

**How can I help you?:
An Exploration of the Experience of Telephone Helpline Workers in
a Crisis Intervention Centre**

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ABSTRACT

This study sets out to explore the work of a crisis intervention centre with particular emphasis on, a general exploration of the services provided by the telephone helpline workers and that of the professional therapists. The discreteness of the telephone helpline service is examined as well as the connection, if any, between the helpline and the face-to-face therapy service. The importance of self-care in a crisis centre is also investigated. These issues are examined within a humanistic/integrative psychotherapy framework. Interviews were conducted with three telephone helpline workers and two therapists in a Dublin city centre crisis centre. The interviews were analysed using qualitative thematic analysis. My exploration showed that there were many connections between the two services, with the benefit being experienced mostly by the therapists. The interviews also demonstrate that the threat of vicarious trauma for the telephone workers validated the notion, that the work they perform on the phone, is in many ways akin to professional therapy. While my exploration of the telephone helpline didn't claim to be an examination of telephone counselling in the true sense, nevertheless exploring the telephone helpline workers day to day experiences revealed that the helpline has a lot in common with actual counselling by phone, with in some instances, the only difference being the length of time spent on the phone by the telephone helpline worker. Overall the findings pointed to the fact that, the work which is currently undertaken by the helpline workers, has many of the characteristics of humanistic and integrative psychotherapy as practiced by professional therapists.

CHAPTER 1

1.1 INTRODUCTION

According to the expert group on mental health policy in their 2006 report, *A Vision for Change* “It is estimated that almost one in four adults experience psychological difficulties that would benefit from expert intervention. In Ireland, the majority of these people are treated by primary care agencies in the community, including GPs, student health services, voluntary organisations and private practitioners.” (*A Vision for Change*, p.92). The Health Service Executive 2005 report, *Mental Health in Ireland: Awareness and Attitudes*, says “While it is far too simplistic to think that encouraging people to talk more will resolve mental health problems in Ireland, there is no doubt that it will help. If mental health becomes more of an everyday issue, that matters to us all, then the stigma attached to getting help can be reduced. While Irish society will continue to experience considerable change and face new challenges ahead, a mentally healthier Irish society will be much better able to cope.” (HSE Report, p. 35). The 2002 SAVI report on *Sexual Abuse and Violence in Ireland* found that half of those affected by sexual abuse and/or violence in Ireland do not disclose their experience to anyone. (McGee, Garavan, de Barra, Byrne, Conroy, p.278). When examining the reasons for not seeking help at the time of the sexual abuse, the most common reason (20%) given was “Did not know where to look” (McGee et al, Table 5.5 p.196). Of those who sought and received help the most valued form of help receivedwas accessed through a variety of agencies and services with the Rape Crisis Centre being the most popular. (McGee et al, 2002, pp.196-197). If the most utilized method of seeking help in adult abuse cases is through a crisis helpline, then the importance of helplines as a means of enabling access to both short and long-term counselling should be of interest to all counsellors. One of the main messages from the report was “...that the demand for medical, counselling and law enforcement re-sources is almost inevitably going to rise. Only a small minority of those abused currently seek professional help, but the trends for help-seeking in this study were of a clear pattern of increase in recent decades. Plans need to be made to cope with this likely increase. (McGee et al, 2002, p.283).

As stated above there is a need to provide access to help and support through counselling and psychotherapy and to examine different ways of offering this help to the public, by using as many means at our disposal as possible, including technology. The continued and increased use of helplines, testifies to their popularity as a means of accessing immediate assistance in a crisis. 10,914 genuine calls were made to the Dublin Rape Crisis Centre's 24 hour national helpline in 2009, an increase of 15% over the 2008 figure. (Annual Report 2009). The future of counselling is moving more and more toward finding new ways of offering counselling in this technological age. Telephone helpline services are usually located in a counselling and psychotherapy centre, which offers services to a discrete population group e.g. those suffering from depression; rape or sexual abuse victims; people in danger of committing suicide; those with substance abuse problems etc. Some of these centres offer follow-on counselling services, to the helpline callers, within the same centre while other centres don't have this facility. I wished to explore the experience of those working professionally on a telephone helpline with a follow-on therapy service. I wanted to explore how they are supported in the centre or how they support themselves in their work; what connection there is between the work of the therapists and that of the telephone workers and what makes the work on the helpline distinct.

Because my focus of attention was on the experience of the people working in crisis centre I choose a qualitative research method which would allow me to conduct a number of semi-structured interviews. Consequently, my research topic dictated the choice of research method. Other considerations which influenced my choice were the time constraints involved in carrying out the research while working full-time and studying part-time. It was also very important that the chosen centre should be easily accessible both geographically and in relation to gaining permission to conduct the interviews. The Dublin Rape Crisis Centre met all these criteria.

1.2 LITERATURE REVIEW

In an early article on the subject of crisis telephone counselling in New York in 1982, Vanda Wark, argues that the necessity for telephone counselling centres can be

gauged mainly by the amount of callers the centre receives. She believed, at that time, telephone counselling was overlooked by counselling professionals and consequently very little research had been done on the topic. This situation still pertains today, with very little research done in the interim into these centres and particular in Ireland. Nonetheless, they continue to exist and to provide a service which, is still needed and of relevance to people in crisis, even in this more technological era. Wark goes on to state that one of the misconceptions about telephone counselling centres at the time in New York was that they were used mainly “as a referral service rather than as a place where people in distress can turn for counseling.” (Wark, 1982, p. 110). In Ireland currently, there are many telephone crisis centres which have no mechanisms in place to refer clients to face-to-face counselling, while others have their own professional therapists who can continue working with clients after the initial telephone call. For Wark, the advantage of telephone counselling is that it allows the client to focus on issues that are critical as opposed to the more in-depth exploration that can be undertaken in long-term counselling. Another advantage which is even more relevant in today’s mobile phone society is the accessibility of the phone. The disadvantages, as Wark outlines, are the lack of continuity in the relationship as the probability is that even if the caller calls back a number of times there is no guarantee that they will get to speak to the same telephone volunteer and also the lack of “visual clues” which can be a drawback for the volunteer, though Wark suggests much can also be gleaned from tone of voice by the experienced telephone volunteer. (1982).

Hall and Schlosar in a study of the Samaritan crisis line in Canada, claim the reason telephone crisis lines are needed in a community can be because of “.....overburdened professionals, waiting lists and an inability to respond in a timely fashion to people in crisis.” (1995, p.66). An *Exploration of Calls to Lifeline Australia* by Watson, McDonald and Pearce in 2006 found that the service was used mostly as social support rather than as a crisis counselling service, which it was set up to provide. Callers presented with a variety of issues but suicidal clients accounted for only a small proportion of calls to the service. This suggested that the service was more of a generalised support than a crisis service. Mary Seeley in an article in *The Journal of Crisis Intervention and Suicide Prevention* emphasises the discreteness of what, she calls, ‘hotlines’ from other mental health services. Her

findings suggested that while there were certain issues which hotlines had in common with other mental and social services, their discreteness lay in their anonymity and the fact that they were technology dependent. For this reason Seeley believed that hotlines should be treated differently when developing policy for mental health services generally. (1996).

In a randomized trial, undertaken with NHS employees in Britain, to compare three occupational stress interventions, including face-to-face counselling versus telephone counselling versus bibliotherapy, the authors found that all three interventions were equally effective. "...the majority of participants appeared generally satisfied with the intervention they received and considered their intervention as effective and beneficial". (Kilfedder, Power, Karatzias, McCafferty, Niven, Chouliara, Galloway & Sharp, 2010, pp. 234). While participants found that they "achieved clinically significant change" in telephone counselling, they expressed "a preference for face-to-face counselling" over the other methods, as they felt that face-to-face therapy "would have been more direct and efficient in helping them with their stressors." (Kilfedder, et al, 2010 pp. 238, 239)

In a study published in 2006, Reese, Conoley and Brossart found that "Telephone counseling clients reported that convenience, accessibility, control, and inhibition were the most attractive attributes of receiving counseling (not crisis intervention) via telephone. The results mirror many opinions in the literature. Of the 186 counseling clients who responded to the survey, 96% would be willing to seek telephone counseling again compared with 63.1% who reported being willing to seek face-to-face counseling. More than half (58%) of the respondents who had experienced both telephone and face-to-face counseling preferred telephone counselling." (2006, p. 54). Ward and Hogan referencing the Reese et al study, found in their evaluation of client-centred counselling, provided via telephone to patients with ME, that they had positive and negative responses to the telephone counselling. They appreciated its accessibility and its anonymity but felt that, the lack of non-verbal communication and not being able to see the counsellor were drawbacks. They assessed the counsellor's "understanding, being genuine and valuing" as very good. (2009, p. 38). This is in line with the responses received in the current study from the telephone helpline workers, with the difference being that

the helpline does not constitute telephone counselling as such, but it demonstrates that the issues are the same.

The above views of telephone helplines see them as existing to ease the burden on other healthcare professionals; as providing social support and anonymity; as convenient, as accessible, as under the control of the callers and as easing inhibitions in clients. One study found that the participants found no difference between telephone counselling and other type of therapy but would prefer face-to-face counselling, while yet another found that more than half preferred telephone counselling. This divergence and complexity of attitudes towards telephone counselling can be accounted for, in part, by the different research approaches used in the studies, the geographical differences and the particular focus of the various studies, but they do show that there is still a discrete service being provided in differing way in many parts of the world and that telephone counselling hasn't as yet been overtaken by online counselling.

In Ireland, the report of the expert group on mental health policy saw the lack of integration of services as one of the many issues to be addressed. Among the most frequently cited issues from the consultation process were,

- “The need for greater access to psychological or ‘talk’ therapies. The demand for psychological and social therapies and the evidence for their effectiveness has been growing in recent years and the consensus among users and service providers was that they should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options that are not consistently available.
- The need for formalised links between specialised mental health services and primary care and mainstream community agencies to support the care and integration of individuals within their local communities was a recurrent theme.” (Expert Group on Mental Health Policy, 2006, p.13).

1.3 AIMS AND OBJECTIVES

My aim in conducting this study was to explore the work of a crisis centre with particular emphasis on, a general exploration of the services provided by the telephone helpline workers and that of the professional counsellors or therapists, what connection, if any, there is between the two services and the importance of self care in a crisis centre.

The objectives of the thesis are:

- To explore the services provided to the public by a crisis centre,
- To explore the relationship between crisis telephone calls and follow-up counselling and to identify lessons to be learned,
- To explore the experience of both the helpline workers and the face-to-face counsellors working in the same centre
- To explore the lessons, if any, for the future of humanistic/integrative psychotherapy.

CHAPTER 2

2.1 METHODOLOGICAL APPROACH

In making a decision about which research method to choose for my research, I came to the conclusion that quantitative research would not give me the answers I wanted. Since one of the main areas of interest I had identified prior to carrying out my interviews was to gather information about the link, if any, between the telephone helpline service and the professional therapy service, I could see no way of obtaining this information using quantitative methods as only the people employed in the centre knew the answer to this.

Miles and Huberman (1984) as quoted by McLeod (1998) define qualitative research as, “words rather than numbers”, while Strauss and Corbin’s definition (1990) also quoted by McLeod (1998) is “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification”. McLeod’s more positive definition is that qualitative research is “a process of systematic inquiry into the meanings which people employ to make sense of their experience and guide their actions” and states that the “..fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people.” (1998, p. 78) I believe that the benefits of using qualitative research for this study were that it enabled me, as outlined by McLeod, to “study real-world phenomena..... with a sense of open-ness regarding whatever emerges”. I allowed my “conclusions to arise from a process of immersion in the data,” as opposed to making a hypothesis fit the conclusions. Using qualitative research required me to put any preconceptions and wishes in relation to the outcome of the research to one side until I could draw actual findings from the data. Qualitative research also dictated that I would find it difficult to draw universal conclusions because the experience of each telephone worker will be unique and special. This has certainly proved to be the case.

My search for a client experience placement, as part of my MA course, required me to make numerous phone calls, to various low-cost centres and led me inadvertently to ring some centres, who it turned out only offered a telephone helpline and

advocacy service and were unable to offer me a placement. These particular centres didn't offer full-time trained counsellors or therapists as part of their services, and I began to wonder what the callers to these helplines did to access further help, once they put down the phone. While I was aware that many helpline callers are in a crisis situation and just require immediate advocacy assistance, obviously there would be others who called because something was triggered for them, from the past, or a current crisis was affecting their ability to lead a normal life. Would a once-off call to a helpline satisfy their needs? Would they consider long-term counselling if they knew it was available or where to access it? Would they require more than one phone conversation to help them through their current crisis? Would this be encouraged in a crisis centre dealing with large volumes of calls each day?

2.2 SAMPLE

Purposive or judgmental sampling is defined by Babbie as "A type of nonprobability sampling in which the units to be observed are selected on the basis of the researcher's judgement about which ones will be of the most use or representative." (2007, p.184).

I considered initially interviewing telephone helpline workers in a number of different centres in the Dublin area. However the timescale and scope of thesis requirements lent itself to a more in-depth study of one centre. I chose the Dublin Rape Crisis Centre principally because it offers a 24 hour crisis phone helpline in conjunction with access to face-to-face, long-term professional therapy. In addition the centre was also chosen because of their willingness to allow access to their employees. Another similar centre had refused access because they were short-staffed and didn't have the time. Included in my interviews was a senior member of the managerial staff, in order to gain an additional perspective on the topic.

2.3 SUBJECTS

For my research I interviewed three telephone helpline workers and two professional therapists from the Dublin Rape Crisis Centre. Between them the interviewees had a total of forty-eight years experience of working in this particular centre. Four of the

interviewees had seventeen years experience between them of working on the telephone helpline. Two interviewees had twenty years experience between them working as therapists in the centre. In addition three of the interviewees also had a total of eleven years experience working as volunteers in the centre.

2.4 RECRUITMENT

I e-mailed the Dublin Rape Crisis Centre outlining my thesis and requesting permission to go to the Centre to conduct some interviews with the telephone helpline workers and with the therapists. I was put in touch with the Clinical Director whom I subsequently visited and she gave me permission to conduct my interviews. I outlined my research proposal to her and with her assistance I was able to interview three telephone helpline workers. These interviews were conducted on the premises of the centre over 4 days a few weeks apart and each interview lasted for between 40-55 minutes each. Due to time constraints on the part of the therapists in the centre, and to my own time constraints, I had to wait for a number of weeks before the final two interviews with therapists working in the centre happened. The interview questions which I had used when interviewing the telephone workers had to be amended slightly for the therapist's interviews, as not all of the questions were relevant. (Appendix 3).

2.5 ETHICS

Before holding my first interview, I drew up an Information Sheet (see Appendix 1) setting out who I was; my contact details; where and what I was studying; what my area of research would focus on and the length of the interview. I then invited the prospective interviewees, to ask me questions concerning any aspect of my study, or the interview process. I encouraged the participants to read the Information Sheet carefully, and I made it clear to them that if they wished to change their minds, at any time, either before or during the interview, that they were at liberty to do so. I drew the participants' attention to the fact that there was a slight risk, that they might find some issues upsetting. In relation to confidentiality, the participants were told that all the interviews were totally confidential; that I would store the transcripts, from the interviews, in a locked filing cabinet; that each participant would be given a code

number to ensure that, I, as the researcher, would be the only person who could identify the interviewee. I told them that the audio recordings of the sessions would be destroyed once a transcript was made. I made them aware that notes from the interviews might be saved, for the purpose of future research, but in that case the same level of confidentiality would apply to the storage and use of materials. Five years after the completion of this thesis all data will be deleted from hard drives and hard copies will be shredded. I included my own contact details and that of my supervisor for further clarification for the participants.

Each participant was then asked to tick and sign a Consent Form (see Appendix 2) stating that they had read the Information Leaflet and that they had an opportunity to ask questions; that their participation was voluntary; that they could withdraw at any time; that they understood that their identity would remain confidential at all times; that they were aware of the potential risks; that audio recordings would be made of the interviews and that unidentifiable data from the interview could be used in future studies.

2.6 SEMI-STRUCTURED INTERVIEWS

“The goal of any qualitative research interview is ... to see the research topic from the perspective of the interviewee, and to understand how and why they come to have this particular perspective.” (Cassell & Symon, 2006, p.11). In attempting to explore the experience that people encounter when they contact a telephone helpline, I will of necessity have to rely on interviews with the people working in the service as it would be impossible for me to gain access to the clients of the centre. One of the disadvantages of this is that I did not personally know, nor have close contact, with the participants. I had to take this into account when I undertook the interviews. However, because the interviews are qualitative rather than quantitative there was scope for me, in the tradition of person-centred counselling, to be more interactive with my interviewees than is the norm in more standard quantitative interviews. McLeod stresses that the qualitative interviewer must pay attention not only to what the interviewee says, but just as importantly, to how it is said. The interviewer must also be aware of non-verbal signs such as gestures, facial expressions and tone of voice. (1998). My method of data gathering was to interview my chosen sample

using a semi-structured interview. The reason for choosing a semi-structured interview was that it enabled me to have a certain amount of control over the questions asked while at the same time allowing the participants a certain freedom in their responses. The interviews were concentrated on themes rather than being rigidly designed. The interview sessions were tape-recorded. Finally, in the true spirit of qualitative research interviews, I endeavoured to ensure that the interview was a positive experience for the interviewee “The interview is a conversation where two people talk about a theme of interest to both parties. A well carried through qualitative interview may be a rare and enriching experience for the interviewee.” (McLeod, 1998, p. 81). Indeed, one of my interviewees did state, at the end of the interview, that she had enjoyed the experience.

2.7 THEMATIC ANALYSIS

“Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data.” (Braun & Clark, 2006, p. 79). Having conducted five interviews with three telephone counsellors and two therapists in the centre I transcribed all five interviews verbatim. The very time-consuming process of transcribing, together with repeated readings of the text, enabled me to get to know the data in detail. Once I had combined the transcripts of all the interviews, I inserted a column to the right of the transcript, where I was able to code aspects of the data, which I felt were note-worthy and relevant. This column enabled me to keep track of where, in the transcript, these codes occurred and how frequently they featured in the different interviews. Having coded the data I assigned separate colours to the codes in order to match the relevant codes with the relevant themes as I developed them.

“A theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning with the data set.” (Braun & Clark, 2006, p. 82). I chose my themes, because I believed that they represented key aspects of the telephone counselling and therapy work in the centre, and because they occurred consistently throughout all the interviews as opposed to just occurring in one particular interview, as described in Braun & Clark (2006). I reconsidered my themes a number of times, and eventually decided to confine myself

to three, because I felt that these three themes, could comfortably incorporate a number of sub-themes, which would in turn, easily encompass the coded data selected. I chose not to label the sub-themes as I believed them to be self-explanatory within the three main themes.

In arriving at my findings and conclusions I took an “essentialist/realist approach” to my analysis which enabled me to take the language and experience of the counsellors/therapists in the centre as articulated by them. (Braun & Clark, 2006).

CHAPTER 3

3.1 INTRODUCTION

The chosen centre runs a telephone crisis helpline manned by four telephone workers in shifts during the daytime and by 70 volunteers throughout the night. It also offers a follow-on therapy service manned by 12 professional therapists. Interviews were undertaken with three of the telephone workers and two of the therapists.

The telephone counsellors had a variety of work experience and training prior to working on the helpline. However, all would have undergone in-house training before commencing work on the helpline. They are provided with continuous training by both in-house and external trainers. There is also an expectation that they would pursue continuous professional training at their own expense. Many had worked as volunteers on the 24 hour helpline before working in the telephone counselling room.

The telephone helpline workers tend to use the title and be referred to within the centre as “telephone counsellors” despite the helpline not constituting telephone counselling as such. The face-to-face psychotherapists are known in the centre as “therapists”. I have chosen to use these titles also to avoid confusion.

3.2 THEME A - Link between telephone counselling and face-to-face therapy

In this section I hope to show that in this particular crisis centre there are definite, clear linkages between the work of the telephone helpline counsellors and the work of the therapists. This theme will underpin further themes in the data analysis which set out to examine how the work of the telephone helpline counsellors is quite distinct while at the same time sharing a humanistic/integrative theoretical framework with the therapists, which will be examined in Theme B and the experience and response of both counsellors and therapists to the issue of self-care

which is of paramount importance in a crisis centre which is examined in Theme C. Since not many crisis centres who have a helpline also offer long-term therapy, the benefits to be gained by providing both services isn't easy to explore. I have to be cognisant of the fact that the experiences of the workers in this particular centre may not be replicated in another such centre, nor can I claim with certainty that this centre should be used as a model for similar centres in the future. Rather I am examining the experience of staff offering different services in a centre which has been in operation for thirty-two years. In addition, the staff in question have amassed a large number of years experience in the centre and consequently their knowledge of how the services interact is of immense value to any study of the workings of such a centre.

Some of the linkages that exist in the centre between the two services have a formal origin, e.g. meetings, protocol for dealing with suicidal clients, arranging of appointments etc. while others occur naturally in the day to day interaction, e.g. holding of clients before and at times, during therapy; providing safety to clients who may as a result go on to consider counselling; assessing clients prior to therapy etc. I will examine, through the views of three telephone helpline workers and two face-to-face therapists, how the two services complement one another; whether one is essential to another; how client confidentiality is handled between services etc.

The most obvious and immediate link between the telephone counsellors is that they make appointments for people who call the centre and want to see a face-to-face counsellor. The callers may wish to make an appointment to see a therapist from the outset or it may happen that they decide to come in for therapy after talking to the telephone counsellors. Obviously the telephone counsellors provide a valuable service to the therapists by ensuring that the caller is suitable for counselling. An assessment is performed on the phone which covers issues such as, whether or not the person has any form of addiction; whether they are under the care of a psychiatrist; if they have clear memories of the assault; whether other family members are also attending the centre; if there are children who are at risk of being abused etc.

Sometimes people say someone assaulted me but I'm not sure..... we only work with people who have clear memories. we don't work with someone who is in addiction or if they're in the early stages of addiction, we say you need to be clean for 12 months before we bring them in.if someone is under the care of a psychiatrist we ask them for a referral letter. (iw4)

In addition if the telephone counsellors feel that there is some specific piece of information that the therapists need to know they are made aware of it.

If the therapist should know something, it would be very important that we would write maybe short notes on the appointment forms we give them or ask them to come into the room to talk to us. We may be concerned about this person and have a piece of information that we think they should know. (iw5).

Because of their contact with the telephone counsellors many callers who would never have considered therapy end up making an appointment to see one of the therapists. The telephone counsellors stressed that they don't "sell" the counselling service but if the caller's issues warrant long-term therapy the telephone counsellors might gently suggest therapy to the caller. In this way, more people end up in therapy than might otherwise be the case.

Family members of the rape victim call the centre for a number of reasons. They may be having difficulty coping with their daughter's/wife's/son's rape, they may want to find out if the victim in question turned up for therapy or why they stopped attending therapy etc. In these situations the telephone counsellors play a vital role in providing support for the family members, while at the same time, ensuring that all information concerning the person attending the centre is kept confidential.

Well we would be very clear about that. We let them know that we are not at liberty to tell them anything that the person may have told us. We don't even let them know that the person is coming in or whether they have made contact. We're very, very strong on that. (iw5)

The telephone counsellors can arrange for a family member to have a supportive therapy session themselves if necessary. They can support them on the phone for the

duration of the victim's therapy or if they wish to talk to a therapist themselves, the telephone helpline service can arrange a support session with the in-house therapist.

*..... if they want to they can use the line for support for themselves.
.....and depending on how distressed the parent might be, the therapist might offer a support session. (iw5)*

They will encourage the family member to try and persuade the victim to make contact with the centre if they have not already done so.

Well, our approach is to ask them if, at all possible, can they persuade the person to call us themselves and that, that is our policy of self-referral, that the person should refer themselves here. We try and stress to them that really we don't do anything until the person is ready to go further and make the decision. That is the first step. (iw5)

In all of these ways the helpline can "hold" the family member if they are upset, thus avoiding the necessity of a face-to-face session with hard-pressed therapists. It also avoids a situation where certain family members might make an appointment with a therapist in the hope of getting information about the rape victim.

The telephone counsellors can also encourage callers, who otherwise might not have thought of it to consider making an appointment to talk to a therapist face-to-face.

..... you will have some people who will be talking about something that happened and you'd ask, 'Have you had any kind of counselling?'" and they might say 'No' and then you'd say, 'Would you like to consider coming in to counselling?'. I mean you may broach that with a person. Tell them about the services we have here and ask them to think about it. (iw4)

For some callers who do eventually go to face-to-face therapy this would not have happened without the initial contact with the helpline.

A lot of the people who come on the phone to us will end up in face-to-face counselling, so you know, they may never have considered it before and they end up in here, so that's the work on the phone.if you introduce it, if you talk to them over time, they may go there. (iw3)

Callers also use the helpline to test out the reliability of the centre and how they might be received if they decide to make an appointment for face-to-face therapy.

Also there's a tie-in that they're testing on the phone to see what it would be like to say it. If they have a good experience, they'll go to the next step of actually saying it to a person. (iw3).

This can be the case with some repeat or even hoax callers to the helpline that they are trying to find out how the people in the centre will receive them and how they will react to their story. If their experience is positive, they may then go on to make an appointment for therapy. For this reason the telephone counsellors have to be very careful how they react to repeat and hoax callers, as they can never be completely sure what is at the bottom of these calls even when they are abusive.

...when I get someone who is hoaxing, I always stay with them and believe them. I would always try to be respectful because I feel if someone is hoaxing us there might be something behind that - they're testing us. (iw3)

You'd go through that in the training, not to let somebody be abusive to you and not to be abusive back, because we're taught, you never know, maybe they're testing out what kind of people are on the phone. (iw4)

Once an appointment has been arranged with a therapist, a very important link between the two services is that a therapy client with suicidal ideation might be encouraged by their therapist to ring the helpline for support between sessions. This can also be used with particularly upset or desperate client when the therapist is away for any length of time. The telephone counsellors can be a container for and can hold the suicidal or desperate client. This particular link between the two services is so important, that it alone, justifies having the two services available to clients in the same centre. The only information that is passed on to the telephone counsellors from the therapists is that the person is in need of support and may call the helpline and that they are a client of the therapist in question. In this way confidentiality is maintained not only within the centre but between the two services.

It is really about holding the person and hanging in there with them and talking to them. Talking them through if they're very bad and then knowing that they are due to meet the therapist at some stage and that we would keep the therapist updated. (iw5)

Obviously this service is of enormous benefit to the therapists also.

And I find that wonderful as a therapist here. I know my clients are safe if I'm away. (iw1).

Having this facility in the same centre means that when the therapist returns they are made aware of the fact that their client contacted the helpline.

It's a great facility to have. The therapist has the facility to say to their client that, for a limited period of time, they can use the helpline for support. Now they'll always notify the helpline staff of that and if somebody is, and many of our clients are, suicidal, or on edge, but actually suicidal, they know to ring the helpline. (iw2)

One of the formal linkages between the two services concerns the protocol that is in place when someone, who is suicidal, rings the helpline. This call could be a new caller or a client who is already in therapy.

We have a very clear system here. You're not left holding a suicidal client. If they ring and they're suicidal there is a backup number for the telephone counsellors to ring and the system is put into place that they're minded, that their therapist gets in touch with them, that their GP is contacted, etc. (iw3)

Both the therapists and the telephone counsellors were asked for their views on the extent to which both services complement one another. Some of the views which demonstrated how the services complement one another were:-

I think we're the first port of call. And I mean, we'd be very aware of different kind of calls like if a person is psychiatric. We kind of weed out all that kind of stuff. The therapist, I don't think, couldn't do all that kind of work and see clients as well. There's an awful lot of stuff that's done on the phone and by the time the person comes in for their appointment it has all been set up for the therapists to work. (iw5)

In this work when people are so traumatised and can be triggered by the slightest little thing and it's all over the place, sex abuse in television programmes, in the news, the papers etc. People can get triggered so easily..... if they're going somewhere where they only

have a therapist it's hard to mind themselves around it. Whereas, if they come here they can ring the helpline..... in the initial stages when they're finding it difficult, or before maybe they have developed the skills to cope with the trauma. Now I would always say to them, "I'll be letting your therapist know you rang". In the early stages when they're opening up for the first time it's good that they have us. (iw4)

Well, they're distinct spheres but we all come together in clinical meetings. we do listen if they want to talk, not about specific calls, but the types of calls, so it's very important that both sides listen to one another and pay attention to one another. So, we do have to keep an eye that there is the integration and sufficient interaction but they are distinct functions..... I think the boundary is important so that's there's interlinking, where it's necessary, but there are boundaries held as well. That's very important, I think, for people using the line and not feeling their information is going all over the place. (iw2)

..... if I ring the helpline (and) how they meet me opens a door for me. Because I do believe that people going to therapy for the first time could walk up and down outside for a long time and then go away and go home. It opens a door, it provides a container almost, where they've started. It's a step in, I do think. (iw1).

However, one telephone counsellor did caution against too much integration. She said,

I actually think that we're working quite well together at the moment. I'd be concerned about us becoming too allied to be honest, it's better that we keep going with uncertainty. We're working well at the moment and we back them up in their client work but we don't necessarily have to be involved in their client work and we're not, that's the next step. (iw3)

As the above quotations demonstrate the links between the two services can be summarised as administrative tasks, such as organising appointments and conducting assessments of potential clients that the telephone counsellors perform for the therapists. In providing support for family members of rape victims they free up time for the therapists to concentrate on the victims. By providing reassurance to callers uncertain about therapy or hoax or repeat callers who are testing the reliability of the centre, the telephone counsellors are ensuring that all callers to the centre experience the centre as being supportive and respectful. Both services co-ordinate the information between them to ensure that client confidentiality is protected at all times. By acting as a container for desperate or suicidal clients between therapy

sessions the telephone counsellors provide a vital service to both the clients and the therapists.

3.3 THEME B – How the experience of working on a day-time crisis helpline is distinctive.

In Theme B I set out to explore how the work of the telephone helpline counsellors is quite distinct from the work of the therapists. However I also hope to demonstrate that what they have in common with the therapists is that they share a humanistic/integrative theoretical framework which forms the basis of their work as it does with the therapists.

The issues discussed focussed on how the telephone counsellors viewed their work on the phone; the extent to which they found it fulfilling or frustrating; if they viewed the service they offer as effective and if they were aware of the callers' view of the service. Counsellors were also asked to discuss the skills and techniques they utilise in the course of an interaction with a caller on the phone. To identify the distinctiveness of the service I endeavoured to get a picture from the therapists of their day to day work including administrative duties for which they also have responsible.

One aspect of the work of the telephone counsellors which makes it very distinct is the administrative duties which form part of their everyday responsibilities. The additional duties, which were identified, included; referrals to the Sexual Assault Treatment Unit (SATU); making appointments for callers for follow-up therapy in the centre; ensuring these appointments go ahead, liaising with the therapists about their availability for therapy; and maintaining a diary on the calls received. These duties are obviously vital to the smooth running of the centre and the work on referring clients and keeping in contact with them until a vacancy arises is of immense assistance to the therapists in the centre. The telephone counsellors did not have strong views about this aspect of their work viewing it as necessary and at times a welcome respite from answering the phone.

However, one of the frustrations which was identified in the work and which could also be viewed as a distinctive aspect was having to deal with repeat callers, many of whom ring the centre continuously.

I mean I'm here for eight and a half years and there are people who are ringing the line for eight and a half years. (iw4)

However, there was an understanding that the reason some people call the centre continuously is because they are stuck and can't move on in their attempts to resolve their problem. The frustration experienced by the telephone counsellors was that it can be difficult to connect with these people but the frustration was also on behalf of the client who can't make progress.

.....someone who you can't connect with; there is no moving, they are stuck, these are the stuck people.... and that's frustrating and difficult because you're hitting a brick wall, everywhere you go with them you're hitting a brick wall and they're circling and they're upset and they're throwing it back at you. You have to stay open to it. (iw3)

Generally the counsellors pick up the phone as required and repeat callers are not encouraged to ask for the same person they spoke to before in case they become dependent on the service. This is obviously very distinct from face-to-face counselling. However, one counsellor did admit that you can sometimes get the same person a lot by accident and you would then build up a relationship with them.

Another distinct frustration was the fact that you don't know what will happen to the person; that you can't go too deep with the person and can't get too involved. Obviously this is exactly what the therapist in face-to-face therapy would be able to accomplish with their client.

.....you're conscious that you're running a crisis line and that there's only so much you can do with a person it is about holding the person for that little bit of time and to try to give them as many options as you can so that when they go off they feel a little bit better or they may do something else about their situations.you can't go in depth on the phone. (iw5)

...the reason it's frustrating is again because you don't know where the person is going to end up or whether they are going to be OK.

So, that can be hard to carry and that can get in on you. Sometimes I'm going to leave here thinking, 'I hope they're going to be OK. (iw3)

The telephone counsellors often have to deal with family members of a recent rape or sexual assault victim and this places a certain amount of strain on them to ensure that client confidentiality is maintained while at the same time appreciating the difficulty and stress that the situation puts family members under and responding appropriately to their need for support.

...you can get supporters, a mother or father, sister, husband or wife or whatever and they could also be quite intense because these people find it very difficult to cope or maybe they want information around it, where can they go, what can they do. (iw2)

From a therapeutic viewpoint another frustration that was cited was that when talking to a client on the phone you miss all the non-verbal clues which the therapist can use to gain additional insight into how the client is actually feeling. The emphasis on the phone has to be on the voice. However the interviewees stressed that the lack of non-verbal clues didn't mean that they didn't know what was going on for the client as they have become very attuned to tone of voice, silences, what is said, what isn't said etc.

...you don't have somebody in front of you that you can read; there isn't any signals coming to you; there's no way of knowing where you're at with someone, it's just their voice, so it's quite a different skill. (iw2)

Just how people talk, what they say, the pauses, you have to listen harder when you're on the phone because all you have is the voice. (iw4)

One of the main advantages of the phonenumber as opposed to face-to-face counselling was felt to be its anonymity. Some people only want to talk on the phone, they can phone in the privacy of their own home, it's free and they can get to talk to someone quickly. For these people the telephone could be their only source of support as they don't want to engage in face-to-face counselling. This is obviously where the telephone helpline is invaluable.

The skills and techniques of working on a crisis helpline while distinct for many of the above reasons also share certain skills in common, albeit that the telephone counsellor has to refine and hone these skills more finely than the face-to-face therapist. Of paramount importance is the skill of active listening.

...the thing I use most on the phone and the thing I find most helpful is listening. And it sounds so simple, but if you listen you hear so much. So it's actively listening to somebody, it's hearing what they say, it's actually saying you know, 'Can I just check.....?' and giving them back a potted version. It sounds so simple but most people don't listen, they think they do but they don't, so to actually have somebody listening to you and really hearing what you're saying can be very helpful to someone on the end of the line who, maybe, has never been heard or has never been believed. To have someone completely listening to them....that's the skill I think is most useful." if someone's hysterical, or panicky or freaking out on the phone, (that) you ground them and calm them. You do that with the tone of your voice. you really have to read the call, if that makes any sense? What comes on the phone, you have to go to where that is. Again the most useful is listening and hearing somebody and them being heard. That's the most useful. (iw3).

While acknowledging that working on the telephone helpline had limitations in terms of not being able to see the body language of the caller and of not knowing what happens to the callers when the call ends, without exception, all of the telephone counsellors interviewed said that they derived huge satisfaction from working on the phonenumber and they believed that the service was very effective in providing a container for extremely emotional callers, in giving them support, supplying them with options, listening etc. This view of the service provided by the telephone helpline workers was confirmed in the interviews with the face-to-face therapists when asked their opinion of the effectiveness of the service.

The telephone counsellors gave the following opinions in relation to their job satisfaction,

The telephone helpline is very rewarding, it's different... you might have a really good interaction with someone on the phone, you can't see them but you can feel their presence. Now you might never hear from them again but, that's part of it. (iw1)

and their evaluation of the effectiveness of the helpline,

I think it's huge. All they have to do is pick up the phone and they get through to someone who understands. Someone who knows that 20,30,40 years after the event, people can still be traumatised and that we can acknowledge that to them. What we offer is huge. (iw4).

The helpline is very effective, because it's accessible, it's there, it's always there and I know people have said to me on the phone 'It's easier to talk to a stranger, to somebody I can't see, to just a voice on the end of the line than sit down face-to-face with someone.' So I think the helpline is brilliant. (iw3)

I think it's effective because it is used and it is used a lot and while there are repeat callers there are an awful lot of new, first-time callers. So, I suppose by definition the fact that it is used and used frequently is telling us that it is of help to people. (iw2).

Building a relationship with a client in face-to-face counselling is regarded as the cornerstone of humanistic/integrative psychotherapy. When questioned in relation to this the telephone counsellors all expressed the view that it was possible to form a bond of sorts with callers on the phone. There was acknowledgement that this relationship couldn't be compared with a therapeutic relationship formed in long-term counselling but it was felt that relationships did form and that this helped to ensure a successful encounter between the telephone worker and the caller.

The nature of the relationship that you build on the phone, because it is crisis, because it is trauma, can be very intense very quickly and that's not always the most healthy thing. Although it's kinda intense and quick, my work would be to get them to look at the resources they have themselves. They're having enough issues, so my job is to hold them, to get them to look beyond the problem that they feel there's no way around. It might be resources of options. (iw3)

Well it depends on what you mean by therapeutic? I mean therapeutic in the sense of healing? I mean if you put yourself in the shoes of the person that's in crisis or very distressed and if they find someone who gives them plenty of time; listens in an open way; is appropriately empathic; picks up on the key points of what they're saying; and somehow pulls it together and steers them towards, maybe phoning again, if that's what they need, or steers them towards practical help, if that's what they want. I think most people will feel... at the very least they'll feel relieved. (iw2).

Initially it would seem obvious that the work of the telephone counsellors is quite distinct from that of long-term therapy. However, as can be seen from the above illustrations there is also a lot that is common to both services, particularly in relation to how the telephone counsellors view the callers, how they interact with them, their perception of their issues and the skills they employ when interacting with them.

3.4 THEME C – Self Care in a Crisis Centre

In examining the issue of self-care I hope to demonstrate that the telephone counsellors have as great a need for support from the centre and encouragement to engage in self-care practices as the face-to-face counsellors have. While the nature of the work in a crisis centre is synonymous with the risk of vicarious trauma the general perception is that it tends to be associated more with face-to-face therapists rather with those working on a telephone helpline. I have discovered and hope to show in this chapter that my perception that the contact with callers appears at times to be superficial and transitory is untrue and that, in fact the opposite is true with the telephone counsellors having to deal with a large amount of acutely distressing calls on a daily basis. This is evidenced by their need and desire for support from the centre and their own techniques for self-care. The necessity for support from the crisis centre and encouragement around the whole area of self-care demonstrates the intensity of the work they do with traumatised clients and that they share the risk of vicarious trauma with the face-to-face therapists giving added importance to their work.

The duration of the calls received by the telephone counsellors can vary from a few minutes to a half-hour or more depending on the nature of the call. Short calls tend to be from people who only want specific information or who wish to make an appointment for therapy. Longer calls, which may sometimes last for half an hour or more, tend to be indicative of the degree of distress of the caller. The telephone counsellors may then have to cope not only with a lengthy call from a very distressed caller and their own response to such a call, but they may also have to deal with the stress of knowing, on days when they are short-staffed, that there is a backlog of callers on the phone.

Well it varies. Sometimes you tend to get calls from someone who might be very distressed; assaults or rapes or whatever, so quite a bit of time goes into those calls. (iw5)

.....if there's only maybe one or two people in the room at a particular time and someone is talking for a very long time and you're aware that there's other phone calls coming through, you might say to the person "I'm going to have to let you go because there's other calls coming through. (iw5)

I suppose one of the challenges is that if you're on rota the phone can go at any time, you can't control the pace of the calls and certainly we can have quite calls and we can have a rush of calls and so it is kind of responding, as best as you can, to all the calls that can come in.(iw2)

Since they are the "first port of call" for people who may have recently been raped, as well as people who suffered sexual abuse of one sort or another many years ago, they carry the burden of being the first person to be told about the trauma. Obviously the caller will be very distraught and this requires the telephone counsellor to be able to act as a container for the distress and trauma of the caller.

Sometimes when you're really busy like after a clerical abuse report, that can become.... that's like warfare. You in the trenches and you're just getting shells lobbed at you and you have to just keep going with something like that and at the end there is a lot of debriefing, obviously. (iw3)

The current economic situation has brought about an increase in domestic violence and other tensions in families.

We're hearing a lot of disturbing material..... I mean, shortage of money, desperate straits, people at their wits end. These have increased, plus the demand has increased so it's kind of trying to process what you're hearing, having the space to somehow get yourself back to your baseline before you take the next call and that's one of the challenges, (iw2)

Another source of stress that is unique to the telephone counsellors is the fact that, with the exception of callers who choose to make an appointment for therapy, they "don't know" what happens to callers once they hang up the phone. This is particularly hard to handle when it involves a caller who is in a very distressed state and was cited by the interviewees as one of the main frustrations of the job.

Because of the immediacy of the call, the lack of any prior knowledge or assessment that might prepare the telephone counsellor for what is to come, the experience is very intense. It goes in through the ear without the mitigating effect of a face-to-face interaction. For this reason there is a great need for support from the centre and for encouraging the telephone counsellors to engage in their own self-care on a regular basis.

...there's something kind of vulnerable about something going in through your ear and into your system and I suppose there are days when something can just go in under the radar, something connects to your own stuff. Maybe someone is talking about a child and you have a niece, a grandchild or whatever that's the same age, you know. (iw2).

The telephone counsellors acknowledged the support that is provided by the Centre in the form of supervision, both individual and group, and debriefing meetings.

We have a counselling meeting every fortnight. We have a staff meeting about once every six weeks. We have team meetings every fortnight. We get together in groups and we're aware that we work hard. Oh, and we have group supervision every three months. That's another external person who comes in. (iw5)

....sometimes at our team meeting we devote our full team meeting to relaxation, meditation tapes.(iw1)

But, you know, it's like you can never have enough of it. The nature of what we're dealing with is very stressful and while we get... you know, I wouldn't say used to it, it is what we deal with but you never know what will zoom in and it's a kind of a cumulative effect as well that you have to watch. Everyone is very fresh at the start but how can you keep that up. People have to keep an eye on taking annual leave, getting a break, making sure they're doing pleasant things outside. (iw2)

Despite the above quotes there seemed to also be a sense with some telephone counsellors that, other than supervision, the Centre doesn't officially provide other supports. Their responses when asked directly if the Centre provided other supports were:

I suppose not really, no. Not officially, but I suppose we're all aware that we do hard work and we have counselling meetings as well. (iw4)

Not really, no, they don't. (iw5)

By contrast other telephone counsellors had the opposite view, believing that the Centre provides a lot of different supports.

Absolutely. We have supervision every fortnight. We have group supervision on a regular basis and also if something is really bad, if it really hits you can always go to the Clinical Director and ask for extra supervision. There is always help there all the time. And we are debriefed all the time.(iw3)

Well, it is quite supportive. There is a lot of supervision, one to one supervision.(iw1)

However when it came to discussing the support that the telephone counsellors team provide to one another there was a unanimously positive reaction, suggesting possibly that the support provided by colleagues was more supportive than that provided by the Centre?

Basically you just take it as it comes and I'll have to say the team are life-savers. You can have tough calls and you can come off feeling wiped out and it's just great to have somebody there who understands where you're coming from because they've have those calls.(iw3)

.....the supervision is good, the support from colleagues is very good. If I have an upsetting call, that's where the people in the room are very useful. You can speak to someone immediately. We are very good at helping one another through if there has been a particularly bad call. We're really always there for one another. You'd be encouraged to go out for 15 minutes. or so to get away from the room, you wouldn't take another call straight away. (iw5)

Well, it's a small room and it's a small team of people. We're very aware of each other. We all know one another very well, so if someone gets a bad call, you'll know. We would suggest you go outside. We have tea and coffee facilities in our room, so you might make somebody a cup of tea. Some people rather go out after a bad call some people prefer to stay with the group. So, we mind each other in that way. (iw4)

The need for self-care in the telephone room demonstrates clearly that this work is equally as traumatic as face-to-face counselling. Indeed because of the immediacy of what they are confronted with it might be more upsetting. By the time the callers

go to therapy they have overcome the hurdle of talking about their traumatic experiences for the first time and consequently it might not be as bad for the clients to talk or the therapists to hear what happened the second time around. The techniques used by the telephone counsellors varied from grounding techniques to meditation and mindfulness to writing in the diary, to leaving the telephone room for a few minutes, to using objects that can be held during or after a particularly upsetting call to help calm the telephone worker.

I suppose you know you're coming in for the day, so it is around grounding yourself a little bit and being aware that you don't know what you're letting yourself in for and what you're going to get. (iw5).

Self-care? It's very hard.... there's nothing in particular that I would do coming in that I can think of. I don't have..... If it's a particularly really, really horrendous call, if the detail is horrific, if it's just unbelievably bad I would just step out of the room to clear my mind because I just can't take that to the next call. I would just step out for five minutes and just let it go and that could be visualisation for me, it could be trying to clear it visualising something that I love as opposed to what I just had at the end of the line. (iw3)

.... for self-care for me I would practice mindfulness, meditation so it's about being able to release whatever was left at the end of the day and it's most important.(iw1)

Yeah, every call we take is written into our diary, which is the diary of the room and you can write as you wish in the diary. Some people write quite a lot, some people don't write much, I find that I write a fair bit because it helps to get rid of the call to write it out. (iw5)

The work of telephone helpline workers can be easily dismissed as not having the same importance as that of the therapists. However, as we have seen in Themes A and B, in a crisis centre every help and support that can be offered to distressed callers needs to be readily available. The importance of self-care and support for the telephone counsellors shows that the work they perform on the phone can be just as stressful as that of the face-to-face therapists and their need for support just as pressing.

CHAPTER 4

4.1 FINDINGS

In attempting to draw some conclusions from my research I am conscious that the experience of each telephone counsellor and therapist is “special and unique” and that it will be difficult to draw universal conclusions from their interviews. From the outset, I set out only to explore the experience of those working in different capacities in a counselling centre and the interaction between these services. Consequently, I was aware that my research findings would not result in scientifically provable facts or figures. My exploration showed that there were many connections between the two services, with the benefit being experienced mostly by the therapists. The interviews also demonstrate that the threat of extreme distress at best, or vicarious trauma at worst, for the telephone workers, validated the notion that the work they perform on the phone, mirrors, in more ways than are appreciated, professional therapy. Were the telephone counsellors merely providing an information and referral service by phone, then they would not require support from the centre in the form of supervision, nor would there be a need for them to engage in self-care practices.

While my exploration of a centre offering a helpline service doesn't purport to be an examination of telephone counselling in the true sense of psychotherapy, nevertheless I wanted to explore what the helpline had in common with the humanistic/integrative work of the therapists in this particular centre as well as exploring the telephone counsellors' day to day experiences. What I discovered was that the helpline has a lot in common with actual counselling by phone, with in some instances, the only difference being the length of time spent on the phone by the telephone counsellor and the fact that the telephone counsellor may not have a professional counselling qualification, though this wasn't always the case. Most professional telephone counselling typically lasts for fifty minutes to one hour. However, as the interviews showed, while calls to the helpline would normally not extend beyond twenty minutes or so, in some instances, calls could last for a half an hour or longer. As a result, the telephone counsellors would be obliged to engage, with one particular client, for a long period of time. These longer calls are usually from clients with serious, immediate or long-term issues and are very distressing for

the telephone counsellors to hear. This exposure to extremely painful and stressful material for considerable lengths of time, resulting in the need for self-care and structured support from the centre, demonstrated clearly to me that the work of the telephone counsellors went way beyond organising referrals to face-to-face counselling or providing information to callers on sources of help they could access.

Consequently, my original question has turned out not to be whether there is a link or connection between the work of the telephone counsellors and that of the therapists and the advantages of that, to either group, but rather, the extent to which some of the work which is currently undertaken by the telephone counsellors, has many of the characteristics of humanistic and integrative psychotherapy as practiced by professional therapists.

4.2 HUMANISTIC/INTEGRATION PSYCHOTHERAPY FRAMEWORK

One of the original building blocks of integrative psychotherapy was the notion that many, if not all, therapies have non-specific variables or factors in common. In attempting to identify common factors as a component of integrative psychotherapy, the aim is to ascertain elements of therapy which are common across different therapies. These common factors then become part of the therapeutic approach in integrative psychotherapy. Jerome Frank claimed that therapeutic change comes about not by specific techniques but by ‘non-specific’ factors. Common factors identified by Frank included, providing the client with a basis for understanding their problems, giving them support and hope and allowing them to get in touch with and express their feelings in therapy (as cited in McLeod, 2003). Other common factors which have been identified include the therapeutic relationship itself, sustaining the client and facilitating change in behaviour and intuition. Research conducted by Llewelyn and Hume in 1979, showed that the client tended to favour non-specific factors as being of more help than specific interventions (as cited in McLeod, 2003). Tallman and Bohart go on to claim that for them, one of the most powerful common factors is the client’s ability to heal themselves. They place the client centre-stage in therapy “..we believe that the primary change agent in therapy is the client.” (1999, p. 94). Regardless of differences between the various techniques and theories of psychotherapy it is the client who assimilates the systems and uses them to effect

change. The client's ability to heal themselves can happen outside therapy as well as inside. "Individuals utilize self-healing methods and change without professional intervention." (Tallman and Bohart, 1999, p. 99) Once in therapy many clients improve after only one session. In fact, the problem was often seen to improve after only making the appointment (Tallman and Bohart, 1999).

In examining the therapeutic relationship as a common factor, the argument is that even if the therapist's specific techniques are not having a direct effect on the client, the presence of the therapist and the client in relationship will have an effect. The therapeutic relationship works because the listening skills and empathy of the therapist make up for relationships in the clients' past which were unhealthy and they now provide an environment for more appropriate behaviours. (Tallman and Bohart, 1999). However, the relationship derives its effectiveness from the way the client interacts and uses it as a means to activate their own "self-healing mechanisms" (Tallman and Bohart, 1999, p. 102). Therapeutic relationships as conceived currently in counselling and psychotherapy, very much presuppose, a face-to-face encounter. However, the telephone counsellors stated that they felt that they had made a close connection with some clients, even in a short space of time and without a face-to-face connection. Historically, classical psychoanalysis insisted on the analyst being out of sight of the patient, while in Gestalt therapy, the therapist, might be out of sight or might even be absent from the room, for periods of time. (Paul Goodman as cited by McLeod, 2003). These sitting arrangement variations, suggest that the therapeutic relationship does not, in fact, have to depend on a face-to-face encounter. So there is no reason to believe that a therapeutic relationship can only come about when therapist and client sit opposite one another. In fact, as Alan Tait said in 1999, because of the prevalence of Internet-based communication between people, ".....physical presence is being challenged as an essential element of human interaction." (p.119). This fact is obviously even more relevant today. For the client who is reluctant to engage in face-to-face counselling, and prefers the "anonymity and security" of home (Tait, 1999, p. 119), the listening skills and empathy of the therapist or telephone counsellor can still be experienced beneficially over the phone, as the telephone counsellors attested in their interviews. Another fundamental factor which makes the relationship successful is the client's belief in the therapeutic power of the relationship. As Tallman and Bohart say, "The client's interpretation of, or

perhaps “creation” of, the relationship, is most crucial to outcome.” (1999, p. 102). McLeod says that this can result in idealisation of the therapist. “The faceless helper is readily perceived as an ‘ideal’, and can be imagined to be anything of anyone the caller needs or wants.” (2003, p. 440). The result of this idealisation is that the clients are unable to objectively assess the therapists work. For Snyder, Michael & Cheavens, another common factor, hope, is concerned with “how people think about goals.” (1999 p.180). This involves the client thinking not only about how to achieve their goals but also whether they have the capacity to start and persist, in their task of trying to achieve their goals. Grencavage and Norcross in their study found that the therapist’s ability to instill hope in the client and maintain a hopeful environment was a factor which was most frequently identified in the literature they examined as being “a crucial contributor to therapeutic improvement” (Neitzel and Bernstein, 1987 p. 196 as cited by Grencavage and Norcross, 1990). In their encounters with clients, the telephone counsellors reported that giving the clients options and hope for the future was an important part of their interaction. The skills which were cited by the telephone counsellors as being most valuable in their work were the core Rogerian skills of active listening, empathy and unconditional positive regard. Additionally, telephone counselling of its nature encounters the person in the “here-and-now” a basis tenet of humanistic psychotherapy.

This demonstrates that while not necessarily professionally trained, the telephone counsellors have received considerable non-professional training, in the basics of humanistic and integrative psychotherapy, and the theoretical orientation and skills and techniques they use on a day to day basis, stem from core humanistic and integrative theories. It is true to say that there is a strong humanistic and integrative basis to their work which allies them closely with the professional therapists.

4.3 LIMITATIONS

In exploring the work of the telephone counsellors I would have liked to expand on the issue of the effectiveness of the service by getting some feedback from clients of the service. While the counsellors reported that they would sometimes get immediate feedback from a client at the end of the call, this feedback tended to be, unsurprisingly, positive. For reasons of confidentiality; the necessity to respect the

client's anonymity and practicality, it was not feasible to attempt to gain access to the clients of the centre. The fact that I confined my exploration to one centre is also a limitation of the thesis. A comparison, with a number of other similar centres in Dublin, would have improved the validity of my research. Client confidentiality meant that the telephone counsellors were unable to give me concrete examples of specific interactions they had with clients. They could only speak in generalities. In addition there may have been a certain reluctance, on the part of the interviewees, to talk as openly as they would have liked, given that the identity of those who volunteered to take part in the interviews, was known in the centre.

4.4 RECOMMENDATIONS

As already noted, some of the work which is currently undertaken by the telephone counsellors, has many of the characteristics and utilises many of the skills of humanistic and integrative psychotherapy as practiced by professional therapists. Consequently, one recommendation is whether there is a need for the centre to consider providing a professional telephone counselling service in addition to its face-to-face counselling. This would of course have to be run by professionally trained psychotherapists, but it would take some of the pressure off the telephone counsellors when it comes to particularly distressing calls, which of their nature, are going to last for a long time. Since some of the telephone counsellors already are professionally trained psychotherapists, they could be freed up to provide the phone therapy, which in turn would take some pressure off the therapists in the centre.

As my literature review demonstrates clearly very little research on the topic has been conducted in Ireland. Consequently there is a need for a thorough examination, of the advantages for counselling and psychotherapy in Ireland, in particular, of new methods of offering services to clients or of combining a few different methods in centres in order to give clients every opportunity to engage with a counselling and psychotherapy service. In an age of ever changing technological advances

counselling centres throughout the country should be constantly changing and adapting with the times.

“The use of information technology widens the repertoire of ways of being in contact that are open to clients and counsellors.” (McLeod, 2003, p. 526)

APPENDIX 1 - INFORMATION LEAFLET



Title:

An Exploration of the Experience of Telephone Helpline Workers in a Crisis Intervention Centre

Researcher's Name:

Monica Roche

Researcher's Title:

Trainee Counsellor

Telephone No. of Researcher:

087 7537625

Dated:

1st April, 2011

I am a student studying for an MA in Psychotherapy in Dublin Business School. I have chosen for my research study to explore the connection between telephone helpline counselling services and long-term humanistic/integrative counselling services.

You are being invited to participate in this study by agreeing to a 30-45 minute taped interview. Before you decide whether or not you wish to take part, you should read the information provided below carefully. If you wish to ask questions please do so. You should clearly understand the risks and benefits of participating in this study so that you can make an informed decision.

You may change your mind at any time, (before the start of the interview, or even after you have commenced the interview) for whatever reason, without having to justify your decision.

WHY IS THIS STUDY BEING DONE?

The objectives of the study are to explore the service provided to callers to a telephone helpline centre. To look at the relationship between crisis calls and follow-up counselling and to identify the current models, if any, that are in use and finally to examine the experience of counsellors who receive referrals from telephone helplines.

WHO IS ORGANISING AND FUNDING THIS STUDY?

This study is part of a Masters Degree in Psychotherapy being undertaken at Dublin Business School.

HOW WILL IT BE CARRIED OUT?

If you choose to take part in this study, you will be invited to take part in a 30-45 minute taped interview with the researcher to obtain your views on the area of telephone counselling and/or long-term humanistic/integrative counselling.

WHAT WILL HAPPEN TO ME IF I AGREE TO TAKE PART?

If you agree to take part, you will meet with Monica Roche at your place of work at a time of your convenience for a 30-45 minute taped semi-structured interview.

RISKS/BENEFITS

There are no known risks to you from taking part in this research. However, there is a slight possibility that taking part in the survey may raise issues which you could find upsetting. The results of the study will be made known to you and may benefit you in your work.

CONFIDENTIALITY ISSUES

All information obtained from you during the research will be kept confidential. Notes about the research will be stored in a locked file. Each person who participates in the research will be given a code number so that the researcher will be the only person who can identify who you are in the notes. The key to the code numbers will be kept in a separate locked file. The audio recordings of the sessions will only be accessible to the researcher and will be destroyed once transcripts have been made of the sessions. After this research is completed notes may be saved for the purposes of future research. However, the same level of confidentiality guaranteed in this research will apply to the storage and use of materials. After five years on completion of study, data will be deleted from hard drives and hard copies will be shredded.

IF YOU REQUIRE FURTHER INFORMATION

For additional information, now or at any future time, please contact:

Monica Roche
Tel: 087 7537625 or

Grainne Donohue
Thesis Supervisor
grainne.donohue@dbs.ie

APPENDIX 2 - CONSENT FORM



Title:

An Exploration of the Experience of Telephone Helpline Workers in a Crisis Intervention Centre

PLEASE TICK THE APPROPRIATE ANSWER

I confirm that I have read and understood the Information Leaflet dated 1st April, 2011 attached, and that I have had ample opportunity to ask questions, all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving a reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions.

Yes No

I have been given a copy of the Information Leaflet and this Consent Form for my records.

Yes No

FUTURE USE OF ANONYMOUS DATA

I agree that I will not restrict the use to which the results of this study may be put. I give my approval that unidentifiable data concerning my responses to this interview may be stored or electronically processed for the purpose of scientific research and may be used in related or other studies in the future.

Yes No

Interviewee _____

Signature and Date

Name in Block Capitals

To be completed by the researcher or her nominee:

I, the undersigned, have taken the time to fully explain to the above interviewee the nature and purpose of this study in a manner that he/she could understand. I have explained the risks involved, the experimental nature of the treatment, as well as the possible benefits and have invited him/her to ask questions on any aspect of the study that concerned them.

Signature	Name in Block Capitals	Qualification	Date
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APPENDIX 3 - SEMI-STRUCTURED INTERVIEW

Experience/professional training of telephone operator

1. How long have you worked with this particular service?
2. Have you worked with another telephone helpline service?
3. What kind of training did you receive for this job:
 - how many hours?
 - is there a qualification at the end of the training?
 - who does the training?
4. Was this on top of your professional qualification?

What's involved in the telephone helpline service?

5. How many hours a day on average would you spend on the telephone helpline?
6. How many calls, on average, would you handle in a day? How long do calls typically last?
7. Do you get many hoax or nuisance calls and how do you handle them?
8. Would it often happen that a caller would call the service more than once?
9. Is there a possibility that you could get to talk to the same caller more than once?
10. If so, do you let them know that you have spoken to them before?
11. After taking the call is the call recorded in any way?
12. Are there time limits on the phone conversations?
13. Do you have any way of tracking callers who call more than once?

14. Do you have a different approach when taking calls from family members than when talking to the victim themselves?
15. How do you maintain confidentiality if a member of the victim's family phones knowing that the victim has already spoken to you?
16. Is confidentiality an issue working in a room with others?

Experience of working on phone helpline

1. Is it generally satisfying working on the phone helpline or do you sometimes feel frustrated and in what ways?
2. What do you consider to be the most effective techniques when supporting someone in a call?
3. Could you give me any examples of where you have used these tools?
4. Are there any specific techniques that you use regularly or that you find particularly useful?
5. Is it possible to build a relationship with the client over the phone?
6. How do you handle not being able to build up a therapeutic relationship with the callers? (if applicable)
7. Is listening enough in a therapeutic relationship? What about not being able to see the callers face or observe their body language?
8. Do you give your name to the caller and/or ask them theirs? How does this help the relationship?
9. Is it possible to build up a picture or profile of the caller – how much general information would you ask them?
10. In what ways would you measure a successful encounter with a caller?
11. How would you describe the relationship between yourself and the caller – what factors, either positive or negative, could effect this?

12. What would you consider a negative encounter with a caller?

Self-Care

13. How do you prepare yourself for a call? Do you feel the need to do something to ground yourself?

14. What do you do around self-care in this work? How does the centre provide support for the telephone workers?

15. What are the difficulties involved in trying to be supportive or empathetic with a caller you cannot see? Does it make a difference to you? to the caller?

16. Are there any issues you find difficult to handle over the phone, or that you think could be better handled in face-to-face counselling?

17. What are your views about the effectiveness of this telephone helpline?

18. Do you think there are areas of the service that could be improved and if so in what way?

19. Is there a system for recording client satisfaction with the service?

Connection with face-to-face counselling

20. What do you think are the advantages and disadvantages of the telephone helpline

21. Do you wait for a caller to enquire about face-to-face counselling before you'd mention it?

22. Have you ever advised a caller to consider face-to-face counselling?

23. In what circumstances would you consider giving a caller this advice?

24. Can you give me some examples of the common reactions of clients to a referral to face-to-face counselling?

25. Would you consider that the face-to-face counselling complements the telephone service that you provide, or do you see any tie-in with it?
26. Can you think of ways in which the face-to-face counselling and the telephone helpline could be more closely integrated?
27. Would it happen often that the full-time counsellors would give a client the telephone number of the helpline in case of emergency?
28. When this happens how much information would the counsellor give you about the client?
29. What do you think of this practice? Is it of benefit to the client?
30. Have you taken any such emergency calls as a result of a counsellor giving the helpline number to a client?
31. What other information do you think might be useful that I've missed?

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