstein (1972) has received considerable research attention and, until recently, was the most commonly used measure of empathy (Davis, 1983, 1994; Dillard & Hunter, 1989; Eisenberg & Miller, 1987a). The 33-item EES treats empathy as a tendency to respond emotionally to the experiences of others and measures a variety of possible emotional reactions experienced by the respondent (e.g., compassion, anger, fear, etc.). The heterogeneity of emotional reactions tapped by EES suggests that it is a global measure of emotionality (Davis, 1994).

The results of a recent factor analysis by Dillard and Hunter (1989) strongly suggest that the EES lacks construct validity: There appears to be no consistent underlying factor

structure to the scale. Consequently, previous research which has used this scale becomes difficult to interpret. Dillard and Hunter suggest that researchers use the Interpersonal Reactivity Index (IRI), a four-factor measure of empathy, developed by Davis (1980, 1983) as a more valid alternative.

Interpersonal Reactivity Index. The 28-item Interpersonal Reactivity Index (IRI) measures both cognitive and affective dimensions of empathy (Davis, 1980, 1983, 1994). The IRI is composed of four subscales: empathic concern (EC), "the tendency to express warmth, compassion, and concern for other people"; perspective taking (PT), "the tendency to adopt the point of view of other people in everyday life"; personal distress (PD), "feelings of personal unease and discomfort in reaction to the emotions of others"; and fantasy (FS), "the tendency to transpose oneself into the feelings and actions of fictitious characters in books, movies, and plays" (Davis, 1983, p. 117). EC and PD are believed to measure affective empathy capacities; PT and FS measure cognitive capacities. The IRI scales are differentially related to unidimensional measures of empathy, intelligence, social competence and interpersonal functioning, self-esteem, emotionality, sensitivity to others, and intelligence.

Empathic concern (EC) is positively associated with measures of emotionality, warmth, and non-selfish concern for others (Davis, 1983, 1994). The scale is positively correlated with the Mehrabian and Epstein EES and moderately correlated with PT and FS. It is weakly associated with self-esteem, shyness, and anxiety. EC is negatively correlated with boastfulness, egotism, and loneliness. Finally, EC is negatively associated with antagonistic hostility (i.e., assault, verbal hostility) in females (Siegman, Dembroski, & Ringel, cited in Davis, 1994).

Perspective taking (PT) is associated with better social functioning, self-esteem, unselfish sensitivity to others, bargaining success, and more democratic conflict resolution in

couples (Davis, 1983, 1994). The scale is associated with the cognitive Hogan Empathy Scale and only moderately with the emotion-oriented EES. Finally, PT is negatively associated with antagonistic hostility (i.e., assault, verbal hostility) in males, fearfulness, "self-centred" awareness of others, and loneliness (Siegman et al., cited in Davis, 1994).

EC and PT are both associated with warmth, consideration of others feelings, altruistic helping, greater tolerance for stigmatized groups (e.g., homosexuals), and interpersonal accuracy (Davis, 1983, 1994). Individuals who rate high on EC and PT and low on PD are seen as better communicators as assessed by tendencies to "opening up" and "readily listening" to others (Davis & Oathout, cited in Davis, 1994).

Personal Distress (PD) is associated with lower self-esteem, poor interpersonal functioning (i.e., shyness and social anxiety), and loneliness (Davis, 1983, 1994). The scale is positively associated with neurotic hostility (e.g., resentment, suspicion) in males. PD is negatively correlated with the cognitive Hogan Empathy Scale and positively with the EES. Finally, PD is negatively associated with PT.

Fantasy (FS) scores are related to verbal intelligence, emotional reactivity, sensitivity to others, and some measures of social dysfunction (Davis, 1983, 1994). The scale is positively associated with the EES and EC and is unrelated to measures of self-esteem and social functioning. The FS scale has not received as much research attention as the EC, PT, and PD scales.

The IRI scales have satisfactory internal and test-retest reliability (Davis, 1980, 1983). Internal reliability ranges from .71 to .78; test-retest reliability ranges from .62 to .81 over a two-month period. Davis and Franzoi (1991) report substantial test-retest associations for the IRI scales over a two-year period in a study of adolescents (from .50 to .62). The four scales also have satisfactory convergent and discriminant validity (Davis, 1983, 1994; Dillard &

Hunter, 1989).

Altruistic Motivation

A number of investigators have developed self-report measures of altruism and altruistic motivation. Rushton, Chrisjohn, and Fekken (1981) developed the Self-Report Altruism (SRA) scale, a 20-item measure of stable individual differences in altruism. Individuals rate the frequency with which they have engaged in a variety of altruistic behaviours. Examples of SRA items include "I have helped push a stranger's car out of the snow" and "I have given directions to a stranger" (p. 297). The scale appears to have good validity and is correlated with other ratings of altruism (e.g., peer-ratings).

Measure of Altruistic Motivation. Clary and Orenstein (1991) recently developed a measure of altruistic motivation (The Measure of Altruistic Motivation; MAM) to be used with crisis counselling volunteers. The MAM lists 25 possible reasons for volunteering to perform crisis counselling. Five of the items represent altruistic reasons (e.g., "a chance to help others"); the remaining items represent egoistic reasons (e.g., "personal growth") (Clary & Orenstein, 1991, p. 63).

Demographic Factors

A number of demographic factors appear to be associated with dispositional empathy and possibly communicative empathy. These include gender, age, and intelligence (Cummings & Murray, 1990; Davis, 1994; Hoffman, 1987, 1990; Rushton et al., 1986, 1989).

Gender. Females tend to score higher on measures of emotional empathy (i.e., affective reactivity) such the Mehrabian and Epstein EES and the EC and PD scales of the Davis IRI (Davis, 1994). Females also score higher on PT but the difference is not as great. Males are also reported to be more aggressive and less altruistic than females (Rushton et al., 1986, 1989). There is considerable disagreement in the literature whether these results

indicate real sex differences (e.g., that females are more empathic) or the presence of sex-role stereotypes (Davis, 1994). Our culture tends to value emotional sensitivity in females and rational objectivity in males. These standards are often internalized and the "obviousness" of many self-report empathy measures (e.g., "I feel sad when I see somebody get hurt") may lead both sexes to endorse items in a sex-role appropriate manner. Females may endorse more emotional empathy items because they wish to be seen as empathic (i.e., impression management), because they believe they are more empathic (i.e., self-deception enhancement), or both. Paulhus and Reid (1991) found self-deception to differentially related to self-report empathy measures (see "Socially Desirable Responding" below).

Age. Another demographic factor associated with empathy and altruism is age (Rushton et al., 1986, 1989). As indicated above, children's cognitive and affective perspective-taking abilities increase with age into adolescence and adulthood (Davis, 1994; Hoffman, 1987, 1990). As adults age and gain more life experiences, their ability to empathize with a wider range of emotions and experiences appears to increase (Davis, 1994; Rushton et al., 1986, 1989). Prosocial (altruistic) tendencies also appear to increase with age while aggressive ones appear to decline (Rushton et al., 1986).

Intelligence. A final factor that may be relevant to empathy research is intelligence. Although measures of empathy are generally unrelated to intelligence (with the exception of the FS scale on the Davis IRI), perspective-taking ability nevertheless requires an advanced level of cognitive ability (Davis, 1994; Hoffman, 1987, 1990). Perspective-taking tendencies vary widely; intelligence however may set an upper limit for perspective-taking ability. Cummings and Murray (1990) have found that communicative empathy involves a "global" empathy factor which can be broken down into two smaller factors that the investigators suggest may correspond to Performance and Verbal categories of intelligence. Intelligence

(as measured by standardized tests of intelligence) is associated with higher levels of education and occupation (Kaufman, 1990).

Socially Desirable Responding

There are two broad classes of socially desirable responding -- impression management and self-deception (Paulhus, 1994; Paulhus & Reid, 1991). Impression management refers to "the tendency to give favourable self-descriptions to others" (Paulhus & Reid, 1991, p. 307). Paulhus and Reid found that impression management was related to perspective taking (on the IRI) and unrelated to fantasy, empathic concern, and personal distress. Self-deception refers to "the tendency to give favorably biased but honestly held self-descriptions" (p. 307). Self-deception is composed of two distinct factors -- self-deceptive enhancement, "the claiming of positive attributes" and denial, "the repudiation of negative attributes" (p. 307). Enhancement appears to be associated with psychological health -- high self-esteem, low social anxiety, and low IRI personal distress. Denial is correlated with empathic concern and perspective taking on the IRI.

Balanced Inventory of Desirable Responding. Developed by Paulhus (1994), the Balanced Inventory of Responding (BIDR Version 6) is a 60-item questionnaire with three (20-item) scales: Impression Management (e.g., "I always declare everything at customs"), Self-Deceptive Enhancement (e.g., "My first impressions of people usually turn out right"), and Self-Deceptive Denial (e.g., "I could never enjoy being cruel"). The BIDR is a well-validated measure with excellent validity and reliability (Paulhus, 1994). Internal consistencies for self-deception (SD) range from .70 to .82; internal consistencies for impression management (IM) range from .80 to .86. Test-retest reliabilities for SD and IM are .69 and .77, respectively. Research indicates that the BIDR scales have good convergent and discriminant validity (see Paulhus, 1994, for a review).

Summary

Research on empathy in developmental and social psychology has focused on how humans' empathic abilities develop over the lifespan and how they are associated with altruistic motivation and helping behaviour (Davis, 1994). Human empathic abilities and behaviours develop over the lifespan -- proceeding from egocentric and basic mechanisms to advanced cognitive processes and altruistic behaviours (Hoffman, 1987, 1990). The development of perspective-taking abilities is associated with feelings of warmth and compassion and negatively associated with personal distress when witnessing a distressed other (Davis, 1994).

Research findings suggest that empathy (i.e., empathic concern and perspective taking) is a relatively stable personality trait that mediates altruistic motivation and helping behaviour: Empathy may be linked to an "altruistic personality" trait and may mediate altruistic/egoistic motivation to help. Perspective taking and empathic concern are associated with helping behaviour (Clary & Orenstein, 1991; Davis, 1994). Affective reactivity (i.e., empathic concern and personal distress) may facilitate helping behaviour: People may help others because they feel sympathy for them (altruistic motivation) or to alleviate their own distress or guilt (i.e., egoistic motivation); egoistic helpers may also help if there are extrinsic rewards for helping (e.g., being seen as helpful).

A number of measures have been developed to measure individual differences in perspective taking, affective reactivity, and motivation (altruistic or egoistic) to help others (Clary & Orenstein, 1991; Davis, 1994). The Interpersonal Reactivity Index (IRI; Davis, 1983, 1994) measures four aspects of empathy -- perspective taking, empathic concern, personal distress, and fantasy. Empathic concern and perspective taking are associated with warmth, consideration of others feelings, altruistic helping, and interpersonal accuracy (Davis,

1983, 1994). Personal distress is associated with lower self-esteem, poor interpersonal functioning, and loneliness (Davis, 1983, 1994). Individuals who rate high on empathic concern and perspective taking and low on personal distress are seen as better communicators as assessed by tendencies to "opening up" and "readily listening" to others (Davis & Oathout, cited in Davis, 1994). The Measure of Altruistic Motivation (MAM; Clary and Orenstein, 1991) measures altruistic or egoistic motivation in crisis counselling volunteers. Altruistic motivation is associated with empathic concern and perspective taking and negatively associated with distress.

Demographic factors such as age, gender, and intelligence appear to be associated with dispositional empathy and possibly communicative empathy. Females tend to score higher on measures of emotional empathy -- empathic concern and personal distress. Another demographic factor is age: As adults age and gain more life experiences, their ability to empathize with a wider range of emotions and experiences appears to increase; prosocial (altruistic) tendencies also appear to increase with age while aggressive ones appear to decline (Davis, 1994; Rushton et al., 1986, 1989). A final factor that may be relevant to empathy research is intelligence: Although measures of empathy are generally unrelated to intelligence, perspective-taking ability does require an advanced level of cognitive ability (Davis, 1994; Hoffman, 1987, 1990). Intelligence may set an upper limit for perspective-taking ability. Standardized tests of intelligence are associated with higher levels of education and occupation (Kaufman, 1990).

Finally, the "obviousness" of many self-report empathy measures (e.g., "I feel sad when I see somebody get hurt") may lead people to endorse items in biased ways -- for example, in order to be seen as empathic by others (i.e., impression management). The Balanced Inventory of Responding (BIDR Version 6; Paulhus, 1994) measures three types of

socially desirable responding: Impression management (i.e., the tendency to give favourable self-descriptions to others), self-deceptive enhancement (i.e., the tendency to claim positive attributes), and self-deceptive denial (i.e., the tendency to deny negative attributes). Impression management is associated with IRI perspective taking, self-deceptive enhancement is negatively associated with IRI personal distress, and self-deceptive denial is correlated with IRI empathic concern and perspective taking (Paulhus & Reid, 1991).

Volunteers who work in telephone crisis intervention and other community services vary widely in terms of their demographic characteristics (age, gender, education), empathic tendencies and abilities, and motivations for volunteering. All of these factors appear to be important in communicative empathy and in the selection and training of crisis-line volunteers. The training of empathic communication skills is reviewed in the next section.

Therapeutic Empathy, Communicative Empathy, and Helping Relationships

The working relationship or therapeutic alliance between a client and therapist is one of the most important variables in effective therapy and counselling, irrespective of underlying therapeutic orientations and interventions (Burns & Nolen-Hoeksema, 1992; Horvath & Luborsky, 1993; Orlinsky & Howard, 1986). Therapeutic empathy -- the therapist's ability to understand the client's psychological experiencing and to communicate that understanding back to the client -- is a key component of the client-therapist relationship (Barrett-Lennard, 1962, 1978, 1981; Carkhuff, 1969; Marcia, 1987; Martin, 1983; Patterson, 1984; Rogers, 1951, 1957; Szalita, 1981; Truax, 1967; Truax & Carkhuff, 1967; Williams, 1990). As indicated previously, therapeutic empathy appears to be related to the early phases of the therapeutic alliance (Horvath & Luborsky, 1993).

Considerable research evidence suggests that therapeutic empathy is a crucial factor in numerous helping relationships including psychotherapy (Barrett-Lennard, 1981; Burns &

Nolen-Gladstein, 1977; Hoeksema, 1992; Horvath & Luborsky, 1993; Marcia, 1987; Martin, 1983; Patterson, 1984; Szalita, 1981), counselling (Carkhuff, 1969; Cummings & Murray, 1990; Gladstein, 1977; Lyons & Zingle, 1990; Meen, 1986), medicine (Kramer, Ber, & Moore, 1989; Weihs & Chapados, 1986; Wolf, Wooliscroft, Calhoun, & Boxer, 1987), and nursing (Herbek & Yammarino, 1990; La Monica, Wolf, Madea, & Oberst, 1987; Williams, 1990).

As indicated above, Rogers (1951, 1957) viewed therapeutic empathy as one of the basic conditions needed for successful therapy. Early research on therapeutic empathy and therapeutic outcome suggested that empathy was an important factor in successful therapy (Truax & Carkhuff, 1967; Patterson, 1984). Gladstein (1977) found that the relationship between empathy and outcome was demonstrated more consistently in psychotherapy than in counselling. He concluded that empathy is crucial in counselling only when the counselling situation resembles psychotherapy and that empathy is "much less helpful in educational/vocational counseling or other non-psychotherapy processes" (1977, p. 76). The content and the emotional intensity of the situation (e.g., client distress) are important factors in empathy-outcome research (Marks & Tolsma, 1986).

Later reviews suggested that empathy had only a minimal effect on outcome (e.g., Gurman, 1977; Lambert, DeJulio, & Stein, 1978; Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978). Patterson (1984) reanalysed several reviews and concluded that in many cases the authors were biased against empathy and that there in fact was clear evidence suggesting a strong relationship between empathy and outcome. According to Marks and Tolsma (1986) conclusions that therapeutic empathy was minimally relevant to outcome were premature given the fact that empathy research has been poorly organized. For example, conclusions about client-perceived empathy and outcome were drawn exclusively from

measures of therapist's dispositional empathy (e.g., Parloff et al., 1978). Marks and Tolsma (1986) argued that therapeutic empathy is a multidimensional construct that needs to be studied in a systematic manner and with a clear underlying conceptual framework. As has been noted previously, the lack of a clear, conceptual framework has been a long-standing problem in empathy research.

Barrett-Lennard (1981) argued that, given the multidimensional nature of therapeutic empathy, "theoretically there is no reason to expect" (p. 95) close relationships between the various aspects of the construct (e.g., therapist understanding and client-perceived empathy). Kurz and Grummon (1972) found that client-perceived empathy (assessed by Barrett-Lennard's RI in the third session of therapy) showed the strongest relationship to outcome (indicated by the MMPI; Hathaway & McKinley, 1943; the Tennessee Self-Concept Scale; Fitts, 1965; and therapist and client evaluation). Tape-judged communicative empathy (assessed by Carkhuff's Empathic Understanding in Interpersonal Process scale; Carkhuff, 1969) was moderately correlated with outcome. Other measures of empathy, including therapist self-ratings, were unrelated to outcome. Gurman (1977) reviewed the outcome literature and concluded that client-perceived empathy was a better predictor of outcome than tape-judged empathy; Lambert et al. (1978) concluded that client-perceived and tape-judged empathy are equally good predictors of therapeutic outcome.

More recent reviews again suggest that "there is very strong evidence" that therapist empathy is related to outcome when empathy is measured "as perceived by" clients and when observers' "ratings of empathy are related to specifically objective measures of outcome" (Orlinsky & Howard, 1986, p. 344). Therapist's ratings of their own empathy, however, are poorly related to outcome. The latter occurs because many therapists either overestimate their own empathy or else claim to have uniform levels of empathy for all clients, both of which

reasons make outcome research difficult.

Burns and Noel-Hoeksema (1992) recently demonstrated that therapeutic empathy on its own has a very strong impact on clinical recovery in clients undergoing cognitive behavioral therapy for depression. "The patients of therapists who were the warmest and most empathic [as rated by the patients] improved significantly more than the patients of the therapists with the lowest empathy ratings, when controlling for initial depression severity, homework compliance, and other factors" (p. 447). Specifically, therapeutic empathy showed a robust correlation with score reductions on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

Finally, the importance of empathy in other helping relationships, for example, in medicine and nursing, has also been demonstrated (Herbek & Yammarino, 1990; Kramer et al., 1989; La Monica et al., 1987; Weihs & Chapados, 1986; Williams, 1990; Wolf et al., 1987). For example, La Monica and her colleagues (1987) found that higher empathy in nurses was associated with decreased levels of patient's hostility and anxiety. Patients also reported less depression and greater satisfaction with nursing care, although these latter findings were not statistically significant.

In summary, there is ongoing support for the position that the effectiveness of psychotherapy and counselling is related to the degree that the therapist or counsellor communicates empathy to the client (Burns & Nolen-Hoeksema, 1992; Lyons & Zingle, 1990; Orlinsky & Howard, 1986). The effects of empathy on client recovery may be direct or indirect: "Empathy per se may have mood elevating effects. Alternatively, therapeutic empathy may mobilize patients' motivation to help themselves, which in turn leads to improvements in depression" (Burns & Nolen-Hoeksema, 1992, p. 441).

Communicative Empathy

Although less-studied in its relation to therapeutic outcome, therapists' communicative empathy appears to be positively associated with outcome (Barrett-Lennard, 1981; Ehrlich, D'Augelli, & Danish, 1979; Meen, 1986; Orlinsky & Howard, 1986). Ehrlich and his colleagues (1979) studied six verbal response types utilized by counsellors and psychotherapists in a counselling analogue study. They found that those responses that emphasized the affective content of client communication facilitated productive interview behaviour and enhanced subsequent ratings of therapist attractiveness, expertness, and trustworthiness. Cognitively and behaviorally focused activities (i.e., advice giving, persuading) reduced or left these perceptions unaffected. Similar outcomes have been reported in actual clinical interactions (e.g., Wenegrat, cited in Orlinsky & Howard, 1986). The present section reviews the literature on the training and measurement of communicative empathy.

Training

In the training of therapists, counsellors, or paraprofessionals, a great deal of emphasis is often placed on the training of empathic communication skills (Carkhuff, 1969; Jimenez & Jimenez, 1990; Miller et al, 1991; Mishara & Daigle, 1992; Young, 1989). Rogers (1951, 1957, 1979) felt that therapeutic empathy could only be learned experientially, through watching and listening to client-therapist interactions, practising role-playing exercises, and participating in individual therapy or encounter groups. Communicative empathy is an objective, interpersonal outcome of therapeutic empathy, a communications skill that can be taught in a number of ways (Carkhuff, 1969; Lambert & Stein, 1984; Meen, 1986; Truax, 1967; Truax & Carkhuff, 1967). A number of early studies indicated that sensitivity training enhanced communicative and client-rated empathy (Meen, 1986). More systematic training

approaches were developed in the 1960's (Carkhuff, 1969; Ivey, 1988; Meen, 1986; Truax, 1967; Truax & Carkhuff, 1967; Carkhuff, 1969). The approach used by Truax and Carkhuff (1967) emphasized both didactic and experiential training. Didactic experiences included modelling, descriptions and examples of response rating, rating of response formulations to taped expressions, role-plays, etc. Truax and Carkhuff (1967) believed that empathy training involves discrimination of empathy levels and communication at facilitative levels.

Martin and Carkhuff (cited in Carkhuff, 1969) found that graduate counselling students who received 45 hours of training to have gained significantly in empathy as rated by judges, clients, and themselves. Gormally, Hill, Gulanick, and McGovern (cited in Meen, 1986) found significant gains in written communicative empathy among subjects who received 40 hours of training. Gantt, Billingsley, and Giordano (1980) found that a 10 week interviewing course increased discrimination of empathic responses by students in a paraprofessional helper training program.

In recent years, a number of effective programs have been developed to train communicative empathy to a wide variety of groups -- psychology and counselling students, crisis-counselling volunteers, medical students, nurses, and hospice volunteers (Gazda et al., 1984; Herbek & Yammarino, 1990; Jimenez & Jimenez, 1990; Kramer et al., 1989; La Monica et al., 1987; Weihs & Chapados, 1986; Williams, 1990; Wolf et al., 1987). Effective programs that teach communicate empathy emphasize demonstrations, modelling, feedback, role-playing, paraphrasing (i.e., restating the client's statement in one's own words), reflecting (i.e., communicating a deep understanding of the client's thoughts and feelings), and nonjudgemental communication (Clary & Orenstein, 1991; Jimenez & Jimenez, 1990; Meen, 1986).

Measurement

A number of measures have been developed to facilitate the training and evaluation of communicative empathy. Many of the investigators cited above have developed specific measures for work with specific populations. For example, La Monica (La Monica et al., 1987) developed her measure in order to teach communicative empathy to nurses; Gazda (Gazda et al., 1984) developed her measure in order to train school counsellors. Measures developed for the training of therapists and counsellors include the Accurate Empathy Scale (AE) (Truax, 1967), the Empathic Understanding in Interpersonal Processes (EU) scale (Carkhuff, 1969), and the Helpful Responses Questionnaire (HRQ) (Miller et al., 1991).

Empathic Understanding in Interpersonal Processes. Developed by Carkhuff (1969), the EU scale is the scale most frequently used in the measurement and training of communicative empathy (Ivey, 1988; Martin, 1983; Meen, 1986). Carkhuff (1969) modeled the scale on previous communicative empathy scales such as the AE (Truax, 1967). The EU scale reduces some of the ambiguity associated with the previous scales and is designed to be applicable to all human relations. The EU scale provides a more objective measure of communicative empathy that is scored by trained judges who rate oral or written statements on a 5-point Likert rating scale (Carkhuff, 1969). A 3 response is rated as being interchangeable in terms of content and affect with the client's statement. Responses rated below 3 are deemed to detract from clients' expression; responses rated above 3 are enhancements of clients' concerns or expressions. The scale has good reliability and validity (Carkhuff, 1969; Ivey, 1988), correlates adequately with measures of empathy (including Barrett-Lennard's RI), and is predictive of empathic behaviour in a variety of clinical settings. The EU scale has good test-retest reliability (Carkhuff, 1969) and correlates adequately with other measures of empathy and empathic behaviour in a variety of clinical settings (Carkhuff, 1969; Ivey, 1988). However, despite its popularity and apparent validity, the EU has been

strongly criticized for using vague and subjective scoring criteria (Marks & Tolsma, 1986; Meen, 1983; Stein & Lambert, 1984).

Helpful Responses Questionnaire. The use of paper-and-pencil measures of empathy and empathic sensitivity is common in research on the effectiveness of the training of empathy (e.g., Carkhuff, 1969; Gantt, Billingsley, & Giordano, 1980; Gazda et al., 1984; Jenkins et al., 1992; Miller et al., 1991; Williams, 1990). Paper-and-pencil skill-oriented measures of communicative empathy generally have good test-retest and inter-rater reliability (Cummings & Murray, 1990). The Helpful Responses Questionnaire (HRQ; Miller et al., 1991) is a standardized instrument developed specifically for use in training and assessing communicative empathy in volunteer crisis counsellors. Miller et al. (1991) found that HRQ scores rose significantly following a 2-day workshop on empathic communication and crisis intervention skills in a sample of 190 paraprofessional trainees. The measure is similar to other well-validated paper-and-pencil measures and appears to have good reliability. Inter-rater coefficients for items range from .71 to .91 and reliability for total HRQ scores is .93.

On the HRQ, subjects respond to six written "paragraphs that simulate communications from individuals with specific concerns" (Miller et al., 1991, p. 444). The situations presented in the HRQ are similar to those encountered in "real life" crisis counselling situations. As in the EU scale, subjects' responses are rated by trained judges on a 5-point rating scale -- where responses below 3 detract from the client's message and responses above 3 enhance the client's message. However, unlike the EU, the HRQ utilizes very specific scoring criteria, which makes the scale more reliable and objective.

Summary

Communicative empathy is an important aspect of helpful relationships such as therapy and counselling. Communicative empathy is a communications skill which can be increased through a variety of training procedures (e.g., modelling, role-playing, direct instruction) and which can be assessed by a variety of means (e.g., client reports, objective ratings, and self-reports). The following section will briefly review the literature on empathy, telephone crisis intervention, and paraprofessional/volunteer counsellors.

EMPATHY AND TELEPHONE CRISIS INTERVENTION

Trained volunteers or paraprofessionals are being used more and more often in mental health service delivery. The increased use of volunteers has been spurred by the rising fiscal constraints in mental health services and the proven effectiveness of paraprofessionals in the delivery of mental health services (Gantt et al., 1980; Glass & Hastings, 1992; Spitz & MacKinnon, 1993). In fact, many mental health services currently available would be unavailable without the help of trained volunteers (Spitz & MacKinnon, 1993). One mental health service which has grown to depend extensively on trained volunteers is telephone crisis intervention (Garland & Zigler, 1993). The present section briefly reviews the literature on crisis theory, telephone crisis intervention, altruistic motivation, and empathy.

Crisis Theory and Intervention

A crisis can be defined as any event which pushes an individual "into a state of disequilibrium or imbalance" (Martin, 1991, p. 730). It is a "time-limited" condition characterized by "distress and disorganization" (Janosik, 1994, p. 17). However, a crisis is also an "opportunity" for growth and development.

The Chinese ideogram for crisis is translated to mean both danger and opportunity. Crisis does not pose a threat to the individual which does not place her equilibrium and her sense of self in jeopardy. Yet, each crisis also provides the individual with the opportunity to grow even though the growth may involve pain. (Klinic Crisis Training Reading Manual (KCTRM), 1993, p. 62)

Successful resolution of a crisis can improve an individual's coping abilities.

A crisis can be developmental or situational in nature (Janosik, 1994). Developmental crises are "universal" stages through which most people have to pass at various points in their lives. Starting a new school, moving out from home, and getting married are examples of

developmental tasks which may lead to crisis. Situational crises, on the other hand, are unpredictable events unrelated to developmental tasks. Examples of situational crises include accidents, natural disasters, and the sudden death of a loved one. Crises are conceptually linked to stress and emergency situations; however, the latter do not readily offer the opportunity for "growth potential" found in successful crisis resolution. According to Janosik (1994), a crisis can be conceptualized as an acute stress in which the individual's coping abilities break down.

Crises often involve actual and or perceived loss. For example, moving to a new city means the loss of old connections. Even though the client may exaggerate or misperceive a loss, "it is essential for crisis workers to accept the client's viewpoint" (Janosik, 1994, p. 22). They must be able to understand how the client sees the situation.

Telephone Crisis Intervention

Telephone crisis intervention is a form of secondary prevention (Caplan, 1964) in that it aims to identify and treat aspects of mental illness before they become exacerbated (Everstine & Everstine, 1983). "Secondary crisis prevention consists of early intervention with persons in crisis in order to restore equilibrium promptly and reduce the severity of distress" (Janosik, 1994, p. 33). "Early identification is an important preventive measure, because it implies the discovery of pathology before it becomes exacerbated, or symptoms before they are compounded into syndromes, or even difficulties before they escalate into problems" (Everstine & Everstine, 1983, p. 12).

In North America, the 24-hour crisis line has become a major mental health service (Garland & Zigler, 1993; Green & Wilson, 1988; Mishara & Daigle, 1992; Stein & Lambert, 1984). There are over 1000 crisis intervention centres in North America, most of which are staffed by trained volunteers (Garland & Zigler, 1993; Mishara & Daigle, 1992). Even

though the effectiveness of crisis lines has been questioned -- in terms of the ability to prevent suicide (Garland & Zigler, 1993; Hirsch, 1981; Stein & Lambert, 1984) -- there is general agreement that crisis lines provide a valuable, cost-effective service (Garland & Zigler, 1993; Green & Wilson, 1988; Hirsch, 1981; Janosik, 1994; King, 1977; Mishara & Daigle, 1992). Crisis lines appeal to callers because of the callers' anonymity and perceived control of the interaction (i.e., they can hang up the telephone anytime) (Garland & Zigler, 1993). According to Miller, Coombs, and Leeper (1984), crisis lines reduce suicide rates among young White women, who are also the most frequent users of suicide prevention services (Shaffer, et al., 1990).

Crisis line workers deal with countless crisis and non-crisis situations and provide information and support to many individuals (Mishara & Daigle, 1992; Stein & Lambert, 1984; Young, 1989). Research suggests that most callers (67%) are satisfied with crisis line services (Stein & Lambert, 1984; Young, 1989) and that the competence of crisis line workers compares favorably with that of mental health professionals (Green & Wilson, 1988; Hirsch, 1981).

Training, Selection, and Communicative Empathy

Given the cost-effectiveness of telephone crisis intervention and the fact that paraprofessionals provide useful assistance, the number of crisis lines in North America will likely continue to increase (Garland & Zigler, 1993; Mishara & Daigle, 1991; Stein & Lambert, 1984). Furthermore, more paraprofessionals will be utilized in mental health service delivery and will likely work with more vulnerable populations (e.g., children, the mentally ill) (Spitz & MacKinnon, 1993). Concomitant with the growing utilization of trained volunteers in mental health services, there is increasing public pressure to ensure that paraprofessionals are well screened and well trained before being allowed to engage in service

delivery (Spitz & MacKinnon, 1993; Stein & Lambert, 1984). There is, however, little research on the selection and training of paraprofessionals working in telephone crisis intervention (Stein & Lambert, 1984).

Therapeutic empathy is a crucial factor in helping relationships, including the crisis line relationship (Everstine & Everstine, 1983; Green & Wilson, 1988; Greenstone & Leviton, 1993; Janosik, 1994). The person in crisis needs to feel "understood" or at least that the helper "is willing to try to understand his or her view of reality" (Everstine & Everstine, 1983, p. 30). The caller's most immediate need may be to talk with someone who cares and understands. Consequently, investigation of the factors that predict communicative empathy in crisis line workers is crucial. The selection of empathic volunteers (i.e., volunteers who demonstrate high communicative empathy) and the development of effective training programs (i.e., programs that teach communicative empathy skills) are key concerns for agencies utilizing paraprofessionals in telephone crisis intervention (Clary & Orenstein, 1991; Janosik, 1994; Miller et al., 1991; Mishara & Daigle, 1992; Stein & Lambert, 1984).

Most programs that train crisis line workers emphasize the importance of empathic communication skills (Carkhuff, 1969; Everstine & Everstine, 1983; Green & Wilson, 1988; Greenstone & Leviton, 1993; Jimenez & Jimenez, 1990; Miller et al., 1991; Mishara & Daigle, 1992; Young, 1989). Empathic and non-judgemental communication skills are the most important skills learned by volunteers (Jimenez & Jimenez, 1990).

Furthermore, crisis line workers engage in a variety of behaviours -- many of which are congruent with communicative empathy. Mishara and Daigle (1992) investigated the types of responses used by telephone crisis volunteers in two crisis centres in Quebec. The most common types of responses were acceptance, "acknowledged understanding of the caller's statement"; orientation-investigation, "asking direct questions"; information-suggestion-

counselling, providing information and advice; reflection, "repeating what the caller said in a 'Rogerian' style"; and clarification-interpretation (Mishara & Daigle, 1992, p. 27). Acceptance, reflection, and clarification-interpretation are all aspects of communicative empathy.

However, a number of studies have also demonstrated that crisis line volunteers are more directive and somewhat less empathic than nursing students or psychotherapists (McCarthy & Knapp, 1984; Ryden, McCarthy, Lewis, & Sherman, 1991). Untrained individuals were found to be the least empathic: They did not listen, gave advice, failed to explore problems, and were very judgemental. The fact that crisis interveners are more directive is not surprising given that the crisis situation requires the volunteer to gather information and provide emotional support to a caller in a short time period. However, given that most crisis line workers are taught empathic communication skills in training, it is reasonable to expect experienced volunteers to have good communicative empathy skills.

Altruistic Motivation and Crisis Counselling

Clary and Orenstein examined the influence of helpers' motives and abilities on the amount and the effectiveness of a long-term altruistic activity (e.g., crisis counselling). The commitment of "egoistic" crisis counselling volunteers increases with the presence of situational benefits; altruistic volunteers maintain a high rate of commitment regardless of variations in situational benefits (Clary & Miller, 1986). Clary and Orenstein (1991) used the Measure of Altruistic Motivation (MAM) to assess altruistic motivation and the Davis Interpersonal Reactivity Index (IRI; Davis, 1980, 1983) to assess empathic understanding in 161 crisis counselling volunteers. Volunteers with lower levels of altruistic motivation terminated volunteer service sooner than those with higher levels. Clary and Orenstein used the perspective taking (PT) scale of the Davis IRI as a measure of perspective-taking ability.

They argued that even though the PT scale measures empathic tendency, the definition of PT is congruent with Rogers' (1951) idea of empathy. High scores of PT are associated with more accurate performance in person perception tasks (Bernstein & Davis, cited in Clary & Orenstein, 1991). Volunteers screened from the volunteer program because they were judged as lacking in counselling abilities after training (e.g., "ability to paraphrase, reflect feelings, make nonjudgemental responses, and become aware of and communicate the caller's thoughts, feelings, and behaviors," p. 60) reported lower levels of PT than did volunteers who completed their commitment or who terminated early on their own. Altruistic motivation was correlated with empathic concern but not with PT. One limitation of the Clary and Orenstein study is the lack of an objective measure of communicative empathy.

Summary

Paraprofessionals are being utilized more and more in helping areas. One such area is telephone crisis intervention. Crisis lines represent a major form health service delivery in North America and rely heavily on trained volunteers in order to provide service. With the increased use of trained volunteers in mental health service delivery, there is increasing public pressure that volunteers be well-screened and well-trained before being allowed to serve the community. There is, however, a paucity of research on the selection and training of effective crisis line volunteers.

Although the nature of crises varies considerably, what the person in crisis most often needs is someone to talk to -- someone willing and able to listen. Skills in listening and in empathic communication are emphasized in the training of paraprofessionals working in crisis counselling and telephone crisis intervention. Consequently, the selection of empathic and altruistic volunteers and the training of empathic communication skills are important factors in telephone crisis intervention.

OVERALL SUMMARY AND STATEMENT OF PROBLEM

Communicative empathy is conceptualized as an objective, interpersonal outcome of therapeutic empathy and a teachable communication skill. Therapeutic empathy is an important aspect of successful helping relationships such as psychotherapy, counselling, and crisis intervention. As has been explored in the preceding sections, communicative empathy may be influenced by factors such as therapists' dispositional empathy, personal experience, and cultural background. The selection of empathic and altruistic counsellors is an important research area for agencies utilizing paraprofessionals in mental health service delivery.

The present study is a preliminary investigation of the factors that predict communicative empathy in paraprofessionals working in telephone crisis intervention. Factors such as telephone crisis intervention training, degree of crisis line experience, dispositional empathy (perspective taking, empathic concern, personal distress, and fantasy), and altruistic motivation are hypothesized to influence communicative empathy. Demographic factors (e.g., age, gender, education, and counselling previous training) and social desirability (e.g., impression management, self-deceptive enhancement, and self-deceptive denial) may also be relevant predictors of communicative empathy. The present study employed a quasi-experimental design and compared 41 trained and 32 untrained crisis line paraprofessionals on communicative empathy. The relationships between variables that best predict communicative empathy were also analyzed.

HYPOTHESES

Based on the literature review and the author's personal experience as a telephone crisis line volunteer, the following hypotheses were advanced:

Hypothesis 1: Effect of Telephone Crisis Intervention Training on Communicative Empathy

Trained volunteers will demonstrate higher levels of communicative empathy (as measured by HRQ rating scale) than untrained volunteers.

Hypothesis 2: Relationship Between Predictor Variables and Communicative Empathy

After controlling for demographic and biased responding variables, it is expected that crisis intervention training, telephone crisis intervention experience, perspective taking, empathic concern, personal distress, and altruistic motivation will significantly predict communicative empathy.

Hypothesis 3: Relationships Between Predictor Variables

Crisis line training and experience will be positively correlated with perspective taking, empathic concern, and altruistic motivation, and negatively correlated with personal distress.

Ancillary Hypotheses

Based on the review of the existing research literature, several ancillary hypotheses were entertained. These were, for the most part, predictions based on existing literature.

Dispositional empathy. Perspective taking will be positively associated with empathic concern and negatively with personal distress; empathic concern will be positively associated with fantasy (Batson et al., 1986; Clary & Orenstein, 1991; Davis, 1983).

Altruistic motivation. Empathic concern will be positively associated with altruistic motivation (Clary & Orenstein, 1991).

Desirable responding. Perspective taking will be positively associated with self-

deceptive enhancement, self-deceptive denial, and impression management; empathic concern will be positively associated with denial; and personal distress will be negatively associated with enhancement and impression management (Paulhus & Reid, 1991).

Demographic variables. Females will have higher empathic concern and perspective taking and lower personal distress. Age will be positively associated with perspective taking, empathic concern and negatively associated with personal distress.

METHOD

Subjects

A total of 73 subjects were recruited for this study. A self-selected sample of 41 trained crisis line volunteers were recruited from a pool of volunteers currently operating the telephone crisis lines at Klinik Community Health Centre in Winnipeg, Manitoba, Canada. A self-selected sample of 32 untrained Klinik volunteers served as a comparison control group for this study. These untrained volunteers were recruited from a pool of potential volunteers who were awaiting crisis intervention training at Klinik (see Procedure section).

Klinik is a community health centre that provides medical, counselling, and community services. Currently, there are 65 paid staff and approximately 150 volunteers working at Klinik. Telephone crisis intervention is part of the counselling services offered by Klinik. The crisis lines are staffed by trained volunteers and full-time counsellors and provide services 24 hours a day, 7 days a week to callers in the Winnipeg metropolitan area.

Klinik crisis line volunteers receive approximately 60 hours of training over a 2 month period. Upon completion of training, volunteers are required to work one 4-hour shift per week for a minimum of 12 months. Volunteers are also required to work 6 overnight (midnight to 8:00 a.m.) shifts during their first six months. Experienced volunteers have the opportunity to supervise and train new volunteers and to do in person counselling.

Instruments

Demographic Information Questionnaire

A brief demographic questionnaire was designed to obtain the following information: subject age (in years), gender, marital status, ethnic background, education (in years), occupation, field of study (if students), previous counselling training and experience (in months), and crisis line experience (how many months at Klinik, if applicable). The

Demographic questionnaire is presented in Appendix A.

Interpersonal Reactivity Index (IRI)

The IRI is an individual difference measure of empathy (Davis, 1980, 1983). The 28-item self-report measure consists of four separate subscales: Perspective Taking (PT), "the tendency to adopt the point of view of other people in everyday life" (e.g., "I believe that there are two sides to every story and try to look at them both"); Fantasy (FS), "the tendency to transpose oneself into the feelings and actions of fictitious characters in books, movies, and plays" (e.g., "When I watch a good movie, I can very easily put myself in the place of a leading character"); Empathic Concern (EC), "the tendency to experience feelings of warmth, compassion, and concern for people" (e.g., "I would describe myself as a pretty soft-hearted person"); and Personal Distress (PD), "feelings of personal unease and discomfort in reaction to the emotions of others" (e.g., "I tend to lose control during emergencies") (Davis, 1983, p. 117). Respondents indicate the degree to which the items describe them on a 5-point Likert scale (1 = does not describe me well; 5 = describes me very well). Each scale consists of 7 items and the scale scores range from 0 to 28. The IRI is presented in Appendix B.

Balanced Inventory of Desirable Responding

The Balanced Inventory of Desirable Responding (BIDR Version 6; Paulhus, 1994) is a 60-item questionnaire with three (20-item) scales: Self-Deceptive Enhancement, "the claiming of positive attributes" (e.g., "My first impressions of people usually turn out right"); Self-Deceptive Denial, "the repudiation of negative attributes" (e.g., "I could never enjoy being cruel"); and Impression Management, "the tendency to give favourable self-descriptions to others" (e.g., "I always declare everything at customs") (Paulhus & Reid, 1991, p. 307). The BIDR uses either a 5- or 7-point Likert format. Respondents indicate how well the given statements describe them (e.g., 1 = not true; 5 or 7 = very true).

Twenty-one items were randomly selected from the BIDR (7 items from each scale) and appended to the end of the Davis IRI in the questionnaire package. This procedure was warranted given the exploratory nature of the present study. The selected items appear in Appendix C.

Measure of Altruistic Motivation

The Measure of Altruistic Motivation (MAM; Clary & Orenstein, 1991, p. 61) is a 25-item list of possible reasons for volunteering to perform crisis counselling. The scale was slightly modified in order to be applicable to Klinik and the province of Manitoba. To assess altruistic motivation, subjects are asked to indicate their 5 most important reasons for volunteering at Klinik in order of importance. The ranks are then reverse-scored, the most important altruistic reason receiving a score of 5 and the least important a reason of 1. Volunteers' altruistic motivation score consists of the sum of the reversed ranks of the altruistic reasons included in their top 5 reasons. If an altruistic response is ranked first, it gets a score of 5, second 4, third, 3, etc. Only altruistic reasons are scored. Scores on the scale range from 0 (egoistic reasons only) to 15 (altruistic reasons only). This scale is provided in Appendix D.

Helpful Responses Questionnaire (HRQ)

The Helpful Responses Questionnaire (HRQ; Miller et al., 1991) is a standardized instrument developed specifically for use in training and assessing communicative empathy in volunteer crisis counsellors. It is a brief free-response questionnaire measuring "the ability to generate empathic statements" (p. 444). The questionnaire presents the subject with "six paragraphs that simulate communications from individuals with specific concerns" (p. 444) and are similar to situations encountered in "real life" crisis counselling situations. For example, a parent says that she is worried about her teenage daughter staying out late at night.

The subject is asked to write a response to each scenario; the responses are then rated for their level of communicative empathy. Subjects' scores can be compared individually for each vignette or can be summed to provide a global communicative empathy score. The HRQ is provided in Appendix E.

Scoring. Subject responses on the HRQ are scored on a 5-point Likert-type scale by trained raters and is similar to Carkhuff's (1969) Empathic Understanding (EU) rating scale. Unlike the EU, HRQ has relatively clearly defined scoring criteria which removes the ambiguity and subjectivity associated with the EU and provides a more objective measure of communicative empathy (Miller et al., 1991). The primary investigator and an expert judge (the primary investigator's research advisor who has extensive training in the Carkhuff scale) modified the HRQ scoring criteria slightly in order to make the scoring criteria even more objective. The scale was modified in order to make the scoring criteria more objective, and to incorporate empathic questions (Martin, 1983) and door opener responses (Gordon, 1970).

Like the Carkhuff (1969) EU scale, the HRQ is scored on a 5-point Likert scale: Responses scored as 3 are seen as being interchangeable with the client's stated content and affect (e.g., simple reflection), responses scored below 3 are said to detract meaning (i.e., content and affect) from the client's statement, and responses scored above 3 are viewed as adding meaning to the client's statement. A 1 is scored if the response contains only a "roadblock" response (Gordon, 1970). A 2 is scored if the response contains a reflection (scored as 3, 4, or 5) and a roadblock response.

A 2 is also scored if the response contains only a "door opener" response (Gordon, 1970). Door opener responses such as "Mmm hmm" and "Tell me more" are not empathic statements as they do not add meaning to the client's message. However, these responses convey the notion that the helper is listening to the client and may, therefore, motivate the

client to continue to talking. Roadblock responses, on the other hand, convey the notion that the helper is not interested or is not listening; they may lead the client to stop talking. Because they are technically unempathic (i.e., do not add meaning), door opener responses are scored below 3; because they are seen as being helpful (i.e., showing interest or attention), they are scored above 1. (Appendix F presents Gordon's (1970) "door opener" and "roadblock" responses.)

A 3 is scored if the response consists of a very simple reflection of emotion or content. A 4 is scored if the response consists of one of the following: a reflection of inferred emotion, content, meaning. An appropriate simile or metaphor on its own is also scored a 4.

A 4 is also scored if the response consists of an "empathic question" (Martin, 1983). A question is normally viewed as a roadblock response; however, at times, a question can indicate that the listener has gone beyond the client's content and is context-appropriate. For example, if the client indicates that "my life is worthless," an empathic question might be, "Are you feeling suicidal?" or, "Are you thinking of hurting yourself?" Similarly, if the client describes a scary situation, an appropriate question might be, "Are you feeling scared right now?" or, "Are you safe right now?"

A 5 is scored if the response includes two or more of the following: a reflection of inferred emotion, content, meaning, an appropriate simile or metaphor, or an empathic question. A 5 is also scored if the response includes a reflection of two different emotions, for example, "scared" and "confused."

Appendix G illustrates the use of the HRQ rating scale with an example taken from the practice exercises used to train the raters in this study.

Procedure

Recruitment

In order to maintain statistical power at level of 0.80, it was estimated (based on $\alpha = .05$ and a large effect size) that a minimum of 60 subjects (30 untrained and 30 trained) were required (Cohen, 1992). Due to the potentially dangerous nature of the work, Klinik has developed relatively strict rules regarding confidentiality and protection of its volunteers. These guidelines restricted the primary investigator's direct contact with subjects for the purpose of recruitment.

One week prior to being given the questionnaire package, trained volunteers received a letter in their Klinik mailboxes informing them about the upcoming study. Approximately 125 questionnaire packages were then dropped off in the volunteers' mailboxes. Each questionnaire package was in a stamped and addressed return envelope and provided instructions for completion of the questionnaire and how to return the questionnaire to the primary investigator (Appendix H). Volunteers had the option of returning the questionnaires by mail or by dropping them off at a designated location at Klinik. Extra questionnaire packages were also made available to the subjects at a designated location at Klinik. Over the next eight weeks, two reminder letters (Appendix I) were dropped off in the volunteer mailboxes and four reminder letters were posted in a volunteer message book at Klinik.

Subject-recruitment for untrained volunteers was somewhat more complicated. Approximately 20 to 25 volunteers are trained every 2 to 3 months at Klinik. Potential subjects were approached by one of two ways. When possible, the primary investigator went to the first training session to briefly introduce the study and to drop off questionnaire packages. The Klinik volunteer coordinator who interviews and screens potential volunteers prior to training volunteered to give out questionnaire packages to subjects after completion

of the screening interview. Furthermore, in order to maintain volunteer confidentiality, she mailed out the reminder letters to the untrained (potential) subjects approximately one week after the screening interview. Untrained volunteers were again reminded of the study at the start of training -- by the primary investigator or the volunteer coordinator and by another reminder letter. Extra questionnaires were available to the subjects at the first session as well at the designated location at Klinik. (The training takes place at Klinik.) The primary investigator also asked the trainers to remind subjects about the study in the first few sessions of training. Since the Klinik crisis training program covers Carkhuff's (1969) empathic understanding scale around the 5th training session, a cut-off of three weeks after the start of training was imposed on the data collection for untrained subjects. Approximately 100 questionnaire packages were given out over a 10-month period.

A total of 76 questionnaire packages were received from 41 trained and 32 untrained subjects (approximately 32% response rate). Three subjects from the Trained group were eliminated due to considerable missing data -- leaving a sample of 73 (32 untrained and 41 trained) subjects.

After completion of the study, Klinik and all subjects were provided with a summary of the study findings.

Training of Raters

Three judges were employed in the study to rate subject responses on the HRQ rating scale. All three were graduate students in clinical psychology with general training in psychotherapy and specific training in communicative empathy. The judges were trained by the experimenter in the use of the HRQ rating scale through instruction and practice. Criterion responses were created by the primary investigator, were examined by the expert judge, and were used in training. Training took approximately 3 hours and consisted of

reading material concerning EU and HRQ rating scales and doing trial runs. This procedure is consistent with recommendations by Kent and Foster (1977) and ensures that judges initially assign response ratings within an acceptable range of similarity to those of an experienced judge. The experimenter monitored the judges' work at two intervals and provided a training booster session in order to prevent any drift from rating.

Rating Procedures

Questionnaires were coded for source and randomly assigned to the raters. Prior to being coded, all responses were typed onto individual index cards so that raters could not readily identify subjects nor discriminate which responses belonged to trained or untrained subjects (Miller et al., 1991). As the data was randomized, the primary investigator was also blind to subject group membership. Each rater independently scored each response for a total of 438 responses. Given the high inter-rater reliability (see below), a mean HRQ total communicative empathy score was calculated for each subject, allowing for greater accuracy in estimating communicative empathy (Meen, 1986). This procedure of scoring allows for the calculation of inter-rater reliability on the actual data (Meen, 1986).

Inter-rater reliability. Kappa values and reliability coefficients were utilized in order to determine inter-rater reliability for the three raters on the HRQ vignettes and the HRQ total scores. Kappa is an indicator of the proportion of agreement between 2 or more judges after chance agreement has been removed from consideration (Cohen, 1960; Conger, 1980). Table 1 presents the kappa values for the three raters on the six HRQ vignettes. Mean kappa values for the three pairs of raters were very high: .819 (raters 1 and 2), .901 (raters 1 and 3), .844 (raters 2 and 3). The mean kappa rating (Conger, 1980) for the three raters was .855. In other words, after taking chance agreement into consideration, the raters agreed in assessment of HRQ responses over 85% of the time.

In their study, Miller et al. (1991) reported reliability coefficients (i.e., inter-rater Pearson-type correlations) ranging between .71 and .91 for the six vignettes and .93 for HRQ total scores. In the present study, reliability coefficients were higher: ranging between .90 and 1.00 for the six HRQ vignettes and .98 for the HRQ total scores.

Three main factors likely contributed to the high inter-rater reliability in the present study. First, the above-mentioned modifications made to the HRQ rating scale may have increased inter-rater reliability -- by making the scoring criteria more clear-cut. Second, the nature of the data may itself have added to the high reliability. Upon completion of the ratings, the raters noted that the responses were quite straightforward to score and that there were a lot of low scores. Finally, on inspection of the ratings, the primary investigator found that there were approximately 5 responses (out of 438) in which one rater's response differed dramatically from the other two ratings. For example, raters 1 and 2 both rated a response as 1 and rater 3 rated the same response as 4. In each case, it was found that the rater had made an obvious mistake (e.g., failure to notice a roadblock response). Upon consultation with the expert judge, the primary investigator approached the rater and had them re-rate the item. Given the small number of errors, this procedure seemed warranted.

Insert Table 1 here

Table 1

Kappa Values for the Three Raters on the Six HRQ Vignettes

HRQ	Raters 1 - 2	Raters 1 - 3	Raters 2 - 3
Vignette 1	0.902	0.936	0.905
Vignette 2	0.780	0.946	0.833
Vignette 3	0.925	0.975	0.901
Vignette 4	0.756	0.831	0.781
Vignette 5	0.726	0.774	0.739
Vignette 6	0.826	0.942	0.903
Mean Kappa	0.819	0.901	0.844

Note. HRQ = Helpful Responses Questionnaire.

RESULTS

Statistical Analyses

Tests of assumptions. Prior to statistical analyses, all the data were examined by statistical procedures and visual inspection for assumptions of normality, linearity, and heteroscedasticity. Although some skewness and mild heteroscedacity were evident, these were within acceptable values given the relatively small sample size (Myers & Wells, 1991; Tabachnik & Fidell, 1989). Furthermore, given the exploratory nature of this study and the robustness of the analyses used, it was decided not to transform the data -- in order to preserve their meaningfulness and to facilitate ease of interpretation of the data (Tabachnik & Fidell, 1989). However, in post hoc analyses, communicative empathy was transformed (see below) for exploratory purposes.

Five subjects (3 trained, 2 untrained) were identified as potential outliers on the basis of their reported experience -- Clinic crisis line experience (in months) or previous counselling-related experience (in months). These subjects had somewhat more experience than other subjects. As suggested by Tabachnik and Fidel (1989), data were analyzed with and without these subjects being included in the data set. The results of the analyses did not appear to be significantly different. Consequently, the decision was made to retain these subjects in order to preserve the completeness of the data.

Missing data. Where appropriate, missing data were replaced by subject means; if missing data was extreme, subjects were deleted from the sample (Tabachnik & Fidell, 1989). As indicated above, a total of 76 questionnaire packages were received from 41 trained and 32 untrained subjects. Three subjects from the Trained group were eliminated due to considerable missing data -- leaving a sample of 73 (32 untrained and 41 trained).

Data analysis. Data were analyzed in a variety of ways. Percentages and univariate

statistics (means and standard deviations) were used to describe the sample and to compare differences between Trained and Untrained groups on demographic/predictor variables. Chi-Square and multiple 2-tailed T-tests were used to test the significance of differences between the groups. A Bonferroni inequality was utilized to control for the potential increase in Type I error associated with multiple pair-wise comparisons (Myers & Wells, 1991).

A 1-tailed T-test was used to test Hypothesis 1 -- that Trained subjects would score higher on communicative empathy than Untrained subjects.

Hypothesis 2 -- examining the relationship between predictor variables and communicative empathy, after controlling for biased responding and demographic variables -- was analyzed by a "mixed" stepwise/hierarchical multiple regression (Dr. C. Huynh, personal communication March 17, 1996). This procedure was designed in order to ensure parsimony of the overall model: First, the large number of predictor variables examined in this study were grouped into "theoretical clusters" (e.g., desirable responding, demographic, etc.) and then run in stepwise regressions. Second, the "best models" for each cluster were then run in a hierarchical regression.

A correlation matrix was also used to examine whether predictor variables were related to communicative empathy in Untrained subjects, Trained subjects, and the total sample. As in the case of multiple comparisons increasing Type I error, examining multiple correlations increases the risk that spurious correlations may be found to be significant (Myers & Wells, 1991). As in the case of multiple T-tests, these comparisons are warranted given the exploratory nature of the present study. They should, however, be interpreted with caution -- as suggesting possible relationships. Correlations significant at $p < .01$ may indicate important relationships (Myers & Wells, 1991).

A correlation matrix was also used to test Hypothesis 3 and the Ancillary Hypotheses

-- both of which examine relationships between predictor and demographic variables. As indicated above, these analyses were exploratory in nature and should be interpreted with caution.

Quantitative post hoc data analyses. Several post hoc analyses were performed to further explore the nature of the data and the relationship of the predictor variables with communicative empathy. These included three additional sets of descriptive analyses (utilizing multiple T-tests) -- comparing subjects on high versus low communicative empathy, previous counselling-related training, and high versus low altruistic motivation -- and additional multiple regression analyses. Additional multiple regressions included smaller sets of predictors, stepwise regressions, and a transformation of HRQ communicative empathy (to its mathematical inverse).

Qualitative post hoc data analyses. Preliminary qualitative analyses were employed to explore whether there were qualitative differences in the HRQ responses of the subject groups -- for example, subjects with Klinik training versus untrained subjects, subjects with previous counselling training versus subjects with no previous training, subjects with high altruistic motivation for volunteering versus subjects with low altruistic motivation, etc. These analyses utilized qualitative methods such as visual inspection, open coding, and frequency counts. A correlation analysis was employed to explore relationships between different frequencies of responses (e.g., empathy, advice-giving, question-asking, etc.) per subject with Klinik training, previous counselling training, altruistic motivation, and HRQ empathy.

Description of the Sample

A total of 76 questionnaire packages were received from 41 trained and 32 untrained subjects (approximately 32% response rate). Three subjects from the Trained group were eliminated due to considerable missing data.

Tables 2 and 3 present the descriptive characteristics of the sample for Trained ($n = 41$) and Untrained ($n = 32$) subjects. Percentages and univariate statistics (means and standard deviations) were used to describe the sample and to compare the trained and untrained groups. Two-tailed T-tests and Chi-Square tests were used to determine whether Trained and Untrained groups differed significantly on demographic and predictor variables. The exploratory nature of the present study warranted the use of multiple T-tests. As noted above, a Bonferroni inequality was utilized to minimize the increase in Type I error associated with multiple pair-wise comparisons (Myers & Wells, 1991). The family of demographic/predictor variables consisted of 16 variables: Age (in years), gender, current marital status (i.e., currently single/separated/divorced versus married/commonlaw/engaged), education (in years), current student status (i.e., currently student), educational/occupational field (i.e., currently working in a counselling/health versus other field), previous counselling/helping training, previous counselling/helping experience (in months), the three subscales of the Balanced Inventory of Desirable Responding (BIDR), the four subscales of the Interpersonal Reactivity Index (IRI), and the Measure of Altruistic Motivation (MAM). Five of these variables (i.e., gender, marital status, field, previous training, and student status) were analyzed by Chi-Square analyses. The remaining 11 predictor variables were tested by T-tests. In order to control for the potential increase in Type I error associated with multiple pair-wise comparisons, a Bonferroni inequality was utilized (Myers & Wells, 1991): alpha was set at a conservative $p < .005$ level (2-tailed; i.e., $p = .05$ divided by 11 predictors).

Insert Tables 2 and 3 about here

Table 2

Demographic Characteristics of Subjects

Variable	Untrained (N = 32)	Trained (N = 41)
<u>Gender</u>		
Male	21.9	22.0
Female	78.1	78.0
<u>Marital Status</u>		
Single	59.4	51.6
Separated/Divorced	15.6	14.6
Commonlaw/Engaged	6.2	12.2
Married	18.8	17.2
<u>Currently Student</u>		
No	68.8	68.3
Yes	31.2	31.7

Note. Numbers represent percentages.

Table 2 (continued)

Variable	Untrained (N = 32)	Trained (N = 41)
<u>Occupational/Educational Field</u>		
Psychology/Social Work	21.9	41.5
Health/Nursing	21.9	12.2
Other	43.7	34.1
N/A	12.5	12.2
<u>Previous Training</u>		
No	68.8	53.7
Yes	31.2	46.3

Note. Numbers represent percentages. Differences between groups are not statistically significant ($p < .1$ (Chi-Square)).

Table 3

Means and Standard Deviations of Demographic and Predictor Variables for Untrained and Trained Groups

Variable	Untrained (N = 32)		Trained (N = 41)	
	Mean	S.D.	Mean	S.D.
Age (Years)	28.88	8.15	31.20	8.67
Education (Years)	15.88	2.51	16.32	2.16
Crisis Experience	...	...	16.17	16.03
Prior Experience	10.28	28.45	15.20	40.13
IRI-PT	21.44	3.29	19.51	4.23
IRI-EC	21.44	4.15	21.27	4.37
IRI-PD	7.69	4.13	8.29	4.11
IRI-FS	15.75	5.41	16.07	5.65
Altruism	4.34	3.60	3.98	3.38
BIDR-IM	18.31	3.91	15.54	4.40
BIDR-SE	16.66	3.65	14.66	3.60
BIDR-DN	17.75	3.57	15.78	4.17

Note. A Bonferroni inequality was utilized to minimize the increase in Type I error associated with multiple pair-wise comparisons: alpha was set at a conservative $p < .005$ level (2-tailed; i.e., $p = .05$ divided by 11). IRI-PT, IRI-

Table 3 (continued)

EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales -- Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

Results of the Chi-Square and T-tests indicated that differences between Trained and Untrained subjects were not statistically significant in terms of gender, marital status, student status, educational/occupational field, and previous counselling training (p's ranging from .191 to .373). Note: The "educational/occupational field" and "marital status" variables were examined as multiple-category variables and as dichotomous variables: Educational/occupational field was coded as (a) psychology/social work, health/nursing, and other; and (b) psychology/social work/health/nursing versus other. Marital status was coded as (b) single, divorced/separated, engaged/commonlaw, and married and (b) single/separated/ divorced and engaged/commonlaw/married. The dichotomous codings were used in T-tests and in correlational/regression analyses.

Even though the differences were not statistically significant, some trends were observed: For example, the Trained and Untrained groups appear to be similar in terms of age, gender, education, marital status, and current student status. However, the Untrained group appears to be slightly younger than the Trained group (in terms of age, being single, and education).

More trained than untrained subjects (41.5% vs. 21.9%) were in psychology or social work in terms of their occupational or educational field. Similarly, more trained than untrained subjects (46.3% vs. 36.2%) had some form of previous helping or counselling training and experience. More untrained than trained subjects (21.9% vs. 12.2%) were in the health or nursing occupational/educational field. When the psychology/social work and health/nursing occupational/educational fields were combined, they accounted for 43.8% of the untrained subjects and 53.7% of the trained subjects.

Untrained subjects appeared to have higher levels of IRI perspective taking, BIDR impression management, enhancement, and denial than Trained subjects. Untrained subjects

also appeared to be higher on altruistic motivation for volunteering.

Hypothesis 1: Effect of Telephone Crisis Intervention Training on Communicative Empathy

It was hypothesized that trained volunteers would demonstrate higher levels of communicative empathy on the HRQ than untrained volunteers. Table 4 lists the means and standard deviations for the two groups.

The HRQ empathy scores were relatively low for both groups. Overall, Hypothesis 1 is supported: Trained subjects showed significantly higher levels of communicative empathy (HRQ mean score) than untrained subjects ($p < .05$, 1-tailed T-test). A one-tailed T-test was utilized as it was hypothesized that the Trained group (because they receive training in communicative empathy) would score higher on communicative empathy than the Untrained group (c.f., Myers & Wells, 1991). The differences between the HRQ vignette scores were generally nonsignificant but tended to be in the expected direction. Vignette 3 showed a very significant difference between the two groups at the $p < .01$ level (1-tailed T-test). On vignette 1, untrained subjects appeared to do somewhat better than trained subjects.

Insert Table 4 about here

Table 4

Means and Standard Deviations of HRQ Communicative Empathy Scores for Untrained and Trained Groups

HRQ	Untrained (N = 32)		Trained (N = 41)	
	Mean	S.D.	Mean	S.D.
Vignette 1	1.41	0.76	1.33	0.60
Vignette 2	1.38	0.78	1.53	0.68
Vignette 3	1.42	0.91	2.02**	1.43
Vignette 4	1.64	1.14	1.85	1.25
Vignette 5	1.39	0.73	1.47	0.77
Vignette 6	2.10	1.53	2.41	1.34
Mean Score	1.56	0.69	1.77*	0.67

Note. * $p < .05$ (1-tailed). ** $p < .01$ (1-tailed). HRQ = Helpful Responses Questionnaire.

Hypothesis 2: Relationship Between Predictor Variables and Communicative Empathy

It was hypothesized that, after controlling for demographic and biased responding variables, crisis intervention training, telephone crisis intervention experience, previous counselling training, previous counselling experience, perspective taking, empathic concern, personal distress, and altruistic motivation would significantly predict HRQ communicative empathy.

Hypothesis 2 was analyzed by univariate correlational analysis and hierarchical regression. Table 5 presents Pearson univariate correlations for HRQ communicative empathy with demographic and predictor variables for Untrained subjects, Trained subjects, and the total sample. As indicated above, multiple correlations were examined, which may increase Type I error rate due to spurious correlations being significant (Myers & Well, 1991). Consequently, these correlations should be interpreted with caution -- as indicating significant relationships. Strong correlations (i.e., $p < .01$ or less) likely indicate true relationships.

Insert Table 5 about here

Table 5

Correlations between HRQ Communicative Empathy with Demographic and Predictor Variables for Untrained, Trained, and Combined Groups

Variable	Untrained	Trained	Total
Age (Years)	0.12	0.35*	0.27*
Gender	0.03	-0.19	-0.09
Education (Years)	0.18	0.12	0.15
Marital Status	-0.02	0.08	0.04
Student	-0.20	-0.01	-0.09
Field	0.49**	0.11	0.28*
Prior Training	0.48**	0.07	0.26*
Prior Experience	0.28	-0.11	0.04
Crisis Training	...	...	0.15
Crisis Experience	...	-0.00	0.08

Table 5 (continued)

Variable	Untrained	Trained	Total
IRI-PT	-0.03	0.02	-0.04
IRI-EC	-0.16	-0.04	-0.09
IRI-PD	0.06	-0.05	0.01
IRI-FS	-0.16	-0.07	-0.10
Altruism	-0.45**	-0.14	-0.29**
BIDR-IM	0.07	0.08	0.02
BIDR-SE	-0.20	-0.21	-0.23*
BIDR-DN	0.00	0.05	-0.01

Note. * $p < .05$ ** $p < .01$. n untrained = 32, n trained = 41, $N = 73$. Gender (1 = male, 2 = female). Marital Status (1 = single, 2 = couple). Student (0 = no, 1 = yes). Field (0 = other, 1 = health/counselling). IRI-PT, IRI-EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales -- Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

Correlational Analysis

The univariate correlations between the demographic and predictor variables with communicative empathy differ somewhat depending on which group one examines -- Untrained, Trained, or the total sample.

Total sample. For the total sample, occupational/educational field, age and prior counselling training were positively correlated with HRQ communicative empathy: Subjects who were working or studying in a health/counselling field, who were older, and who had previous helping/counselling experience had higher scores on communicative empathy. Clinic crisis intervention training and years of education also showed trends in the positive direction: Subjects who had Clinic crisis training and who had more years of education also scored higher on communicative empathy. Altruistic motivation and BIDR self-deceptive enhancement were negatively associated with HRQ communicative empathy: Subjects who volunteered for altruistic reasons (e.g., wanting to help people) and subjects who made more positive self-attributions (e.g., my first impressions of others are usually right) scored lower on communicative empathy.

Subjects without Clinic training. For untrained subjects, being in health/counselling field and having prior helping counselling training were positively correlated with HRQ communicative empathy: Untrained subjects who were working or studying in health/counselling field and subjects who had previous helping/counselling experience scored higher on communicative empathy. Previous counselling experience (in months) and years of education also showed trends in being positively associated with empathy: Untrained subjects who had higher levels of previous helping/counselling experience and subjects who had more years of education also scored somewhat higher on communicative empathy. Altruistic motivation was negatively associated with HRQ communicative empathy: Untrained subjects

who reported volunteering for altruistic reasons scored lower on communicative empathy. BIDR self-deceptive enhancement, currently being a student, IRI empathic concern, and IRI fantasy all showed trends in being negatively correlated with communicative empathy: Untrained subjects who made more positive self-attributions, untrained subjects who were currently students, untrained subjects who indicated feeling sympathy for persons in distress, and untrained subjects who indicated feeling empathy for fictional characters (e.g., in books and movies) also scored somewhat lower on communicative empathy.

Subjects with Clinic training. For trained subjects, age was positively associated with HRQ communicative empathy: Trained subjects who were older scored higher on communicative empathy. Gender (i.e., being male) and BIDR self-deceptive enhancement showed trends in being negatively correlated with communicative empathy: Trained subjects who were male and trained subjects who made higher levels of positive self-attributions tended to score somewhat lower on communicative empathy.

Hierarchical Regression

Hierarchical regression was employed to determine whether crisis intervention training improved the prediction of HRQ communicative empathy, after controlling for impression management (and denial), demographic variables (age, gender, marital status, years of education, and current student status), field/training variables (educational/ occupational field, previous counselling training, and previous counselling experience), and dispositional variables (IRI empathy scales, BIDR enhancement and denial, and altruistic motivation).

As indicated above, due to the large number of predictor variables investigated in this exploratory study, a "mixed" stepwise/hierarchical regression was employed in order to preserve the parsimony of the regression model (Dr. C. Huynh, personal communication, March 17, 1996). A two-step process was employed: (1) stepwise regressions were

performed on "theoretical clusters" in order to find the best model for that cluster; (2) the "best" models were then entered into a hierarchical regression.

Cluster 1 involved the BIDR impression management (IM) and self-deceptive denial (DN) measures. Although a form of biased responding, BIDR self-deceptive enhancement is qualitatively different from impression management and denial, and may be linked to more "positive" personality traits, such as self-esteem and optimism (c.f., Paulhus, 1994). Consequently, enhancement was included in a cluster consisting of dispositional measures (cluster 4, below). Although neither IM nor DN were significant, IM was retained for the hierarchical model in order to control for biased responding: $R^2 = .000$, $F_{\text{model}}(1, 71) = 0.03$, $p < .87$.

Cluster 2 consisted of basic demographic variables: age, gender, marital status (coded as 1 = currently single/separated/divorced; 2 = currently engaged/cohabitating/ married), years of education, and current student status (coded as 0 = currently not student; 1 = currently student). Only age was found to be significant: $R^2 = .074$, $F_{\text{model}}(1, 71) = 5.66$, $p < .02$.

Cluster 3 involved three variables: educational/occupational field, previous counselling training, and previous counselling experience (in months). Initially, these variables were viewed as being part of the "demographic variables" cluster; however, as they are all in some way related to being in the helping/counselling field, it was decided to treat them as separate theoretical cluster. Educational/occupational field and previous training were found to be significant: $R^2 = .106$, $F_{\text{model}}(2, 70) = 4.16$, $p < .02$.

Cluster 4 consisted of dispositional variables: BIDR self-deceptive enhancement, the four IRI scales (perspective taking, empathic concern, personal distress, and fantasy), and measure of altruistic motivation. Only altruistic motivation and BIDR enhancement were found to be significant: $R^2 = .115$, $F_{\text{model}}(2, 70) = 4.54$, $p < .01$.

Finally, cluster 5 consisted of Klinik crisis-intervention training (coded as 0 = untrained; 1 = trained) and months of experience at Klinik. Neither training nor online experience were found to be significant; nevertheless, training was retained in the hierarchical model: $R^2 = .023$, $F_{\text{model}}(1, 71) = 1.71$, $p < .20$.

Table 6 displays the standardized regression coefficients (β), R^2 , and F_{model} for each step of the regression.

At step 1, BIDR impression management was forced into the model to control for artifactual variance. Impression management was not a significant predictor of HRQ empathy: $R^2 = .000$, $F_{\text{model}}(1, 71) = 0.029$, $p < .87$. At step 2, age (i.e., "demographic" cluster) was added to the equation: $R^2 = .075$ (Adjusted $R^2 = .048$), $F_{\text{model}}(2, 70) = 2.824$, $p < .07$. The demographic cluster accounted for about 5 percent of the variance in communicative empathy. At step 3, field and previous training (i.e., the "helping field" cluster) was added to the model: $R^2 = .158$ (Adjusted $R^2 = .109$), $F_{\text{model}}(4, 68) = 3.194$, $p < .02$. The model now accounted for nearly 11 percent of the variance in HRQ communicative empathy. Next, altruistic motivation and BIDR enhancement (i.e., the "dispositional" cluster) were added to the model: $R^2 = .214$ (Adjusted $R^2 = .142$), $F_{\text{model}}(6, 66) = 2.988$, $p < .01$. The model now accounted for about 14 percent of the variance in communicative empathy.

 Insert Table 6 about here

Table 6

Hierarchical Regression of Predictor Variables on HRQ Communicative Empathy

Variable	F_{model}	β	R^2
<u>Step 1</u>			
BIDR-IM	0.029	0.019	0.000
<u>Step 2</u>			
Age (Years)	2.824	0.015	0.075
<u>Step 3</u>			
Field		0.229	
Previous Training	3.194	0.118	0.158
<u>Step 4</u>			
Altruism		-0.035	
BIDR-SE	2.988	-0.027	0.214
<u>Step 5</u>			
Crisis Training	2.650	0.136	0.222

Note. N = 73. Field (0 = other, 1 = health/counselling). Altruism = Measure of Altruistic Motivation. BIDR-IM and BIDR-SE = Balanced Inventory of Desirable Responding subscales -- Impression Management and Self-Deceptive Enhancement, respectively.

Finally, at step 5, Klinic crisis line training was added: $\underline{R}^2 = .222$ (Adjusted $\underline{R}^2 = .138$), $F_{\text{model}}(7, 65) = 2.650$, $p < .02$. The combination of demographic, personality, and Klinic training variables only accounted for about 14 percent of the variance in communicative empathy.

Given the weak relationship between the predictor variables and HRQ communicative empathy using hierarchical multiple regression, additional regressions were run as post hoc analyses. Furthermore, the results of the above multiple regression suggested that the dependent variable -- HRQ communicative empathy -- may have to be transformed in order to allow for a better fit of the model (Tabachnik & Fidell, 1989). These analyses are presented in the "Post Hoc Analyses" section, below.

Hypothesis 3: Relationships Between Predictor Variables

It was hypothesized that crisis line training and experience would be positively correlated with perspective taking, empathic concern, and altruistic motivation, and negatively correlated with personal distress.

As indicated above, multiple correlations were examined in order to test this hypothesis. Given the potential increase in Type I error (Myers & Well, 1991), these correlations should be interpreted with caution -- as exploratory analyses indicating potentially significant relationships. Strong correlations (i.e., $p < .01$) may indicate true relationships.

Table 7 presents the correlations between the demographic and predictor variables for the total sample. Hypothesis 3 was not supported. Crisis intervention training and crisis line experience (in months) were negatively associated with perspective taking: Trained subjects and trained subjects with higher levels of crisis line experience reported lower levels of perspective taking than untrained subjects and trained subjects with less experience. Furthermore, crisis intervention training and crisis line experience were relatively uncorrelated

with empathic concern, personal distress, fantasy, and altruistic motivation: Trained and more experienced crisis line volunteers did not appear to differ from untrained and lesser experienced subjects on reported feelings sympathy for distressed persons, feelings of anxiety in the presence of distressed persons, and empathy for fictional characters; they also did not appear to differ on reasons for volunteering at Klinik.

Insert Table 7 about here

Table 7

Pearson Correlations for Demographic and Predictor Variables

Variable	IRI-PT	IRI-EC	IRI-PD	IRI-FS
Age (Years)	-0.04	-0.32**	-0.05	-0.34**
Gender	0.21	0.20	-0.07	0.35**
Marital Status	-0.24*	-0.25*	-0.10	-0.26*
Years Education	-0.15	-0.01	0.21	-0.00
Student	0.06	0.04	0.17	0.09
Field	0.16	0.03	-0.03	0.12
Prior Training	-0.02	-0.23*	0.02	-0.03
Prior Experience	0.15	0.02	-0.10	0.02
Crisis Training	-0.24*	-0.02	0.07	0.03
Crisis Experience	-0.22	-0.08	-0.02	-0.10
Altruism	0.05	0.21	-0.18	0.09
BIDR-IM	0.32**	0.26*	-0.20	-0.04
BIDR-SE	0.32**	0.07	-0.47***	-0.17
BIDR-DN	0.37**	0.18	-0.39**	-0.12
IRI-PT	...	0.47**	-0.37**	0.18
IRI-EC	0.47***	...	-0.04	0.45***
IRI-PD	-0.37**	-0.04	...	0.22

Table 7 (continued)

Variable	Altruism	BIDR-IM	BIDR-SE	BIDR-DN
Age	-0.25*	-0.03	-0.07	0.03
Gender	0.14	0.14	0.13	0.03
Marital Status	-0.10	-0.06	-0.06	-0.07
Years Education	-0.06	-0.28*	-0.29**	-0.30**
Student	0.08	0.17	-0.05	0.03
Field	-0.15	0.12	-0.21	0.05
Prior Training	-0.23*	-0.18	-0.17	-0.11
Prior Experience	-0.21	0.01	0.00	0.04
Crisis Training	-0.05	-0.32**	-0.27*	-0.24*
Crisis Experience	-0.01	-0.23*	-0.24*	-0.21*
BIDR-IM	0.14	...	0.31*	0.65***
BIDR-SE	0.20	0.31**	...	0.38**
BIDR-DN	0.25*	0.65***	0.38**	...

Table 7 (continued)

Variable	Age	Gender	Marital	Education	Student
Gender	-0.26*	...	-0.19	-0.23*	0.00
Marital Status	0.32**	-0.19	...	0.02	-0.02
Years Education	0.04	-0.23*	0.02	...	0.03
Student	-0.26*	0.00	-0.02	0.03	...
Field	0.00	0.15	-0.21	-0.03	0.12
Prior Training	0.31**	-0.04	-0.06	0.21	-0.19
Prior Experience	0.28*	0.12	0.06	-0.06	0.00
Crisis Training	0.14	-0.00	0.05	0.10	0.00
Crisis Experience	0.21	-0.21	-0.08	0.11	-0.13

Variable	Field	Prior Train.	Prior Exper.	Crisis Train.
Prior Training	0.39**	...		
Prior Experience	0.23**	0.46***	...	
Crisis Training	0.04	0.15	0.07	...
Crisis Experience	0.14	0.05	-0.05	0.56***

Table 7 (continued)

Note. * $p < .05$ ** $p < .01$. *** $p < .001$. n untrained = 32, n trained = 41, N = 73. Gender (1 = male, 2 = female). Marital Status (1 = single, 2 = couple). Student (0 = no, 1 = yes). Field (0 = other, 1 = health/counselling). IRI-PT, IRI-EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales -- Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

Ancillary Hypotheses

As indicated above, a number of ancillary hypotheses were also entertained. These were primarily predictions based on the existing literature. Multiple correlations were again examined in order to test this hypothesis. Given the potential increase in Type I error (Myers & Well, 1991), these correlations should be interpreted with caution -- as exploratory analyses indicating potentially significant relationships. Strong correlations (i.e., $p < .01$) may indicate true relationships.

Dispositional empathy. It was hypothesized that IRI perspective taking would be positively associated with empathic concern and negatively with personal distress; and empathic concern would be positively associated with fantasy (Batson et al., 1986; Clary & Orenstein, 1991; Davis, 1983). As seen in Table 7, this hypothesis was supported. Subjects reporting higher levels of perspective taking reported higher levels of sympathy for persons in distress; they also reported lower levels of feeling anxiety when witnessing a person who is in distress. Subjects who reported higher levels of sympathetic feelings for a person in distress also reported higher levels of empathy for fictional characters (i.e., as in a movie or novel).

Altruistic motivation. It was hypothesized that empathic concern will be positively associated with altruistic motivation (Clary & Orenstein, 1991). Clary and Orenstein found the correlation between the two scales to be 0.22. In the present study, the correlation was found to be .21 (see Table 7), supporting this hypothesis. Altruistic motivation also showed a trend in being negatively associated with personal distress. Subjects who reported altruistic reasons for volunteering (e.g., in order to help people) reported feeling higher levels of sympathy for persons in distress; they also reported somewhat lower feelings of anxiety when being exposed to a person in distress.

Altruistic motivation was also to positively correlated with BIDR denial and showed positive trends in correlation with impression management and enhancement. In other words, subjects who reported more altruistic reasons for volunteering also reported higher levels of self-deceptive denial -- that is, they were more likely to deny negative qualities about themselves. Altruistic subjects were also somewhat likely to make more positive self-attributions (enhancement) and to try to portray themselves in a positive light to others (impression management).

There was a slight trend for altruistic motivation to be associated with gender: Females reported somewhat more altruistic reasons for volunteering (e.g., wanting to help people). Altruistic motivation was negatively associated with age, previous helping/counselling training and experience: Subjects who were older, subjects who had previous helping/counselling training, and subjects who had higher levels of previous helping/counselling experience reported less altruistic reasons for volunteering.

Finally, altruistic motivation was uncorrelated with crisis intervention training and experience: Trained Klinik subjects and trained Klinik subjects with more crisis line experience did not appear to differ on altruistic reasons for volunteering from untrained Klinik subjects and trained subjects with less experience.

Desirable responding. It was hypothesized that perspective taking would be positively associated with self-deceptive enhancement, self-deceptive denial, and impression management; that empathic concern will be positively associated with denial; and that personal distress will be negatively associated with enhancement and impression management (Paulhus & Reid, 1991). Perspective taking was found to be correlated with enhancement, denial, and impression management (see Table 7): Subjects who reported higher levels of perspective taking also made more positive self-attributions, denied more negative self-

attributions, and were more likely to portray themselves in a positive manner to others. Empathic concern was positively correlated with impression management and showed a trend in being positively correlated with denial: Subjects reporting higher levels of sympathy for a distressed other were more likely to portray themselves in a positive manner to others; sympathetic subjects also tended to deny more negative self-attributions. Paulhus and Reid (1991) found the correlation between empathic concern and impression management to be .11 and the correlation between empathic concern and denial to be .35. Finally, personal distress was negatively correlated with enhancement, denial, and impression management: Subjects who reported feeling more anxiety when witnessing a person in distress were also less likely to portray themselves in a positive manner to others. Even though only selected items of the BIDR were used, this hypothesis was for the most part supported.

The BIDR scales were also negatively associated with years of education, previous counselling training, Clinic crisis intervention training, and crisis intervention experience. Subjects who either had more years of education, had previous counselling training, had Clinic training, or who had more experience (in months) working on crisis lines tended to make less positive self-attributions, deny less negative self-attributions, and be less likely to portray themselves in a positive manner to others.

Demographic variables. It was hypothesized that females will have higher empathic concern and perspective taking and lower personal distress and similarly that age will be positively associated with perspective taking, empathic concern and negatively associated with personal distress. As seen in Table 7, gender (being female) was associated with fantasy (which is correlated with empathic concern) and shows strong positive trends in being associated with perspective taking and empathic concern. In other words, females reported significantly higher levels of empathy for fictional characters and somewhat higher levels of

perspective taking and sympathy. Personal distress appears to be uncorrelated with gender -- or shows a very weak negative trend: Males seemed to report slightly higher levels of anxiety around persons in distress. Age, on the other hand, showed significantly negative correlations with empathic concern and fantasy; and appeared uncorrelated (or very weakly negatively correlated) with both perspective taking and personal distress. In other words, older subjects reported lower levels of sympathy for persons in distress and lower empathy for fictional characters; older did not appear to differ from younger subjects on perspective taking and on feelings of anxiety around persons in distress. Consequently, this hypothesis was supported for gender but not for age.

Post Hoc Analyses

In order to get a better understanding of the sample and communicative empathy, a number of additional analyses were performed on the data. First of all, three additional sets of descriptive statistics were done for the sample in terms empathy (high vs. low), previous counselling training (previous training vs. none), and altruistic motivation (high vs. low). Percentages and univariate statistics (means and standard deviations) were used to describe the sample and to compare the groups. Two-tailed T-tests and Chi-Square tests were used to determine whether the respective groups differed significantly on demographic and predictor variables. The analyses were similar to those carried out when comparing Clinic Trained and Untrained subjects: Chi-Square analyses were utilized in comparing dichotomous variables such as marital status, student status, etc.; conservative Bonferroni-corrected T-tests ($p < .005$) were used in comparing interval-scaled variables such as age, years of education, etc. T-tests were also used to see if the groups differed on HRQ communicative empathy scores.

Second, a number of additional multiple regressions were also run. These included

standard regressions with smaller sets of predictors and stepwise regressions for the total sample and trained/untrained groups. Additional regressions were also run with communicative empathy transformed into its mathematical inverse -- these included another hierarchical regression, standard regressions with smaller sets of predictors and stepwise regressions for the total sample and trained/untrained groups.

Communicative Empathy

Even though the overall empathy scores were low, the dataset was split into Low and High Empathy groups. Subjects whose total HRQ scores were below 10 were coded as Low Empathy; subjects with total scores of 10 or more were coded as High Empathy. Tables 8 and 9 present the descriptive characteristic of the sample for Low and High Empathy subjects.

As seen in Tables 8 and 9, the High Empathy group was slightly older and had more years of education. More of the High Empathy group appeared to have had Klinik's crisis training (64.5% vs. 50.0%) or other previous counselling training (54.8% vs. 28.6%). The trained Klinik volunteers in the High Empathy group also appeared to have slightly more months of crisis line experience. Furthermore, more of the High Empathy group were working or studying in a psychology/social work field (48.4% vs. 21.4%) or in a health/nursing field (22.6% vs 11.9%). Consequently, having Klinik training (and more crisis line experience), having previous counselling training, and working/studying in a health/counselling field were all associated with higher levels of empathy.

 Insert Tables 8 and 9 about here

Table 8

Demographic Characteristics of Subjects by Empathy

Variable	Low (N = 42)	High (N = 31)
<u>Gender</u>		
Male	19.0	25.8
Female	81.0	74.2
<u>Marital Status</u>		
Single	59.5	54.8
Separated/Divorced	11.9	19.4
Commonlaw/Engaged	14.3	3.2
Married	14.3	22.6
<u>Currently Student</u>		
No	66.7	71.0
Yes	33.3	29.0

Table 8 (continued)

Variable	Low (N = 42)	High (N = 31)
<u>Occupational/Educational Field</u>		
Psychology/Social Work	21.4	48.4**
Health/Nursing	11.9	22.6
Other	47.6	25.8
N/A	19.0	3.2
<u>Crisis Line Training</u>		
No	50.0	35.5
Yes	50.0	64.5
<u>Previous Training</u>		
No	71.4	45.2
Yes	28.6	54.8*

Note. * $p < .05$; ** $p < .01$ (Chi-Square). Numbers represent percentages.

Table 9

Means and Standard Deviations of Demographic and Predictor Variables for Low and High Empathy Groups

Variable	Low (N = 42)		High (N = 31)	
	Mean	S.D.	Mean	S.D.
Age (Years)	28.10	6.80	33.00	9.71
Education (Years)	15.71	2.55	16.68	1.85
Crisis Experience	6.36	9.54	12.77	18.72
Prior Experience	12.24	40.03	14.13	28.40
IRI-PT	20.36	4.29	20.35	3.48
IRI-EC	21.26	4.24	21.45	4.32
IRI-PD	7.67	4.27	8.52	3.87
IRI-FS	16.21	5.48	15.55	5.63
Altruism	5.05*	3.81	2.90	2.47
BIDR-IM	16.60	4.57	16.97	4.20
BIDR-SE	16.58*	3.91	14.13	3.91
BIDR-DN	16.80	3.98	16.41	4.12

Table 9 (continued)

Note. * $p < .005$ (2-tailed). A Bonferroni inequality was utilized to minimize the increase in Type I error associated with multiple pair-wise comparisons: alpha was set at a conservative $p < .005$ level (2-tailed; i.e, $p = .10$ divided by 11). IRI-PT, IRI-EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales - - Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

The groups did not differ on the IRI measures of dispositional empathy -- perspective taking, empathic concern, personal distress, and fantasy. In terms of the BIDR, the Low Empathy group appeared to be higher on self-deceptive enhancement: They tended to make more positive self-attributions. The Low Empathy group also showed higher levels of altruistic motivation: They were more likely to volunteer for altruistic reasons.

Previous Training

Forty-four subjects had indicated that they had had some form of previous counselling training -- ranging from doing peer counselling to psychiatric nursing: 31.2% of untrained Klinik subjects and 46.3% of trained Klinik subjects (Table 2). Tables 8 and 9 present the descriptive characteristic of the sample for Previously Trained and Untrained subjects.

Insert Tables 10 and 11 about here

Table 10

Demographic Characteristics of Subjects by Previous Training

Variable	Untrained (N = 44)	Trained (N = 29)
<u>Gender</u>		
Male	20.5	24.1
Female	79.5	75.9
<u>Marital Status</u>		
Single	59.1	55.2
Separated/Divorced	11.4	20.7
Commonlaw/Engaged	13.6	3.4
Married	15.9	20.7
<u>Currently Student</u>		
No	61.4	79.3
Yes	38.6	20.7

Table 10 (continued)

Variable	Untrained (N = 44)	Trained (N = 29)
<u>Occupational/Educational Field</u>		
Psychology/Social Work	22.7	48.3**
Health/Nursing	13.6	20.7
Other	47.7	24.1
N/A	15.9	6.9
<u>Crisis Line Training</u>		
No	50.0	34.5
Yes	50.0	65.5

Note. ** $p < .01$ (Chi-Square). Numbers represent percentages.

Table 11

Means and Standard Deviations of Demographic and Predictor Variables for
Previously Untrained and Trained Groups

Variable	Untrained (N = 44)		Trained (N = 29)	
	Mean	S.D.	Mean	S.D.
Age (Years)	28.07*	7.49	33.38	8.96
Education (Years)	15.73	2.04	16.72	2.60
Crisis Experience	8.48	14.32	10.00	14.78
Prior Experience	...	...	32.83	50.39
IRI-PT	20.41	4.03	20.28	3.87
IRI-EC	22.14	3.98	20.14	4.42
IRI-PD	7.95	4.16	8.14	4.08
IRI-FS	16.05	5.38	15.76	5.80
Altruism	4.77*	3.86	3.17	2.49
BIDR-IM	17.41	3.62	15.76	5.26
BIDR-SE	16.05	4.00	14.76	3.19
BIDR-DN	17.00	3.83	16.01	4.30

Table 11 (continued)

Note. * $p < .005$ (2-tailed). A Bonferroni inequality was utilized to minimize the increase in Type I error associated with multiple pair-wise comparisons: alpha was set at a conservative $p < .005$ level (2-tailed; i.e, $p = .10$ divided by 11). IRI-PT, IRI-EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales - - Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

As seen in Tables 10 and 11, the Previously Trained (Pretrained) subjects were slightly older, more of them were divorced or separated (20.7% vs. 11.4%), and more of them appeared to have had Klinik's crisis training (65.5% vs. 50.0%). Furthermore, more of the Pretrained group were working or studying in a psychology/social work field (48.3% vs. 22.7%) or in a health/nursing field (20.7% vs 13.6%).

The Previously Untrained subjects appeared to be somewhat higher on IRI empathic concern and altruistic motivation: They reported feeling higher levels of sympathy for persons in distress and indicated more altruistic reasons for volunteering at Klinik. More of the Untrained subjects were currently students (38.6% vs. 20.7%) and were engaged or living commonlaw (20.7% vs. 13.6%). The groups did not appear to differ on the BIDR subscales, years of education, or Klinik crisis line experience.

Table 12 presents the vignette and mean scores for the previously trained and untrained groups on the HRQ. Pretrained subjects appear to score significantly higher on HRQ communicative empathy than subjects without previous counselling training.

Insert Table 12 about here

Table 12

Means and Standard Deviations of HRQ Communicative Empathy Scores for
Previously Untrained and Previously Trained Groups

HRQ	Untrained (N = 44)		Trained (N = 29)	
	Mean	S.D.	Mean	S.D.
Vignette 1	1.32	0.59	1.43	0.79
Vignette 2	1.34	0.54	1.66*	0.92
Vignette 3	1.67	1.27	1.87	1.24
Vignette 4	1.60	1.01	1.99*	1.34
Vignette 5	1.29	0.47	1.66**	1.01
Vignette 6	1.95	1.30	2.77	1.47
Mean Score	1.53	0.60	1.89**	0.75

Note. * $p < .05$ (1-tailed). ** $p < .01$ (1-tailed). HRQ = Helpful Responses Questionnaire.

Altruistic Motivation

Finally, the dataset was split in terms of Low and High Altruistic Motivation. A median-split was performed on subjects' total MAM scores. Subjects scoring less than 3 were coded as Low Altruistic; subjects scoring 3 or more were coded as High Altruistic. Tables 13 and 14 present the descriptive characteristic of the sample for Low and High Altruistic subjects.

Insert Tables 13 and 14 about here

Table 13

Demographic Characteristics of Subjects by Altruistic Motivation

Variable	Low (N = 37)	High (N = 36)
<u>Gender</u>		
Male	29.7	13.9
Female	70.3	86.1
<u>Marital Status</u>		
Single	45.9	69.4
Separated/Divorced	18.9	11.1
Commonlaw/Engaged	10.8	8.3
Married	24.3	11.1
<u>Currently Student</u>		
No	73.0	63.9
Yes	27.0	36.1

Table 13 (continued)

Variable	Low (N = 37)	High (N = 36)
<u>Occupational/Educational Field</u>		
Psychology/Social Work	32.4	33.3
Health/Nursing	24.3	8.3
Other	29.7	47.2
N/A	13.5	11.1
<u>Crisis Line Training</u>		
No	45.9	41.7
Yes	54.1	58.3
<u>Previous Training</u>		
No	56.8	63.9
Yes	43.2	36.1

Note. Numbers represent percentages. Differences are not statistically significant.

Table 14

Means and Standard Deviations of Demographic and Predictor Variables for Low and High Altruistic Motivation Groups

Variable	Low (N = 37)		High (N = 36)	
	Mean	S.D.	Mean	S.D.
Age (Years)	32.78	9.61	27.50	6.13
Education (Years)	15.84	2.17	16.42	2.45
Crisis Experience	9.23	15.45	8.94	13.51
Prior Experience	18.43	46.87	7.50	15.74
IRI-PT	20.43	3.51	20.28	4.39
IRI-EC	20.32	4.06	22.39	4.24
IRI-PD	8.35	4.58	7.69	3.57
IRI-FS	15.19	5.81	16.69	5.16
Altruism	1.32	1.20	7.03*	2.48
BIDR-IM	16.62	4.44	16.89	4.40
BIDR-SE	15.03	3.56	16.06	3.88
BIDR-DN	16.05	4.22	17.25	3.76

Table 14 (continued)

Note. * $p < .005$ (2-tailed). A Bonferroni inequality was utilized to minimize the increase in Type I error associated with multiple pair-wise comparisons: alpha was set at a conservative $p < .005$ level (2-tailed; i.e., $p = .10$ divided by 16). IRI-PT, IRI-EC, IRI-PD, and IRI-FS = Interpersonal Reactivity Index subscales - - Perspective Taking, Empathic Concern, Personal Distress, and Fantasy, respectively. Altruism = Measure of Altruistic Motivation. BIDR-IM, BIDR-SE, and BIDR-DN = Balanced Inventory of Desirable Responding subscales -- Impression Management, Self-Deceptive Enhancement, and Self-Deceptive Denial, respectively. Previous Experience = previous counselling experience (months). Crisis Experience = months at Klinik.

As seen in Tables 13 and 14, subjects in the High Altruism group were slightly younger, more of them were female (86.1 vs 70.3), more of them were single (69.4% vs. 45.9), and more of them were working or studying in a non-helping field (47.2% vs. 27.9%). They also scored higher on IRI empathic concern. In other words, younger, single females who were not working or studying in a helping field were more likely to volunteer for altruistic reasons (e.g., help people) and to report feeling higher levels of sympathy for persons in distress.

More of the Low Altruism group were male (29.7% vs. 13.9%), older, married (24.3% vs. 11.1%) or separated/divorced (18.9% vs. 11.1%), and working or studying in a health/nursing field (24.3% vs. 8.3%). In other words, older males working or studying in a health/nursing field were more likely to volunteer for egoistic reasons (e.g., build resume).

The two groups did not differ on the BIDR, years of education, previous counselling training and previous experience, and Klinik training and Klinik experience. In other words, reasons for volunteering did not appear to be related to levels of impression management, making positive self-attributions, denying negative self-attributions, years of education, having previous counselling training and experience, and having Klinik training and experience.

Table 15 presents the vignette and mean scores for the previously trained and untrained groups on the HRQ. Subjects in the Low Altruism group appear to score significantly higher on HRQ communicative empathy than High Altruistic subjects.

Insert Table 15 about here

Table 15

Means and Standard Deviations of HRQ Communicative Empathy Scores for Low and High Altruistic Motivation Groups

HRQ	Low (N = 37)		High (N = 36)	
	Mean	S.D.	Mean	S.D.
Vignette 1	1.57**	0.83	1.15	0.35
Vignette 2	1.53	0.64	1.40	0.80
Vignette 3	2.03	1.40	1.47	1.02
Vignette 4	2.11**	1.35	1.39	0.90
Vignette 5	1.57	0.92	1.30	0.49
Vignette 6	2.54	1.60	2.00	1.16
Mean Score	1.89**	0.76	1.45	0.52

Note. * $p < .05$ (1-tailed) ** $p < .01$ (1-tailed). HRQ = Helpful Responses Questionnaire.

Regression Analyses

As indicated above, several additional multiple regressions were run in order to get a better understanding of the sample and the relationship between the predictor variables and HRQ communicative empathy. These included standard regressions with smaller sets of predictors and stepwise regressions for the total sample and trained/untrained groups. Furthermore, it was determined that the high frequency of low empathy scores may have made it too difficult to model the data appropriately; consequently, HRQ communicative empathy was transformed into its mathematical inverse (Tabachnik & Fidell, 1989). Additional regressions run with inverse communicative empathy included mixed stepwise/hierarchical regression and three stepwise regressions -- for the total sample and trained and untrained groups.

Previous counselling training and crisis intervention training. A standard regression was run with previous and crisis training as the predictor variables for HRQ empathy. The regression was significant: $R^2 = .083$, (adjusted $R^2 = .057$), $F_{\text{model}}(2, 70) = 3.156$, $p < .05$. -- but explained only about 6 percent of the variance associated with HRQ communicative empathy.

Previous counselling training, crisis intervention training, and altruistic motivation. A standard regression was run with previous training, crisis training, and altruistic motivation as predictor variables for HRQ empathy. The regression was significant -- $R^2 = .136$, (adjusted $R^2 = .098$), $F_{\text{model}}(3, 69) = 3.614$, $p < .05$. -- but only predicted about 10 percent of the variance associated with HRQ communicative empathy.

Previous counselling training, altruistic motivation, and age. A standard regression was run with previous training, altruistic motivation, and age as predictor variables for HRQ empathy. The regression was significant ($R^2 = .148$, (adjusted $R^2 = .111$), $F_{\text{model}}(3, 69) =$

4.006, $p < .01$) but still only predicted about 11 percent of the variance associated with HRQ communicative empathy.

Stepwise regression for the total sample. A stepwise regression was run for the total sample with a set of potential predictors of HRQ communicative empathy that included the BIDR scales, the IRI scales, altruistic motivation, and demographic variables, and Clinic training and experience. Only three predictors were found to be significant: altruistic motivation ($\beta = -0.04$; partial $R^2 = .08$; model $R^2 = .08$), working/studying in a health/counselling field ($\beta = 0.34$; partial $R^2 = .06$; model $R^2 = .14$), and age ($\beta = 0.02$; partial $R^2 = .05$; model $R^2 = .18$). The regression was significant ($R^2 = .18$, $F_{\text{model}}(3, 69) = 5.20$, $p < .003$) but explained only about 18 percent of the variance associated with HRQ communicative empathy.

Stepwise regression for untrained Clinic subjects. A stepwise regression was run for the Untrained group ($n = 31$) with a set of potential predictors of HRQ communicative empathy that included the BIDR scales, the IRI scales, altruistic motivation, and demographic variables, and Clinic training and experience. Four predictors were found to be significant: previous counselling training ($\beta = 0.13$; partial $R^2 = .23$; model $R^2 = .23$), altruistic motivation ($\beta = -0.04$; partial $R^2 = .11$; model $R^2 = .34$), working/studying in a helping field ($\beta = 0.14$; partial $R^2 = .07$; model $R^2 = .41$), and months of education ($\beta = 0.02$; partial $R^2 = .03$; model $R^2 = .44$). The regression was significant ($R^2 = .44$, $F_{\text{model}}(4, 27) = 6.54$, $p < .002$) and explained 44 percent of the variance associated with HRQ empathy in untrained subjects.

Stepwise regression for trained Clinic subjects. A stepwise regression was run for the Untrained sample ($n = 41$) with a set of potential predictors of HRQ communicative empathy that included the BIDR scales, the IRI scales, altruistic motivation, and demographic variables. Only one predictor was found to be significant: age ($\beta = 0.03$; partial $R^2 = .13$; model $R^2 =$

.13). The regression was significant ($R^2 = .13$, $F_{\text{model}}(1, 39) = 5.75$, $p < .02$) and explained only about 13 percent of the variance associated with HRQ communicative empathy for trained subjects.

Inverse Communicative Empathy

As indicated above, it was determined that the high frequency of low empathy scores may have made it too difficult to model the data appropriately; consequently, HRQ communicative empathy was transformed into mathematical inverse (Tabachnik & Fidell, 1989). Inverse communicative empathy was strongly negatively associated with HRQ communicative empathy: $r = -.94$ ($p < .0001$). Consequently, scores negatively associated with inverse communicative empathy can be viewed as being positively associated with untransformed communicative empathy. Additional regressions run with inverse communicative empathy included hierarchical regression and stepwise regressions for the total sample and trained and untrained groups.

Hierarchical regression. Hierarchical regression was employed to determine whether crisis intervention training improved the prediction of inverse HRQ communicative empathy, after controlling for impression management (and denial), demographic variables (age, gender, marital status, years of education, and current student status), field/training variables (educational/occupational field, previous counselling training, and previous counselling experience), and dispositional variables (IRI empathy scales, BIDR enhancement and denial, and altruistic motivation). As indicated above, given the large number of predictor variables, a "mixed" stepwise/hierarchical regression was employed in order to preserve the parsimony of the regression model (Dr. C. Huynh, personal communication, March 17, 1996). A two-step process was employed: (1) stepwise regressions were performed on "theoretical clusters" in order to find the best model for that cluster; (2) the "best" models were then entered into

a hierarchical regression.

The 5 clusters used in these regressions were the same as were used to test Hypothesis 2: Cluster 1 involved the BIDR impression management (IM) and self-deceptive denial (DN) measures. Although neither IM nor DN were significant, IM was retained for the hierarchical model in order to control for biased responding: $R^2 = .003$, $F_{\text{model}}(1, 71) = 0.200$, $p < .66$.

Cluster 2 consisted of basic demographic variables: age, gender, marital status (coded as 1 = currently single/separated/divorced; 2 = currently engaged/cohabitating/ married), years of education, and current student status (coded as 0 = currently not student; 1 = currently student). Only age was found to be significant: $R^2 = .095$, $F_{\text{model}}(1, 71) = 7.42$, $p < .01$.

Cluster 3 involved three variables -- educational/occupational field, previous counselling training, and previous counselling experience (in months) -- all of which were related to being in the helping/counselling field. Only educational/occupational field was found to be significant: $R^2 = .107$, $F_{\text{model}}(1, 71) = 8.54$, $p < .01$.

Cluster 4 consisted of dispositional variables: BIDR self-deceptive enhancement, the four IRI scales (perspective taking, empathic concern, personal distress, and fantasy), and measure of altruistic motivation. Only altruistic motivation and BIDR enhancement were found to be significant: $R^2 = .115$, $F_{\text{model}}(2, 70) = 4.57$, $p < .01$.

Finally, cluster 5 consisted of Klinik crisis-intervention training (coded as 0 = untrained; 1 = trained) and months of experience at Klinik. Only Klinik training was found to be significant: $R^2 = .050$, $F_{\text{model}}(1, 71) = 3.76$, $p < .06$.

Table 16 displays the standardized regression coefficients (β), R^2 , and F_{model} for each step of the regression.

At step 1, BIDR impression management was forced into the model to control for artifactual variance. Impression management was not a significant predictor of HRQ empathy:

$R^2 = .003$, $F_{\text{model}}(1, 71) = 0.200$, $p < .66$. At step 2, age (i.e., "demographic" cluster) was added to the equation: $R^2 = .098$ (Adjusted $R^2 = .073$), $F_{\text{model}}(2, 70) = 3.820$, $p < .07$. The demographic cluster accounted for about 7 percent of the variance in communicative empathy. At step 3, educational/occupational field (i.e., the "helping field" cluster) was added to the model: $R^2 = .158$ (Adjusted $R^2 = .109$), $F_{\text{model}}(4, 68) = 3.194$, $p < .02$. The model now accounted for nearly 11 percent of the variance in HRQ communicative empathy. Next, altruistic motivation and BIDR enhancement (i.e., the "dispositional" cluster) were added to the model: $R^2 = .254$ (Adjusted $R^2 = .199$), $F_{\text{model}}(5, 67) = 3.519$, $p < .01$. The model now accounted for about 20 percent of the variance in communicative empathy. Finally, at step 5, Klinik crisis line training was added: $R^2 = .284$ (Adjusted $R^2 = .219$), $F_{\text{model}}(6, 66) = 2.650$, $p < .001$. The combination of demographic, personality, and Klinik training variables accounted for about 22 percent of the variance in communicative empathy.

Insert Table 16 about here

Table 16

Hierarchical Regression of Predictor Variables on HRQ Communicative Empathy(Inverse)

Variable	F_{model}	β	R^2
<u>Step 1</u>			
BIDR-IM	0.200	-0.008	0.003
<u>Step 2</u>			
Age (Years)	3.820	-0.006	0.099
<u>Step 3</u>			
Field	5.814	-0.114	0.202
<u>Step 4</u>			
Altruism		0.012	
BIDR-SE	4.571	0.008	0.254
<u>Step 5</u>			
Crisis Training	4.370	-0.087	0.284

Note. N = 73. Field (0 = other, 1 = health/counselling). Altruism = Measure of Altruistic Motivation. BIDR-IM and BIDR-SE = Balanced Inventory of Desirable Responding subscales -- Impression Management and Self-Deceptive Enhancement, respectively.

Stepwise regression for the total sample. A stepwise regression was run for the total sample with a set of potential predictors of inverse HRQ communicative empathy that including the BIDR scales, the IRI scales, altruistic motivation, demographic variables, and Klinik training and experience. Four predictors were found to be significant: working/studying in a health/counselling field ($\beta = -0.14$; partial $R^2 = .11$; model $R^2 = .11$), age ($\beta = -0.01$; partial $R^2 = .09$; model $R^2 = .20$), Klinik crisis intervention training ($\beta = -0.08$; partial $R^2 = .03$; model $R^2 = .23$), and altruistic motivation ($\beta = 0.01$; partial $R^2 = .03$; model $R^2 = .26$). The regression was significant ($R^2 = .18$, $F_{\text{model}}(4, 68) = 5.88$, $p < .0004$) but explained only about 26 percent of the variance associated with inverse HRQ communicative empathy.

Stepwise regression for untrained Klinik subjects. A stepwise regression was run for the Untrained sample ($n = 32$) with a set of potential predictors of inverse HRQ communicative empathy that including the BIDR scales, the IRI scales, altruistic motivation, and demographic variables. Only three predictors were found to be significant: previous counselling training ($\beta = -0.14$; partial $R^2 = .23$; model $R^2 = .23$), altruistic motivation ($\beta = 0.02$; partial $R^2 = .11$; model $R^2 = .34$), and working/studying in a health/counselling field ($\beta = -0.14$; partial $R^2 = .07$; model $R^2 = .41$). The regression was significant ($R^2 = .41$, $F_{\text{model}}(3, 28) = 6.47$, $p < .002$) and explained about 41 percent of the variance associated with inverse HRQ communicative empathy for untrained subjects.

Stepwise regression for trained Klinik subjects. A stepwise regression was run for the Untrained sample ($n = 41$) with a set of potential predictors of inverse HRQ communicative empathy that including the BIDR scales, the IRI scales, altruistic motivation, and demographic variables. Only one predictor was found to be significant: age ($\beta = -0.01$; partial $R^2 = .09$; model $R^2 = .09$). The regression was significant ($R^2 = .09$, $F_{\text{model}}(1, 39) = 5.75$, $p < .02$) and

but explained only about 9 percent of the variance associated with inverse HRQ communicative empathy for trained subjects.

Preliminary Qualitative Analyses

Preliminary qualitative analysis was carried out by the primary investigator. As indicated above, the primary investigator, having randomized the data, was blind to individual subjects' group membership. The method involved a two step process: First, the primary investigator systematically went through the HRQ responses and coded them as roadblocks (e.g., question, advice-giving, problem-solving, reassurance, etc.), door-openers, empathic responses, etc., as seemed appropriate. This procedure is consistent with the open coding methodology described by Straus and Corbin (1990), which involves going through the data and picking out and coding themes, patterns, and categories. A key point in open coding is that the investigator is "open" to new codes/categories as they "emerge" from the data. Although the primary investigator had had some coding categories in mind at the onset (e.g., door-opener, advice-giving, etc.), from the literature (e.g., Mishara & Daigle, 1992) and his own crisis line work, he remained open to creating new categories as seemed warranted by the data. For example, "mixed responses" were common -- that is, responses that were best coded as combinations of coding schemes. For instance, subjects often asked information-seeking questions that also involved problem-solving and/or advice-giving and/or blaming components. For example, on vignette 4, a subject asked, "Have you tried to talk to your daughter in a way that listens to her feelings and was not just you telling her what to do?" The response asks a question but also implies what the mother should do and how she should do it, and it blames her for not doing so.

Coding. Several categories of responses were coded: Empathy, generating empathic statements or empathic questions (scored 3, 4, or 5 on the HRQ); door-openers, statements

aimed conveying the helper is listening and wants to hear more (e.g., "Tell me more."); advice-giving, giving advice (e.g., "You should talk to him about how you feel."); problem-solving, trying to help the client solve a problem (e.g., "What would happen if you tried to tell him how you feel?"); question-asking, asking questions, seeking information, empathic questions, problem-solving, etc. (e.g., "How long has this been going on?"); normalizing, telling the client that they are not alone in feeling the way they do (e.g., "A lot of people find this kind of thing difficult."); reassurance, offering the client reassurance or support (e.g., "I'm sure your daughter cares about you."); strokes, making positive statements about the client, reinforcing them for making good decisions (e.g., "It's good that you've decided to make a change."); diagnosing, telling the client what the problem is (e.g., "It sounds like she has a self-esteem problem."); blaming, blaming the client for the problem (e.g., "Why do you let him take advantage of you?"); and misses, ignoring or minimizing the content of the client's message (e.g., the client says he's depressed and lists a number of negative life events; the helper then asks, "Has anything happened to make you feel like this?"). Mixed responses were coded as belonging to multiple categories. For example, if a response involved empathy, advice-giving, and problem-solving, each category received a point.

Step 2 of the analysis involved comparing some of the data through visual inspection of the patterns of codes obtained in step 1 and by comparing frequency counts of coded responses (i.e., number of questions, number of advice-giving statements, etc.) for different subgroups of subjects. Given that these were preliminary analyses and the fact that the coding schemes used may need to be modified, statistical analyses were not performed; only descriptive analyses are presented here. Five sets of comparisons were analyzed: (1) Clinic Training versus No Clinic Training; (2) Previous Counselling Training versus No Previous Counselling Training; (3) High versus Low Altruistic Motivation; (4) Clinic Training and

Previous Training versus No Training; and (5) Klinik Training versus Previous Counselling Training. The results of the preliminary analyses suggest some interesting differences between the various groups.

Klinik training. The first set of analyses compared the responses of two groups (20 subjects each) who differed in terms of Klinik training -- and controlled for previous counselling training and altruistic motivation for volunteering at Klinik. That is, only the responses of subjects who had a) no previous counselling training and b) who were matched on altruistic motivation were compared. Untrained subjects appeared to be four times as likely to miss the emotional content of a client's statement, almost three times as likely to give advice and strokes, and twice as likely to give reassurance and make diagnoses. The groups were about equal on door-openers and blame. Klinik Trained subjects appeared to be twice as likely to make empathic responses, ask questions, problem-solve, and normalize.

Previous counselling training. The second set of analyses compared the responses of two groups (10 subjects each) who differed in terms of previous counselling training -- and controlled for Klinik training and altruistic motivation. That is, only the responses of subjects who had a) no Klinik training and b) who were matched on altruistic motivation were compared. The Previously Untrained group appeared to offer almost eight times as much reassurance, make three times as many misses, and give four times as much advice as the Pretrained group. Both groups tended to be about equal on door-openers, problem-solving, diagnoses, normalization, strokes, and blame. Although both groups asked a lot of questions, the Pretrained group appeared to ask somewhat more questions. Finally, the Pretrained group were about two times more likely to generate empathic responses.

Altruistic motivation. The third set of analyses compared the responses of subjects who differed in terms of altruistic motivation for volunteering at Klinik -- and controlled for

Klinic training and previous counselling training. That is, only the responses of subjects who had a) no Klinic training and b) no previous counselling/helping training were compared. The High Altruism group (i.e., the ones volunteering because they want to help people) appeared to offer twice as much reassurance and advice than the Low Altruism group; they also appeared to make more misses and blaming responses. Both groups asked a lot of questions and both tended to be fairly low on problem-solving. Both groups tended to be about equal on diagnoses, normalization, door-openers, and strokes. Finally, although both groups were generally low on empathic statements, the Low Altruism group appeared to give almost three times more empathic responses.

Klinic training and previous counselling training versus no training. The next set of analyses compared the responses of two groups (20 subjects each) who differed in terms of Klinic training and previous counselling training -- and controlled for altruistic motivation. That is, the responses of subjects who had both kinds of training (i.e., Klinic and previous) were compared with those of subjects who had no training at all. Preliminary results suggest that the No Training group appeared to be four times as likely to miss the emotional content of a client's statement, almost three times as likely to give advice, and twice as likely to give blame, reassurance, and strokes. The groups appeared to be about equal in making diagnoses and door-openers. On the other hand, the Both Training group appeared to be three times as likely to make empathic and problem-solving responses, and twice as likely to ask questions and to normalize.

Klinic training versus previous training. The final set of analyses compared the responses of two groups (13 subjects each) who differed in terms of having Klinic training or having previous counselling training -- and controlled for altruistic motivation. Preliminary results suggest that the groups were about equal in terms of generating empathic statements -

- with the Klinic group scoring slightly higher. The Klinic group appeared to be almost three times as likely to give advice and reassurance, and twice as likely to ask questions, problem-solve, and normalize. The Previous group appeared to give almost three times more strokes. The groups appeared to be about equally low in making diagnoses, door-openers, misses, and blame.

Correlation analysis. Finally, a correlation analysis was employed to further explore the relationship between different categories of responses (e.g., empathy, advice-giving, question-asking, etc.) per subject with Klinic training, previous counselling training, altruistic motivation, and HRQ communicative empathy. The results of the analysis are presented in Table 17.

As can be seen in Table 17, HRQ communicative empathy was positively associated with empathy (i.e., empathic content) and door-openers, and negatively associated with advice-giving and misses. Also, there was a trend for HRQ empathy to be negatively associated with question-asking and blaming. In other words, more "empathic" subjects did more empathic responding and door-openers, were less judgemental, gave less advice and reassurance, and made less misses.

Klinic training was positively associated with problem-solving, empathy, and question-asking, and negatively associated with "misses" and advice-giving. Also, there was a trend for Klinic training to be negatively associated with reassurance and blaming. In other words, Klinic training teaches empathic communication as well as problem-solving and question-asking.

 Insert Table 17 about here

Table 17

Pearson Correlations for Frequencies of HRQ Responses with Altruistic
Motivation, Previous Training, Clinic Training, and HRQ Communicative
Empathy

Variable	Altruistic Motivation	Previous Training	Klinic Training	HRQ Empathy
Empathy	-0.34**	0.32**	0.37***	0.79***
Door-openers	-0.09	0.10	0.09	0.24*
Validation	-0.07	-0.06	0.13	0.15
Normalization	-0.12	0.04	0.14	-0.12
Problem-solving	-0.05	0.04	0.32**	-0.08
Question-asking	0.01	0.13	0.43***	-0.20
Strokes	0.19	0.07	-0.05	0.03
Diagnosing	0.20	0.05	-0.11	-0.02
Advice-giving	0.20	-0.31*	-0.29**	-0.42***
Reassurance	0.06	-0.16	-0.19	-0.08
Blaming	-0.08	-0.09	-0.19	-0.15
Misses	0.23*	-0.18	-0.32***	-0.29**

Note. * $p < .05$ ** $p < .01$. *** $p < .001$.

Previous counselling training was positively associated with empathy, and negatively associated with advice-giving. Also, there was a trend for previous training to be negatively associated with reassurance and misses. In other words, persons with previous counselling training tend to be more empathic, give less reassurance and advice, and make less misses.

Klinic training and previous counselling training appeared to be about equally positively associated with empathy and negatively associated with advice-giving and less reassurance. In other words, trained (Klinic or other) individuals tend to be more empathic and give less advice and reassurance. However, Klinic training also appeared to be associated with less misses than previous counselling training. In other words, Klinic trained subjects were less likely to miss empathic content than subjects with other kinds of training. Finally, Klinic training was also associated with problem-solving, whereas other counselling training was not -- suggesting, again, that Klinic training emphasizes problem-solving.

Finally, altruistic motivation was positively associated with misses and negatively associated with empathy. Also, there was a trend for altruistic motivation to be associated with diagnosing, advice-giving, and strokes. In other words, subjects volunteering because they wanted to "help people" tended to be less empathic, tended to make more misses, give more advice-giving, diagnoses, and reassurance.

DISCUSSION

The goal of the present study was to determine whether crisis intervention training was associated with higher levels of communicative empathy in persons volunteering to be crisis line workers and to explore some of the relationships between the factors that might contribute to higher levels of communicative empathy. As indicated throughout this document, communicative empathy represents one objective measure of therapeutic empathy -- a multidimensional relational construct associated with positive therapeutic outcome. One of the primary goals of the study was to determine some of the main factors important in the selection and training of crisis line paraprofessionals.

The factors that were investigated in this study included demographic variables such as age, gender, years of education, previous counselling training, and field of study/occupation. Other factors included measures of dispositional empathy (e.g., feeling concern for persons in distress, reporting high tendencies to engage in perspective taking, etc.), reasons for volunteering to be a crisis line worker (e.g., wanting to help people, wanting to build one's resume, etc.), and measures of biased responding (e.g., wanting to portray a positive image to others or having a self-deceptive view of one's traits). These factors were hypothesized to be potentially important predictors of paraprofessional skill on crisis lines -- as measured by communicative empathy. These factors were viewed to be potentially important variables in the selection and training of successful crisis line workers. As indicated in the introduction, crisis lines have become a major form of mental health service delivery in North America over the last few years. Crisis lines provide valuable service to many people in need. Most of the lines are serviced by trained volunteers. Empathic communication is an important aspect of crisis line training: As indicated above, what the person in crisis most often needs is to have someone to talk to -- someone who understands

and who is willing to listen.

The number of crisis lines will likely continue to increase in North America and trained paraprofessionals will likely be increasingly more involved in mental health service delivery -- and will likely be working with more distressed and potentially more vulnerable groups. Although the trend to utilize more paraprofessionals is welcomed, there is also increasing public concern that potential volunteers be well screened and well trained before being allowed to engage in service delivery. However, as indicated in the introduction, there is a paucity of research on the selection and training of paraprofessionals.

This final section summarizes the results of the present study and analyzes the implications for the training and selection of empathic crisis line volunteers. Particular attention is paid to the relationship between factors such as crisis training, previous counselling training, dispositional empathy, and altruistic motivation with communicative empathy. The section also assesses the strengths and weaknesses of the present study and suggests areas for future inquiry.

Crisis Intervention Training

One of the main hypotheses in this exploratory study was to assess whether crisis intervention training leads to higher levels of communicative empathy. For the most part, this hypothesis was supported: Trained crisis line workers scored significantly higher on communicative empathy (as measured by the HRQ) than untrained subjects. However, the training effect was weak, and both trained and untrained subjects scored rather poorly on communicative empathy. If one uses Carkhuff's (1969) classification of empathy, both groups responded at levels which detracted from the clients' messages.

To some extent, as was noted in the introduction, the low levels of communicative empathy for both groups were somewhat to be expected. Previous research has shown that

untrained persons score quite low on communicative empathy (Carkhuff, 1969; McCarthy & Knapp, 1984). Moreover, crisis line workers -- given the nature of their work -- also score somewhat lower than other health and counselling professionals (McCarthy & Knapp, 1984; Ryden et al., 1991). Although both groups score low, this does not necessarily mean that they are responding in the same way. For example, untrained persons tend to listen less, give more advice, and be more judgemental (Ryden et al., 1991). Although most crisis line workers are taught nonjudgemental and empathic communication skills (Jimenez & Jimenez, 1990; Mishara & Daigle, 1992), they are also taught behaviours aimed at solving a crisis situation. In addition to being empathic, they are trained to assess dangerous situations, gather information, and offer support. In effect, crisis line workers are taught competing behaviours -- empathic communication and problem solving. On scales such as the EU and the HRQ, these competing behaviours are scored as unempathic.

Qualitative analyses. The results of the preliminary qualitative analyses offer some support to the above conclusions. Both Klinik trained and untrained groups gave a lot of "mixed" responses -- responses that contained elements of door-openers, empathy, and roadblocks (i.e., questions, problem-solving, advice-giving, blame, etc.). However, the quality of the responses differed between the groups. Untrained subjects made more misses and gave more advice, reassurance, diagnoses, and blame; trained subjects gave more empathy, problem-solving, and normalization. Even though Klinik trained were more empathic, the fact that they gave "mixed" responses lowered their HRQ scores.

Furthermore, when the responses of untrained subjects (i.e., subjects with no Klinik training and no previous training) were compared against those of subjects who had both Klinik and other counselling training, it was found that the untrained subjects made more misses, gave more advice, reassurance, and blame. Trained subjects were more empathic, but

also asked more questions, did more problem-solving, and more normalizing.

Previous Counselling Training

Subjects who had previous counselling training scored higher on communicative empathy than subjects who did not have prior training, and it appeared that previous training was stronger predictor of communicative empathy than Klinik crisis line training. Moreover, a positive relationship between prior training and communicative empathy was seen only in the subjects who had not yet received Klinik training. The results add some support to the hypothesis that crisis intervention training teaches competing behaviours: Subjects with previous training will be more empathic than subjects with no previous training -- especially if the previous counselling training tends to focus on empathic communication. Since the previous training/communicative empathy association is not seen in subjects who have received Klinik training, it is possible that Klinik crisis training overshadows previous training.

Qualitative analyses. The results of the preliminary qualitative analyses offer some support to the conclusions about previous training: Untrained subjects (that is, subjects with no Klinik training and no other previous counselling training) gave more reassurance, advice, and made more misses than subjects with previous counselling training (and no Klinik training); previously trained subjects made more responses with empathic content. "Mixed" responses were common.

Furthermore, when Klinik trained subjects were compared with subjects who had previous counselling training, it was found that although Klinik-trained subjects were slightly more empathic, they also gave more advice and reassurance, asked more questions, and did more problem-solving -- behaviours that reduced their HRQ scores.

Working or Studying in a Health/Counselling Field

Working or studying in a health or counselling field was also strongly associated with higher levels of empathy -- especially for untrained volunteers. Working/studying in a helping field was also associated with having had some sort of previous counselling/helping training.

Experience

The fact that previous training, working/studying in a helping field, years of education, and age were found to be associated with higher levels of communicative empathy is supportive of the notion that experience plays a role in empathic responding. Similarly, currently being a student was found to be negatively correlated with age -- and with communicative empathy for the untrained subjects.

Altruistic Motivation

Altruistic motivation was found to be negatively correlated with age and communicative empathy -- especially for subjects who had not received Clinic training. Previous training was also found to be negatively associated with altruistic motivation. One implication is that younger, less experienced persons, tend to be more altruistically motivated than older, more experienced persons. Altruistic motivation is associated with IRI empathic concern, which also showed a negative correlation with communicative empathy -- for untrained subjects. One possible implication is that experience, age, and previous training lead to a decrease in sympathy or empathic concern. A decrease in sympathetic feelings might reflect therapist burnout. Younger people may also be more idealistic in their desire to help people.

At first glance, the results that altruistic motivation (and empathic concern) was negatively associated with communicative empathy -- especially for Untrained subjects -- was

somewhat surprising. One interesting hypothesis for this result might be that subjects who volunteer for altruistic reasons (e.g., wanting to help people in need) are more inclined to try to reassure and give advice to the distressed person. Reassuring and advice giving are roadblock responses on the HRQ and are consequently given low scores. The fact that this correlation is the strongest for the untrained group suggests that Klinik crisis intervention training is correlated with fewer of these behaviours (see below).

The results suggest different patterns of motivation and communicative empathy for different groups. As indicated in Tables 13 and 14, altruistically-motivated subjects tended to be younger, female, and working or studying in a non-helping profession. More egoistically-motivated subjects tended to be older, male, and working/studying in a health-care profession (e.g., nursing). In effect, younger subjects and subjects who have less helping/counselling training may volunteer because they want to help people in distress -- and may try to help people by giving them reassurance and advice. Altruistic motivation in combination with empathic concern may also reflect a level of over-involvement with clients. Older people and people working in helping professions may have more realistic or healthier levels of involvement. These people -- because they are already studying or working in a helping profession -- are more likely to volunteer for more egoistic reasons: For example, they may volunteer in order to build their résumé or because they have friends who are volunteering. Furthermore, given they have more experience (and possibly training), they may have more empathic communication skills.

Qualitative analyses. The results of the preliminary qualitative analyses offer some support to the conclusions about altruistic motivation: Untrained subjects high on altruistic motivation tended to make more misses and give more reassurance, advice-giving, and blaming responses than subjects low on altruistic motivation. Low altruism subjects gave

more empathic responses.

Dispositional Empathy and Desirable Responding

It was also hypothesized that the IRI dispositional measures of empathy would be related to HRQ communicative empathy. The results, however, indicated almost no relationship between these constructs -- with the exception of empathic concern (and fantasy), which pointed to a negative relationship with communicative empathy for untrained subjects (see previous section). As was noted in the introduction, Barrett-Lennard (1981) has argued that because therapeutic empathy is a broad multidimensional construct there is theoretically little reason to assume that different aspects of therapeutic empathy -- for example, dispositional empathy and empathic communication -- will be correlated. It can be argued that dispositional empathy and empathic responding represent extremes of a multidimensional relational empathy model. Consequently, they would be marginally correlated because they represent quite separate entities.

The results also suggested Clinic training was associated with decreased levels of IRI -- that trained subjects reported less perspective taking than untrained subjects. Again, one might expect training to increase perspective taking, in that the therapeutic empathy construct is based on "seeing the world through the client's eyes." One hypothesis is that most potential crisis line volunteers are relatively high on perspective taking -- creating a ceiling effect. It is also possible that the IRI dispositional empathy scales are simply not related to therapeutic empathy. Nevertheless, as indicated in the introduction, persons scoring higher on both perspective taking and empathic concern are more likely to be seen by others as good communicators and better listeners (Davis, 1994). Furthermore, Clary and Orenstein (1991) used high scores on perspective taking scale as representing perspective taking ability in crisis line workers.

Another hypothesis, however, may be that the negative relationship with Klinik crisis training involves a different factor -- related to the BIDR scales. The BIDR are also negatively associated with Klinik training -- and positively associated with IRI perspective taking. Apart from its didactic components, Klinik training is very experiential in nature: Volunteers encounter a variety of emotionally-laden material and are encouraged to share their feelings. Consequently, one effect of crisis training may be to make the people more "honest" -- to others (i.e., less impression management) and to themselves (i.e., less self-deceptive denial and self-deceptive enhancement). The negative association between perspective taking at training may simply reflect the association between perspective taking and the BIDR. On the other hand, some untrained subjects may be trying to give a favourable impression regarding their perspective taking tendencies in order to be selected for training.

Evaluation of the Current Study and Implications for Future Research

The present study is limited by the fact that the design was quasi-experimental in nature. Subjects were self-selected and it was not possible to follow individual subjects through training -- pretest, post-test -- to see if they actually increased on communicative empathy. Because subjects were self-selected, it was difficult to control for subject mortality. Furthermore, as indicated above, multiple T-tests, correlations, and regressions were analyzed. As indicated above, these multiple comparisons increase Type I error; however, given the exploratory nature of the present study, these comparisons were justified.

The study does suggest that there is a small but statistically significant difference between trained and untrained subjects in the expected direction -- trained subjects score higher on communicative empathy than untrained subjects. The preliminary qualitative analyses support this conclusion as well and suggest the presence of different patterns of responding for trained and untrained subjects. The overall variance accounted for by the

predictor variables was small. Although the response rate -- around 32% -- was somewhat low, the sample size was relatively large. Furthermore, the measures used have good validity and reliability -- and the inter-rater reliability on the HRQ was excellent.

The findings of the present study are likely generalizable to other institutions such as Klinik. The results suggest that the sample characteristics were similar to those in other crisis centres (e.g., Clary & Orenstein, 1991; Miller et al., 1991; Mishara & Daigle, 1992). Furthermore, the correlations and intercorrelations for the various scales used in this study replicate those found in the literature. For example, the correlations between the MAM and the IRI measures suggest that the study is generalizable to other crisis counselling centres.

As indicated above, the low rates of empathy found in trained crisis line workers may reflect the presence of competing behaviours. The HRQ asks subjects to write down the "most helpful" response to each vignette. For a crisis line worker trained in empathic responding and problem solving, it may be difficult to choose between the most helpful response. Given that crisis line workers are trained in empathic communication, a more appropriate instruction might be to ask subjects to do something like "demonstrate that you have heard and understood the client."

Furthermore, additional measures of empathic responding could be incorporated in conjunction with the rating scales such as the HRQ. For example, content analysis might be considered to differentiate empathic responses. The preliminary qualitative analyses conducted in this suggest that this may be a more valid measure of communicative empathy.

Another direction of study might be to explore further what crisis professionals feel are "helpful responses." The main assumption in the present study and in the literature, in general, is that empathic responding is the most helpful type of responding. However, the literature also indicates that empathy perceived by the client is the best predictor of outcome.

It is possible that clients may at times perceive "unempathic" responses (e.g., reassurance, problem-solving) as helpful or empathic. The investigation of what crisis line workers themselves would call helpful -- for example, if they were clients -- and also what callers actually perceive as helpful would be useful areas of future study.

Future research should also evaluate the utility of pencil-and-paper measures of empathy, such as the HRQ. The present study does indicate that the HRQ does differentiate trained and untrained subjects on communicative empathy. However, given that this is a pencil-and-paper test, it suffers somewhat on external validity: Although one may assume that subjects would respond the same in real-life situations, there is no way of knowing for sure. Analogue or real-life studies would also be useful in this area. Furthermore, the HRQ is a relatively new measure and needs further research to establish its validity. Although the scale is similar to the Carkhuff EU, the scales may not be equivalent.

Implications for the Selection and Training of Crisis Line Workers

As indicated above, the goals of this study were to explore and determine some of the factors important in the selection and training of crisis line volunteers. First of all, it appears that crisis training is associated with an increase in communicative empathy. The effect of training, although statistically significant, appears to be weak. As indicated above, this small effect may reflect the nature of crisis work and possibly the training of competing behaviours. Given that training does increase communicative empathy, it should be possible to increase and maintain paraprofessionals' communicative empathy -- by emphasizing it more in training and perhaps by having supplementary "booster sessions" or workshops.

The study also indicated that volunteers vary widely in terms of the skills and experience they bring to the crisis lines and in their reasons for volunteering on the lines. Older volunteers, better educated volunteers, volunteers who have had previous counselling

training experience, and volunteers who are working or studying in a health/counselling area will likely be more empathic than volunteers who are younger, who do not have any previous counselling training, and who are working or studying in other-than-helping fields. Based on these differences, potential volunteers may require differential treatment during training: Younger and less experienced volunteers will likely require more training in communicative empathy.

Furthermore, younger and less-experienced persons may volunteer for overly altruistic and sympathetic reasons. The present study indicated that overly altruistic and sympathetic volunteers may be less honest in their reasons for volunteering (i.e., the association between altruism, empathic concern, and impression management and self-deception) -- because they want to be selected for the program or because they truly believe that they are more empathic. One implication is that volunteer abilities need to be evaluated and not taken at face value: Volunteers who claim to be empathic may not be empathic.

Given that people vary in their reasons for volunteering, it is important that agencies meet the needs of prospective volunteers. Some volunteers may want practical experience -- in order to further their career; others may want to feel useful or helpful to others.

In summary, it was found that crisis line training was associated with higher levels of HRQ communicative empathy. Other important factors appeared to be associated with communicative empathy were age, years of education, having prior counselling training, and working or studying in a health/counselling field. Volunteering for overly altruistic reasons, impression management, and self-deception appeared to be negatively associated with communicative empathy. Gender and dispositional measures of empathy did not appear to be related to communicative empathy.

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APPENDICES

Appendix A

Demographic Questionnaire

Before you answer the questionnaires, please tell us a little bit about yourself. All of this information will be kept confidential and will not be linked to your name. We will be looking for general patterns across all participants in this study.

1. Are you male or female?
2. What is your age (in years)?
3. What is your marital status?
4. What is your ethnic background?
5. How many years of school have you completed (including primary, secondary, and post-secondary)?
6. What is your present occupation?
7. If you are a student, what is your field of study?
8. If you are currently a Klinik crisis line volunteer, how many months have you been working on the lines?
9. Have you had any other crisis line or counselling experience prior to working at Klinik? What kind of experience? How long?
10. Any additional comments?

Appendix B

Davis (1980) The Interpersonal Reactivity Index (IRI)

Instructions. The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

ITEM

1. I daydream and fantasize, with some regularity, about things that might happen to me.
2. I often have tender, concerned feelings for people less fortunate than me.
3. I sometimes find it difficult to see things from the "other guy's" point of view.
4. Sometimes I don't feel very sorry for other people when they are having problems.
5. I really get involved with the feelings of the characters in a novel.
6. In emergency situations, I feel apprehensive and ill-at-ease.
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.
8. I try to look at everybody's side of a disagreement before I make a decision.
9. When I see someone being taken advantage of, I feel kind of protective towards them.
10. I sometimes feel helpless when I am in the middle of a very emotional situation.
11. I sometimes try to understand my friends better by imagining how things look from their perspective.
12. Becoming extremely involved in a good book or movie is somewhat rare for me.
13. When I see someone get hurt, I tend to remain calm.

14. Other people's misfortunes do not usually disturb me a great deal.
15. If I am sure I'm right about something, I don't waste much time listening to other people's arguments.
16. After seeing a play or movie, I have felt as though I were one of the characters.
17. Being in tense emotional situations scares me.
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.
19. I am usually pretty effective in dealing with emergencies.
20. I am often quite touched by things that I see happen.
21. I believe that there are two sides to every question and try to look at them both.
22. I would describe myself as a pretty soft-hearted person.
23. When I watch a good movie, I can very easily put myself in the place of a leading character.
24. I tend to lose control during emergencies.
25. When I'm upset at someone, I usually try to "put myself in their shoes" for a while.
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.
27. When I see someone who badly needs help in an emergency, I go to pieces.
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix C

Paulhus (1994) Balanced Inventory of Desirable Responding (Selected items)

Using the scale below as a guide, write a number beside each statement to indicate how true it is.

Not true 0 1 2 3 4 Very true

Self-Deceptive Enhancement

1. My first impressions of people usually turn out to be right.
2. It would be hard for me to break any of my bad habits.*
6. When my emotions are aroused, it biases my thinking.*
7. Once I've made up my mind, other people can seldom change my opinion.
12. I sometimes lose out on things because I can't make up my mind soon enough.*
17. I am very confident of my judgements.
19. It's all right with me if some people happen to dislike me.

Impression Management

21. I sometimes tell lies if I have to.*
22. I never cover up my mistakes.
26. I always obey laws, even if I'm unlikely to get caught.
35. I have done things that I don't tell other people about.*
37. I have taken sick-leave from work or school even though I wasn't really sick.*
39. I have some pretty awful habits.*
40. I don't gossip about other people's business.

Denial

41. I sometimes feel irritated when I don't get my own way.*
44. I have never felt joy over someone else's failure.
47. There have been occasions when I took advantage of someone.*
51. Once in a while I think of things too bad to talk about.*
54. I can't think of anyone I hate deeply.
56. Few of the things I do are simply for my own gain.
58. I never get jealous over the good fortune of others.

Items followed by an * are reverse scored.

Appendix D

Clary & Orenstein (1991) The Measure of Altruistic Motivation (adapted for use at Klinik)

The following is a list of possible reasons for volunteering at Klinik. As honestly and accurately as possible, please indicate your top five (5) reasons for volunteering (place a 1 before the item that represents your major reason for volunteering, a 2 before the next most important reason, and so on until your fifth most important reason).

- personal growth
- to acquire new skills, experience
- *a chance to help others
- to acquire information about career possibilities
- to use special talents that I have
- *to express concern to people in need
- to meet new people
- to increase my self-confidence
- to "repay" previous use of volunteer services
- to enhance my self-image
- academic internship/experiential learning
- *a chance to give of myself without expecting some sort of "pay-off"
- to learn about some of the social services available in the province
- self-understanding
- *to provide a good experience for people in need
- to help maintain a social service agency
- to become more sensitive to others
- to develop better human relations skills
- *to help those less fortunate than I
- to become a better citizen
- to gain skills which will be applicable to other situations
- to have fun and do something constructive at the same time
- to help build my resume'
- other people (e.g., parents, spouse) want me to do volunteer work
- my friend (or friends) is (are) volunteering

*Scored as an altruistic reason.

Appendix E

Miller, Hedrick, and Orlofsky (1991) The Helpful Responses Questionnaire (HRQ)

Instructions

The following six paragraphs are things that a person might say to you. For each paragraph imagine that someone you know is talking to you and explaining a problem that he or she is having. You want to help by saying the right thing. Think about each paragraph as if you were really in the situation, with that person talking to you. In each case write the next thing that you would say if you wanted to be helpful. Write only one or two sentences for each situation. Please print or write clearly.

1. A 41-year-old woman says to you: "Last night Joe got really drunk and he came home late and we had a big fight. He yelled at me and I yelled back and then he hit me really hard! He broke a window and the TV set, too! It was like he was crazy. I just don't know what to do!"

Write here what you would say next.

2. A 36-year-old man tells you: "My neighbour is really a pain. He's always over here bothering us or borrowing things that he never returns. Sometimes he calls us late at night after we've gone to bed and I really feel like telling him to get lost."

Write here what you would say next.

3. A 15-year-old girl tells you: "I'm really mixed up. A lot of my friends, they stay out real late and do things their parents don't know about. They always want me to come along and I don't want them to think I'm weird or something, but I don't know what would happen if I went along either."

Write here what you would say next.

4. A 35-year-old parent says: "My Maria is a good girl. She's never been in trouble, but I worry about her. Lately she wants to stay out later and later and sometimes I don't know where she is. She just had her ears pierced without asking me! And some of the friends she brings home--well I've told her again and again to stay away from that kind. They're no good for her, but she won't listen."

Write here what you would say next.

5. A 43-year-old man says: "I really feel awful. Last night I got drunk again and I don't even remember what I did. This morning I found out that the screen of the television is busted and I think I probably did it, but my wife isn't talking to me. I don't think I'm an alcoholic, you know, because I can go for weeks without drinking. But this has got to change.

Write here what you would say next.

6. A 59-year-old unemployed teacher tells you: "My life just doesn't seem worth living any more. I'm a lousy father. I can't get a job. Nothing good ever happens to me. Everything I do turns rotten. Sometimes I wonder whether it's worth it."

Write here what you would say next.

Appendix F

Gordon's (1970) "Typical Twelve" Responses

1. Ordering, Directing, Commanding. Telling the person to do something, giving her an order or a command.

"I don't care what other people do, you have to do this."

"Don't talk like that."

"Now you go back up there and try it again."

"Stop complaining."

2. Warning, Admonishing, Threatening. Telling the person what consequences will occur if he does something.

"If you do that, you'll be sorry."

"One more statement like that and you'll leave the room."

"You'd better not do that if you know what's good for you."

3. Exhorting, Moralizing, Preaching. Telling the person what she should or ought to do.

"You shouldn't act like that."

"You ought to do this...."

"You must always respect your elders."

4. Advising, Giving Solutions or Suggestions. Telling the person how to solve a problem, giving him advice or suggestions; providing answers or solutions for him.

"Why don't you ask both of them to come here?"

"I suggest you talk to him about that."

"Go and make friends with some other people."

5. Lecturing, Teaching, Giving Logical Arguments. Trying to influence the person with facts, counter-arguments, logic, information, or your own opinions.

"College can be the most wonderful experience you'll ever have."

"Children must learn how to get along with one another."

"When I was your age, I had twice as much work to do."

"Let's look at the facts about college graduates."

6. Judging, Criticizing, Disagreeing, Blaming. Making a negative judgement or evaluation of the person.

"You're not thinking clearly."

"That's an immature point of view."

"You're very wrong about that."

"I couldn't disagree with you more."

7. Praising, Agreeing. Offering a positive evaluation or judgement, agreeing.

"Well, I think you're pretty."

"You have the ability to do well."

"I think you're right."

"I agree with you."

8. Name-Calling, Ridiculing, Shaming. Making the person feel foolish, putting her into a category, shaming her.

- "You're a spoiled brat."
- "Look here, Mr. Smarty."
- "You're acting like a wild animal."
- "Okay, little baby."

9. Interpreting, Analyzing, Diagnosing. Telling the person what his motives are or analyzing why he is doing or saying something; communicating that you have him figured out or have him diagnosed.

- "You're just jealous of him."
- "You're saying that to bug me."
- "You really don't believe that at all."
- "You feel that way because you're not doing well at school."

10. Reassuring, Sympathizing, Consoling, Supporting. Trying to make the person feel better, talking her out of her feelings, trying to make her feelings go away, denying the strength of her feelings.

- "You'll feel different tomorrow."
- "All people go through this sometime."
- "Don't worry, things will work out."
- "You could be an excellent student, with your potential."
- "I used to think that too."
- "You usually do pretty well in that kind of thing."

11. Probing, Questioning, Interrogating. Trying to find reasons, motives, causes; searching for more information to help you solve the problem.

- "When did you start feeling this way?"
- "Why do you suppose you hate school?"
- "Do the kids ever tell you why they don't want to play with you?"
- "Who put that idea into your head?"
- "What will you do if you don't go to college?"

12. Withdrawing, Distracting, Humouring, Diverting. Trying to get the person away from the problem; withdrawing from the problem yourself; distracting the person, kidding him out of it, pushing the problem aside.

- "Just forget about it."
- "Let's not talk about it at the table."
- "Come on - let's talk about something more pleasant."
- "How's it going with your basketball?"
- "Why don't you try burning the school building down?"
- "We've been through all this before."

Gordon's (1970) "Simple Door-Openers"

One of the most effective and constructive ways of responding to people's feeling-messages or problem messages is the "door-opener" or "invitation to say more." These responses do not communicate any of the helper's own ideas or judgments or feelings; they invite the helpee to share his own ideas, judgments, or feelings. They open the door for him, they invite him to talk. The simplest of these are such noncommittal responses as:

"I see."	"Really."
"Oh."	"You don't say."
"Mm hmmm."	"No fooling."
"How about that."	"You did, huh."
"Interesting."	"Is that so!"

Others are somewhat more explicit in conveying an invitation to talk or say more, such as:

"Tell me about it."
 "I'd like to hear more about it."
 "Tell me more."
 "I'd be interested in your point of view."
 "Would you like to talk about it?"
 "Let's discuss it."
 "Let's hear what you have to say."
 "Tell me the whole story."
 "Shoot, I'm listening."
 "Sounds like you've got something to say about this."
 "This seems like something important to you."

These door-openers or invitations to talk can be potent facilitators of another person's communication. They encourage people to start or continue talking. They also "keep the ball with him." They don't have the effect of your grabbing the ball away from him, as do messages of your own, such as asking questions, giving advice, teaching, moralizing, and so on. These door-openers keep your own feelings and thoughts out of the communication process. [Adapted from Gordon, 1970, pp. 41-44, 47-49.]

Appendix G

Examples of the HRQ Rating Scale and Responses

A 35-year-old married man says: "I'm getting really tired of the whole thing. I love her, but it's just not working. I'm always doing something wrong. No matter what I do, she is never satisfied."

Level 1 Responses

"I think you should sit down and talk to her about how you are feeling."

"All relationships go through rough periods.... Things will get better in time."

"Have you tried talking to her about how you feel?"

"What do you mean when you say you're 'always doing something wrong'? What kinds of things do you do?"

"Have you guys thought about taking a holiday together - or doing something fun together?"

"Have you and your wife considered seeing a marriage counsellor?"

"Sounds like your wife is being a real nag!"

"It's often pretty hard to make a relationship work."

"All relationships go through rough periods. You should try talking to your wife and telling her about how you feel. I'm sure that things will get better."

"It sounds like it's time to end the relationship."

"Sounds like you're feeling really sorry for yourself. There are people who are in much worse relationships than yours."

"Are there any positive things about your relationship with your wife? Are there times when things are good between the two of you?"

"You sound like a really caring individual. I don't know why your wife can't see that."

"It sounds like you and your wife are having a communication problem."

Level 2 Responses

"That sounds pretty frustrating and difficult. But I'm sure things'll work out."

"Mmmm hmmm."

"Sounds like you'd like to talk about this. I'm listening."

"Sounds like you feel really torn up about this. You're sick and tired of trying to make the relationship work. But you love your wife and you don't want to lose her. What do you think would happen if you told her how you were feeling?"

"Sounds like you blame yourself for some of the problems in the marriage: It's like you can't do anything right -- you're always doing something wrong. It's like you're beating your head against a wall. But you shouldn't blame yourself."

"You're tired of trying to make the relationship work.... All relationships go through rough periods.... Things will get better in time."

"Sounds like you're really angry with your wife. You're doing all of this work - trying to make the relationship work - but she's never satisfied.... I don't blame you for feeling frustrated. Your wife is being a real nag!"

"When I hear you say that - 'I'm tired of the whole thing' and 'it's not working' - it sounds like you're thinking that maybe the marriage is in trouble - that maybe you guys are going to get divorced.... It sounds like you're blaming yourself, too. 'I can't do anything right.' 'No matter what I do, she's never satisfied.' It's really hard to feel that way. But you really shouldn't blame yourself. A relationship is made up of two people. Your wife is also to blame."

"You sound pretty down about the whole thing ... and tired. Have you tried to talk to your wife about how you feel? Have you talked about seeing a marriage counsellor?"

"Sounds like you feel your marriage is in trouble. You love your wife but you're getting tired of the whole thing - of trying to make things work, doing things wrong, your wife being unhappy. Have you thought about talking to someone about this - like a marriage counsellor? Do you think your wife would go for that?"

"Sounds like you feel pretty down about how your marriage is going. What about your wife? Do you think she feels the same way?"

"Sounds like you're pretty worried and frustrated about the whole thing. It kind of feels like the marriage is in really big trouble. What are you going to do about it?"

Level 3 Responses

"Hmmm. You love your wife ... but you are also getting tired of trying to make the relationship work. Tell me more."

"You're really tired of the whole thing."

"You're tired of trying to make the relationship work."

"I'm listening. I hear you say how you are doing all of these things ... but nothing seems to work ... nothing seems to make your wife happy."

"You're really tired of the whole thing ... tired of doing things, tired of your wife not being happy...."

"You love your wife ... but you're really tired of the whole thing - tired of doing things, tired of your wife not being happy...."

"No matter what you try to do to make the relationship work, nothing seems to work - nothing seems to make your wife happy. Let's talk about this some more if you'd like."

"No matter what you do ... nothing seems to work."

"Sounds like your marriage is important to you."

"No matter what you do, your wife just isn't satisfied."

"It feels like the marriage is not working."

"Sounds like things have been difficult for you and your wife in your relationship. Would you like to talk about it?"

Level 4 Responses

"That sounds pretty frustrating."

"You're feeling kind of helpless about the whole thing."

"It's frustrating when it feels like you can't do anything right."

"Sounds like your wife blames you for a lot of the problems in your marriage."

"You just can't see any solutions how to make this relationship work."

"It sounds like your marriage is in trouble."

"Sounds like you're thinking of a divorce or a separation."

"Sounds like you think the marriage might be in trouble. I'm here if you want to talk about it."

"You're really tired of the whole thing ... tired of doing things, tired of your wife not being happy.... Sounds like your thinking that maybe the marriage is over...."

"You're really tired of the whole thing ... tired of doing things, tired of your wife not being happy.... Sounds like you're almost ready to give up on the marriage."

"You love your wife, but you're getting tired of trying to make your relationship work.... It sounds like you're thinking that maybe you guys will get divorced ... or that maybe you need some help - like a marriage counsellor or something. Does that sound right?"

"Hmmm. Sounds like things have been getting rough between the two of you ... and you're wondering if the relationship will survive or if maybe the two of you will split up."

"When I hear you say that - 'I'm tired of the whole thing' and 'it's not working' - it sounds like you're thinking that maybe the marriage is in trouble - that maybe you guys are going to get divorced."

"You're feeling pretty frustrated right now, aren't you?"

"Are you thinking that you guys might get a divorce?" [Note. This is an "empathic question" as it goes beyond the content of the client's message.]

Level 5 Responses

"No matter what you try to do to make the relationship work, nothing seems to work - nothing seems to make your wife happy. That sounds pretty frustrating."

"It kind of feels like you've been banging your head against a wall in order to make this relationship work. It's really frustrating and it really hurts."

"You're feeling really frustrated...."

"You just can't see any solutions how to make this relationship work."

"It sounds to me like you are feeling a lot of pressure to make this relationship work."

"You're feeling really tired of trying to make this relationship work ... tired and frustrated ... and you're afraid that maybe it's going to end."

"Hmmmmm. Sounds like you feel really torn up about this. You're sick and tired of trying to make the relationship work. But you love your wife and you don't want to lose her."

"Boy, this is tough. You're pretty worried and frustrated about the whole thing. It kind of feels like the marriage is in really big trouble."

"It kind of sounds like you blame yourself for some of the problems in the marriage: It's like you can't do anything right - you're always doing something wrong. It's like you're beating your head against a wall."

"You're really angry with your wife. You're doing all of this work - trying to make the relationship work - but she's never satisfied. It's like, 'What's wrong with her? Why can't she see how hard I'm trying?'.... It's really frustrating."

"Sounds like you've been trying really hard to make this relationship work - so hard that it feels like you've been banging your head against a wall. It's really hard work ... and you're not sure if it's worth it."

"You're feeling really frustrated.... You just can't see any solutions how to make this relationship work."

Appendix H

Questionnaire Instructions

Dear Klinik Volunteer:

The University of Manitoba and Klinik Community Health Centre are conducting a joint research project in order to investigate some of the factors associated with therapeutic communication and the training of volunteer counsellors on crisis lines. We would very much appreciate your participation in this study. It is only through the continued interest and participation of people like you that we can continue to increase our knowledge of effective crisis line counselling.

If you are willing to assist us with this research, please complete the enclosed questionnaire package and return it to us as soon as possible. Your participation is entirely voluntary and you may refuse to answer any of the questions posed to you. The questionnaire package takes about 45 minutes to complete. Please complete the questionnaires on your own. You can return the questionnaire package to us by dropping it off in the CRISIS PROGRAM SURVEY mail-slot next to the Klinik staff mailboxes or by mailing it to us in the enclosed stamped, addressed envelope.

Please do not put your name of any of the questionnaires. All research materials will be kept strictly confidential. Only the researchers will have access to the data. Klinik staff will not have access to any individual's answers. We are not concerned with the answers of any one person but with the answers of all the people who participate in this research as a group. We will provide Klinik staff and all volunteers with a summary of the research results at the end of the study.

We hope that the results yielded by our study will enrich our understanding of the development and training of therapeutic communication in crisis line workers. Such understanding can assist us to better support crisis line workers in their development and improve the services offered by crisis lines. If you have any questions about the study, please feel free to call Andy Lubusko at 474-9338 during regular business hours.

Sincerely,

Andy Lubusko
Research Investigator
Department of Psychology

David Martin
Professor
Department of Psychology

Tim Wall
Crisis Coordinator
Klinik

Appendix I

Follow-up letter to Subjects

Dear Klinik Volunteer:

The purpose of this letter is to make sure that you have received a questionnaire package and to remind you to complete and return it to us if you have. If you have not received a questionnaire package, please pick one up from the box marked "CRISIS PROGRAM SURVEY (BLANK QUESTIONNAIRES) next to the Klinik staff mailboxes. We appreciate the time and effort it takes to fill out the questionnaire package. If you are having any difficulty understanding or completing any of the questionnaires, please give Andy Lubusko a call at 474-9338 during normal business hours. If you have already completed and returned a questionnaire package, please disregard this letter. Thank you again for helping us with this important study.

Sincerely,

Andy Lubusko
Research Investigator
Department of Psychology

David Martin
Professor
Department of Psychology

Tim Wall
Crisis Coordinator
Klinik