TRAINING PROCEDURE FOR PARAPROFESSIONALS IN THE FIELD OF MENTAL HEALTH

enhancement of first echelon workers

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PROEFSCHRIFT

ter verkrijging van de graad van doctor in de geneeskunde aan de Erasmus Universiteit te Rotterdam, op gezag van de Rector Magnificus Prof.Dr.P.W. Klein en volgens besluit van het college van dekanen. De openbare verdediging zal plaats vinden op woensdag 30 oktober, des namiddags te 3.00 uur

door

ODED OREN

geboren te Affula (Israël)

1974

Academic Service, Vinkeveen

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I INTRODUCTION

Standard of living in the Western World has greatly increased during the last decade, having all but reached the welfare level.

People being less occupied with the fulfilment of primary (biological) needs, have become more sensitive to personal (psychological) difficulties; the attained higher standard of living is accompanied by striving to better living, also in the psychological sense of the word. Trimbos (1972) formulated the problem in terms of looking for qualitative improvement after a quantitative improvement has been attained.

The mental health service has proved to be unprepared for the requirements of this development; the number of helpers has remained limited, in comparison to the on growing needs in the community, the service is generally located outside the physical-social field of the consumer, mostly bureaucratic and of a complicated structure, as well as expensive and stigmatizing.

In order to decrease the gap between demand and offer and thus to be able to supply help without delay, it seems necessary to increase use of paraprofessionals within the mental health care[1] and to improve the functioning of those who already actively participate in it.

[1] Mental health service is an organization charged with preventive and/or curative tasks in the community, whereas mental health care could rather be defined as the authorities' obligation to improve the qualitative level of life of the individual community members

I define[1] paraprofessionals (in the field of mental health) in this study as those persons who have any (formal or informal) first echelon function whereby they come into (continuous) contact with others, though not being explicitly trained to deal with personal problems.

Their direct and immediate presence and involvement in other people's (personal) difficulties is probably the most apparent advantage and justification for incorporating them in mental health care. Their possibilities to deal with difficulties at a very early stage can partially solve the serious problem of waiting-lists in the services, which results apart from escalation of the original problems in an enhancement of clients' dependency. Their physical presence enables a wide range of community members to apply to them directly whereby contact is not kept exclusively with the person in question but rather with his entire social environment.
By reference to a known agent within the community, appliance to official (mental health) services is reduced; besides obtaining a decrease in the existing overburden in the services, this means a considerable gain for the applicant in preventing the generally attached stigma to mental health service.
The initial relationship with the paraprofessional, resulting in a sketch of the problem and the situation, can be of importance and use also when reference to a formal agent of mental health is needed; a better decision can be made on basis of the already obtained material.

[1] other approaches and definitions of the concept of paraprofessionalism as well as the specific contribution of my own definition are discussed in the "Theoretical Background"

The significance of the relationships maintained by these first echelon agents must not be neglected; however, if an optimal contribution to mental health care is expected they should be equipped with the necessary skills to improve dealing with other people's difficulties.
After a pioneer work in the sixties, various training procedures for non (para) professionals were developed and conducted both in the U.S. and in Europe. However, as most projects do not refer to paraprofessionals as existing (functioning) first echelon agents, development of a specific program according to this definition is unavoidable.

The purpose of this study is to construct a training procedure, which, based on some common principles of psychotherapy, should meet the actual needs of the participants in question.
A pretest - post test control group design was set up, including two experimental groups and a control group undergoing three measurement moments, after a preliminary stage of preparing the proposed training procedure and the assessment devices.
After reporting the construction and evaluation of the training procedure, a discussion concerning its possible use and significance in the field of mental health will follow.

II THEORETICAL BACKGROUND

1. The paraprofessional in the mental health

> "We are looking for people with a certain sensitivity and the ability to work with people" (Arnhoff, 1969)

"The increasing need for health manpower is an outgrowth of several developments, including the total population growth; the greater dissemination of health information (particularly through the mass media); the proliferation of new knowledge stemming from medical research; and the increasing availability of health services as a result of national legislation, the growing national affluence and the growing acceptance of the concept that health services are the right of all rather than a privilege for few.
The consequent need for manpower in all occupations is impressive" (Kadish, 1969).
Bearing in mind the shift that has taken place in the second half of this century - from an exclusive endeavour to fulfil the primary needs to looking as well for attainment of secondary needs - which has been accompanied by rapid fundamental social changes in all social classes (bringing about various problems of adjustment), the increasing need for manpower Kadish speaks about, lies probably most strikingly within the mental health sector. As it was impossible to meet the growing needs of manpower

within the mental health sectors, many efforts were made to enlarge the capabilities of existing different agencies by focussing on the use of paraprofessionals as potential manpower in these services.
The 1960's will be recorded in the history of mental health services as the years during which many problems that for a long time had plagued mental health systems were attacked: it was during the sixties that mental health services made a major approach towards the community, it was also during the sixties that individuals with less than graduate professional training were recognized as possible role bearers in the work with individuals who have emotional problems or mental disabilities. Already at the very beginning of the sixties Albee (1959) made a strong plea for the development of a new kind of workers who could be trained in a shorter period of time than the one mostly used for professional trainings. His plea was recognized and applied throughout the mental health system, resulting eventually in various attempts to bring about this development.

Viewing the development of the increased use of this kind of new workers, two basic approaches can be distinguished:
a) the job factoring approach, where existing professional jobs are broken down into separate tasks and abilities, which are assigned to workers of various levels. The new worker functions then as an aid or assistant to an existing professional.
With this approach, new dimensions to traditional practices have seldom been conceived.
b) the developmental approach, based rather on the needs and problems of clients, their families and communities; the tasks and activities to be carried out are determined after identification and description of the needs. Various

criteria are applied in order to decide the possibilities for groupings of activities to be assigned to workers of various levels.
This approach is more difficult and more controversial, but it can contribute to the creation of jobs that are more responsive to needs of people, more challenging to the job holders and allow the professionals to extend their own knowledge and competence without risking their established position.
In line with the starting point of the developmental approach, viz. central and primary consideration of clients' needs, it could be stated that these needs indicate the use of workers who have no specialized profession within the mental health but are representatives of a more general approach. Many people in the community cannot rely on cultural, psychological and/or educational resources in order to find their way in the complex of mental health services; they need a trustworthy person to bring them into contact with one of the many specialists and/or agencies.
Grosser (1969) states that the employment of paraprofessionals in district health centers contributed to provide better and more personalized services to the residents as well as to dispel both the image of 'non-caring' public service agencies and the 'hard to reach' client.
He conceives the paraprofessional as having a bridge-position: interpreting values and particular needs of the community to the professionals and providing to the residents the necessary direction to the (needed) health services.
In his summary of the initial developmental stage of employing paraprofessionals, he indicates some advantages of involving them in the system: they can fill (formal) manpower needs and herewith bridge the gap between demand

and offer (caused by a radical shift towards fulfilment of secondary needs); employing them means, besides providing jobs for the unskilled from lower classes, that some ideas of an active participation of all citizens in decision making procedures are realized.
Together with these advantages, Grosser mentions another aspect of involving paraprofessionals in health services; it is connected with the principle of the 'helper therapy' which states that any help relationship can be successful in helping the provider as well as the recipient of help.

In order to meet the needs of the population, two different 'new' types of paraprofessionals in the mental health services - besides the already existing 'old' type of paraprofessionals serving as aids in hospitals - have been parallely developed (in the U.S.):
(1) The middle class paraprofessional, mostly a woman with some graduate degree who has undergone a special training in mental health skills and is generally engaged in substantive therapeutic work.
(2) The indigenous paraprofessional, mostly recruited from the community where he is working. He is often employed in some mental health center, holds no college degree and is engaged in therapeutically relevant work.

(1) The 'middle class' approach is mainly based on the assumption that middle class (ungraduate) educated individuals, with some sensitivity to psychological aspects of personal difficulties are capable to succeed in any intensive program intended to supply them with basic psychotherapeutic information and skills. They are conceived, afterwards, as being able to share the therapeutic work with the (formal) professionals in the mental health services.

Since some efforts are necessary to meet the demands of such a program, high motivation on the part of the participants is considered crucial. In literature dealing with this approach, we can find three factors which possibly evoke and keep participants' motivation:

-previous (formal or informal) contacts with individuals who sought help for their personal problems.

-unemployment of middle-aged, educated (yet unprofessional) individuals who would like to work but expect difficulties in attaining a suitable job for their educational level.

-promised perspective for an appropriate occupational status, including advance possibilities.

The first two factors are suggested to be used as making part of the admission criteria for training procedures whereas the third one implies necessary changes in the structure of mental health services.

The best known studies in the area of the 'middle class paraprofessional' are probably the early works of Rioch and those of Carkhuff and Truax which together with other reports provide evidence of the effectiveness of paraprofessionals as treatment agents.

Rioch's program was designed to meet the need for staff who could be able to provide a low-cost psychotherapy. The subjects were college graduate women. They were chosen on ground of their successful child-rearing, experience and maturity. The program, limited to the psychotherapy, lasted two years. It emphasised professional principles (theoretically process directed) rather than technical specificities (manipulative tricks).

The general schedule consisted of the following five areas:

- practical work and supervision at the training center;
- practical work and supervision in the community placements;

- observation of individual, family and group interviews;
- lectures and seminars;
- additional readings and report writing.

Since Rioch's project was considered a successful one, many similar programs were carried out differing in some minor aspects, such as clients' or trainees' backgrounds[1]. A report of the National Association of Mental Health (1968) on the use of paraprofessionals, concluded "that innovation and experimentation should be undertaken by the traditional professionals to expand and develop the roles of allied and auxiliary personnel ... through the use of mental health counselors to extend mental health services; and the use of volunteers, appropriately prepared and supervised, to augment manpower resources". (Matarazzo, Albee & Arnhoff, 1968).

(2) A parallel yet different approach in attacking problems within the field of mental health makes use of the so-called laymen as employed workers in the mental health services.

This approach was initiated by Reissman, Pearl and others who introduced the terms 'indigenous paraprofessional', 'the new careers movement' or 'new careers for the poor'. The term 'new careers' was introduced in a description made by Pearl and Reissman (1965) of a possible way to provide permanent, socially useful jobs with career potential for the unskilled, uneducated and unemployed. The concept points, in fact, at a radical and long-term change in the provision of social services. It is based on the premise of a necessary change in the structure and

[1] One of them is the Purdue Program initiated at Purdue University (Hadley, 1970), intended to educate middle level generalists to a function in the field of mental health.
Another important contribution was made in Washington (Eisdorfer et al., 1969); it concerned, however, rather
(continued on next page)

functioning of agencies and educational institutions charged with training and accreditation of those engaged in mental health work.

Reissman (1964) states that the nonprofessionals should be people who originate in disadvantaged communities of the lower class culture, and have (later) moved into a more stable way of life, without, however, having rejected their past. They are thus disposed of a special personal knowledge and understanding for the kind of people and problems with which they have to deal.

Grosser (1969) conceives, as well, the indigenous paraprofessional as being able to communicate freely with helpees because, like them, he is poor, shares a status of a minority group, resides in the same neighbourhood and has a common background and language. However, as he is per definition a native nonprofessional, he should be trained to keep workable bounds to the (narrow) focus and identification he has with the clients and use them in order to enhance communication and understanding.

Beck (1969) expressed obvious critical considerations concerning this new movement. He argues that by bearing the label 'nonprofessional' these individuals are cheated of their basic right to receive any education as well as of the right of access to occupational ladders leading eventually to a middle class profession; "as a consequence of this thinking, individuals who have been locked into the ghetto are now being employed in the name of curing poverty, at minimum wages".

Referring to training programs of nonprofessionals, Mitchell (1969) insists on incorporation of two points of view: skill (information) - content together with

[1]continued:
some accomplishing principles (such as selection) than a detailed program

interpersonal - content, resulting eventually in a program that provides besides insight in understanding the complexity of relationships and interactional skills, an emphasis on personal goals, values and attitudes of the workers (trainees) themselves, helping them to develop personal as well as occupational identity.
One of the training programs originated from this approach is described by Goldberg (1969). It is a pragmatical as well as practical program made up of:

- a brief pre service period intended to inform the worker about the particular service and the necessary basic skills.
- a combination of supervised field work and instructive material, leading eventually to a full independent day work on the field, supplemented by supervision and regular - but gradually less frequent - training sessions.

The instructive material concerned specific skills and general knowledge required of all participants in social services; in this sense some accordance can be found between the training (instructive) material and the program as suggested by Mitchell.
Goldberg concludes that "it may be important to think in terms of goals rather than learning styles, in which case the quick, nondidactic method may be appropriate for the job at hand, especially at the entry level".

To sum up, the wide range of data on both the middle class and the indigenous paraprofessional (in the U.S.) is an indication for the increasing role of the paraprofessional in the area of mental health.
Though not every separate study is conclusive in itself, the multiplicity of evidence derived from the great variety of different sources could lead to the conclusion that the paraprofessional is gradually conceived (and

accepted) as an important treatment agent who can contribute to the attempts made towards improvement within mental health.
Generally stated, the contribution of the paraprofessionals refers mostly to two issues:
1) filling new roles, based on clients' needs, which were previously unfilled by any staff;
2) performing parts of tasks, previously performed by professionals, but tailoring the task to the paraprofessionals' (special) abilities.
From a literature survey on the use of paraprofessionals as therapeutic agents, Durlack (1971) concludes that they can function effectively in any subscribed role and setting of treatment; that the central figure in any helping-relationship (the client) can be directed and influenced to act by himself as a therapeutic agent; and that the success of paraprofessionals can suggest an effective and economic alternative to the traditional therapeutic practices.
Whether perceived as para (sub) professional or as non-professional (indigenous), their contribution to the widening of the staff charged with caseload is useful and effective; "one proposed remedy for the shortage is to make more effective use of persons who lack the Master's degree" (Beck, 1969).
Enlargement of the staff is accomplished with both approaches by creation of secondary professionals, where however the term 'secondary' has to be interpreted differently in each of them.

I would like to suggest additional possible approach concerning the role of paraprofessionals within the area of mental health: I define them as those who have any (formal or informal) first echelon function whereby they come

into (continuous) contact with others, though not being explicitly trained to deal with personal problems.
This definition consists of four elements:
- 'formal or informal' indicates the basis (occupational/ social) on which the position (of the helper) in the community is determined.
- 'first echelon function' is defined as a non-specialized (mental health) role located within the community (e.g. general practitioner).
- 'continuous contact' is considered important as it makes possible the development of a profound relationship (e.g. an arbitrary busdriver vs. a familiar grocer).
- by 'not explicitly trained' is understood getting no formal education and/or training in dealing with personal problems.
This definition differs from the ones mentioned above in its evidently wider extent: whereas in the surveyed approaches specific individuals are chosen to be trained and function as paraprofessionals, I recommend no selection criteria at all and define every first echelon function as a paraprofessional one in the mental health sector.
According to my definition, paraprofessionals are not created but rather exist; the only question that may rise is whether their functioning and contribution are optimal. In this train of thought functioning as a paraprofessional does not necessarily mean occupying a certain job, either within the mental health services or anywhere else. Yet, in his daily contacts the paraprofessional in our sense cannot but face his fellow human beings as individuals who, at times, happen to be in difficulties. This then implies an indirect relationship with mental health; this indirect relationship becomes more comprehensible when we conceive mental health as originating from the existing needs in the community rather than from the available -

existing services. This point of view, together with the belief that extension of mental hygiene can be realized by meeting existing problems where the (professional) qualification of the helper can be neglected, emphasises the growing importance of paraprofessionals.
It should be very clearly stated that my definition and interpretation of the term para(professional) is exclusively restricted to the area of mental health: anyone, either professional in another area or lacking any profession at all, who has not explicitly been trained and educated to deal and/or treat interpersonal - mental - difficulties, is defined as paraprofessional. He is, in this sense rather para with reference to mental health professions whatever his own profession may be.
I consider, therefore, the term 'paraprofessional' more suitable than either sub- or non-professional, as his functioning within mental health is rather parallel to the functioning of professionals, than subordinate or inferior.
With the engagement of paraprofessionals in mental health, no attempt is made to develop any therapeutic pretentions nor to create a new profession; what I rather state is that use should be made of those individuals who are already present (in any function or job they occupy) and are ready and able (possibly after some training) to help others and herewith to contribute to the enlargement of (national) mental health.
As they make no (integral) part of the formal system of mental health, the contacts they form with helpees are usually not experienced as connected with mental health but rather as mere human, interpersonal help. This experience (and lack of labelling) is an important advantage of making use of individuals who are in fact outsiders to the system, but can exert a considerable positive

influence on the system as a whole.
A similar train of thought is stated by Caplan (1970) who in search of new methods in preventive psychiatry introduced the concept of care-taking agents of the community. With this concept he understood the professional representatives of the surrounding community (e.g. doctors, nurses, clergymen) whose designated or assumed role is to help people in trouble.
Concerning the new methods he introduced, Caplan suggested that the goal of mental health consultation could be to bring a limited number of mental health experts into contact with a large number of care-taking agents, in order to help them to intervene in a positive way whenever their clients are in a crisis.

2. Mental health service in the Netherlands; the position of the paraprofessional

> "The mental health service must rather be directed on the whole population than merely taking care for the individual patient who is looking for help"
>
> (Trimbos, 1970)

According to Goudsblom (1967) the national structure of the Netherlands, established in the late 16th and early 17th centuries, has not been assaulted by the popular emancipationist movements; the formerly excluded minorities have claimed an acquittable share in it, seeking integration according to the typical pattern of "verzuiling". For some generations "verzuiling", based upon the two dimensions of religious and social-economic differences, has more or less monopolized expressions of various relationships in Dutch society.

Looking at the framework within which mental health activities are carried out in the Netherlands, a somewhat peculiar situation could be noticed: private agencies play a stronger role than in most other countries; though in all countries there is a reciprocity between government and private agencies, the place that private initiative undertakes in public health in the Netherlands is obviously of greater importance than elsewhere[1]. Another

[1] the government supports or interferes merely when private initiative in public health fails to meet the needs of the population

noticeable feature is that the organization of private initiative is on a denominational basis[1]; the underlying principle is that (public health) care should be provided, as much as possible, by personnel of the same denomination as the applying person. This makes the whole organization more complex and less efficient or economical. However, recently there has been a perceptible tendency towards abandoning this denominational pattern of organization; an increasing number of joint institutions is being set up, accompanied by joint activities that are undertaken for the whole population.

Agencies which were developed according to local needs, like child-guidance clinics, marital and family guidance centers, social psychiatric services, mostly do not restrict their activities to practical case work, but keep regular contacts with various branches of social work and public health, serving thus as an advisory organ.

In the mental health care, emphasis has gradually shifted from institutional-curative attitude to social-preventive care; this means, besides a shift to community centers, an extension of the service to include the family and other environmental factors. Services charged with preventive work see to it that principles of mental health are observed in the different kinds of health and social activities.

Recent developments have led to a somewhat stronger provincial or regional organization with mental health services intended to be able to guide all mental health activities in the province or region. Different national organizations of mental health agencies, which until recently led a separate existence per activity and/or per

[1] consisting of three different religious trends (Protestant , Roman-Catholic, Non-denominational) functioning parallely

denomination are nowadays combined within the bureau of National Center of Mental Health (N.C.G.V.), a central institution which undertakes all national tasks in the field of mental health care and is charged with stimulation of the application of principles of mental health in the wide areas of health, education and social work.

A governmental report concerning mental health service (Nota 1970) gives account of a clear shift from interest in clinical psychiatry to emphasis on social psychiatry and increased attention to environmental factors.
It becomes apparent from this report that besides medical staff, many other professions have got involved in problems of mental health, coming forth in their daily work routine. However, on the value schedule maintained in the wider population, mental health is still ranked low in comparison with the new attitudes developed in the professional world of mental health.
It is further stated that besides the care for the mentally disturbed, a care for an optimal (psychic) functioning of the whole population is regarded as very important; and as public health is influenced by somatic, psychic and social factors, it is suggested that the work done by some professionals, not necessarily included within public health services (e.g. social workers, teachers, priests) can be seen as part of the first echelon[1] mental health care. (Herewith the role of paraprofessionals within the area of mental health is actually recognized.)
A (given) list of the main services that make up the

[1]First echelon can be defined as the non-specialized services located within the (near) community, functioning as a possible gateway to specialized (mental health) services

(existing structure of the) mental health care, mentions the following services: social psychiatric and youth psychiatric services; child guidance clinics; marital and family as well as alcohol and drug guidance centers; institutions for psychotherapy; private psychiatrists; psychiatric policlinics; psychiatric wards of general hospitals; institutions for day or evening treatment; psychiatric institutions; therapeutic family hospitalizations; complementary services (lock boarding school, hostel, nursing home); services for geriatric-psychiatric patients as well as mentally retarded and (disturbed) delinquents. (Not mentioned in this Nota is the 'alternative relief-work[1] (including e.g. Youth Guidance Center[2], Release, Social Unit[3]) initiated in order to supply some supplementary help, to meet actual needs of the population, not being (completely) covered by the existing services.)
The report ends with the conclusion that primary prevention of psychic disturbances is of utmost importance and should be advanced by the public health services together with other sectors of the welfare services.

According to Trimbos (1969) mental health services, besides being population-centered, should function in accordance with the actual existing (psychic) needs within the community; this means in fact initiating services from the very bottom, adjusting (conventional) concepts of psychiatric care to present and situational requirements, intending primarily to set up a preventive program to be carried out by inter-disciplinary teams rather

[1]Alternatieve Hulpverlening
[2]Jongeren Advies Centrum
[3]Sosjale Joenit (Den Haag)

than by psychiatrists exclusively.
In comparison with the extent of psychic difficulties, the given amount of psychotherapeutic help is very limited, which results in an accumulation of the problem, causing in turn, an extension of the misery beyond its original proportions.
Regarding the restricted potential of those suited for education or training in psychotherapy, Trimbos pleads for an involvement of 'help professions' - parallel to the professional psychotherapists - who would be specially trained to initiate and maintain (under supervision of a professional) various kinds of help relationships; in this case psychotherapy will become one of the various kinds of possible therapies.
These ideas reflect recent movements within mental health such as structural (organizational) changes consisting of, inter alia, enlargement of the services' capacity by an incorporation of para(non)professionals.
A committee appointed in October 1969[1] and charged with preventive work, stated clear rules which could be considered a gateway to the use of nonprofessionals within mental health services.
The concept of nonprofessional evoked among mental health workers reactions of both acceptance and rejection. However, a work-group was set up to continue this initial work of the committee with the task of studying the role and function of nonprofessionals. This study can be looked on as the last phase of preliminary work concerning non-(para)professionals in mental health.

[1]Center for Catholic Marital Bureaus

The necessity to bring about a radical change in the structure of the services (including a.o. manpower), was proclaimed during a national congress on mental health held in September 1970[1].
One of the participating workshops submitted a (suggestion of a) new model for supplying help[2], originating from either living, work or school environment. In each of these milieus an advisory organ was suggested to be set up in order to lower the entrance-anxiety of the applicants. Each of these advisory groups was suggested to be coached by counsellors, thus making possible a transfer of problems to a professional (in case of necessity).
Corresponding with the already formulated plea, a committee charged with the study of mutual relationships between the ambulant psycho-social service and the social service (1971) insisted on the importance of nonprofessionals as elements in the struggle with various problems in the community.

In the same period efforts were made (Bremer, 1971) to attain a somewhat clearer definition of nonprofessionals or 'key figures' in the new movement of mental health.
A distinction is suggested between general and categorial nonprofessionals:

by general nonprofessional is understood selected individuals who had already participated in some prevention project and were motivated to carry out the same kind of work on their own; after some training they could be allocated in any mental health service.

by categorial nonprofessional is understood individuals who were also motivated, selected and trained but intended

[1] "Te gek om los te lopen", Amsterdam
[2] 'The Changer'

to work with their own origin groups (who had no previous contact with any mental health service). In the same token a distinction is made between two kinds of 'key figures': the formal ones, conceived as an authority because of their position and function (e.g. teacher, priest) and the informal ones whose authority is merely and exclusively due to their personal (relative) position in their neighbourhood (e.g. barber, doorkeeper). Trimbos (1972) emphasises the potential significance of key figures: considering their natural position and (physical) presence in the neighbourhood they can use simple means in order to supply immediate help.

A contribution to the functioning of nonprofessionals in mental health was recently made by Bremer (1973) who focused her investigation on encounter groups.
The topic of this study was furtherance of the inner well-being of individual group members participating in a project of mental health care.
Nonprofessionals were defined as co-helpers functioning as facilitators in encounter groups.
The possibility to participate in these (encounter) groups (where co-helpers functioned as group leaders) was conceived as a form of preventive (and positive) mental health care.
Satisfying results were obtained with regard to an increase in social involvement of the participating group members, manifesting itself in the acquisition of a more positive attitude towards working in and with groups.
On account of the narrow focus of the investigation, this study supplies a somehow specific (limited) contribution to the field; since its topic is the inner well-being of the functioning individuals themselves, it merely represents one possible approach and definition of the task of

paraprofessionals, not necessarily corresponding with other existing approaches[1].

A contact group consisting of representatives of the National Council of Societal Welfare, the Ministry of Culture, Recreation and Social Work, the Ministry of Public Health and Environmental Hygiene, the National Center for Public Mental Health (Utrecht, 1973) was appointed in order to study the possibilities to use volunteers in psychosocial care.
On basis of information gained in other European countries some organizational projects for volunteers' work were suggested:

- set up of a department for volunteer-help-service which would make part of (the existing) mental health service; it would consist of trained and supervised individuals charged with supplying information and advice as well as with 'simple individual care'.
- supply of intensive training for selected volunteers (on a severe selection basis) and allocation of trained persons to independent work in the curative sector of the service.
- set up of an independent co-helpers' center (attached to the mental health service) charged mainly with supporting and guiding contacts.
- allocation of volunteers in district welfare centers, to be charged (together with other professionals) with practical activities of curative work.

The underlying idea in all these suggestions was that every individual should be able to function as a helper to his neighbour(s) and to introduce professional help

[1] Since I define paraprofessionals in a completely different way, it seems to me that a detailed report of the study would be exaggerated

only when he himself cannot offer any more help.
The already functioning volunteers, mentioned later in this report, participated in cultural work or in guidance of groups aimed either at personal furtherance or at the solution of daily problems.

This new position of nonprofessionals in mental health is clearly reflected in the very recent governmental report (Nota 1974) which states explicitly that one of the authorities' obligations (concerning mental health) is to facilitate and stimulate the use of paraprofessionals in the service.
It was suggested to supply a specific educational program to those paraprofessionals who already function in the public health service; the program was suggested to consist of both theoretical material referring to the psychic and social factors which are of influence on illness and health and practical training to acquire the needed skills.
The report suggests that extensive use of professionals might cause anxiety to and alienation of the (applying) individuals and, therefore, a strong plea is made to shift emphasis to any possible help within the first echelon. The above mentioned interdepartmental contact group (charged with the study of suitable projects for nonprofessionals in ambulant mental health services) can be representative of the course of thought taken by the authorities.
This approach towards nonprofessionals is clearly shown in the declared (governmental) policy and (various) research projects concerning psychohygiene in general and methods of prevention in particular, developed to enhance first echelon (psychosocial) activities and the introduction of nonprofessional workers. Study of introduction

possibilities, selection criteria, training procedures and optimal patterns of work relationship (e.g. supervision) with professionals is considered of urgent necessity.

Out of the variety of possible mental health agents (e.g. social worker, nurse, teacher) I would like to refer here to one specific and very important potential paraprofessional[1] within mental health care; it is the family doctor[2] who possesses, according to Tellegen (1970), the specific expertise of being acquainted with the history and the actual situation of the patient.
The research finding of Smith (1967) that "the general practitioner sees a very large number of emotionally disturbed patients" is supported by Zweens (1968) who found that family doctors thought about half of their patients' complaints to be determined either predominantly or partly by psychological factors.
Since psychological factors can lead to somatic disease (Silverman, 1970), it is no wonder that the family doctor is a common reference agent for both psycho-social and somatic complaints.
Bearing in mind the statement of Trimbos (1970) that the enormous extent of psychic problems in the population can in the present situation only partially be tackled with, the conclusion Bremer (1964) draws is very important. He states that "by the very nature of his relation to the patients, the general practitioner's possibilities to recognize those patients by whom physical symptoms must be interpreted as a sign of decompensation

[1] according to my own definition

[2] I prefer the term 'family doctor' to the term 'general practitioner' as I think it represents better the (specific) role he has in the Netherlands

under stress of certain problems of life, are superior to those of the specialist."
The English psychiatrist Balint, whose groups of family doctors[1] are widely spread in the Netherlands, insisted on the principle that not the illness but the patient must be treated.
The potential task of the family doctor within mental health care is obvious.
Many efforts were made (during the last few years) to supply medical students with the appropriate knowledge of giving not-somatic help. However, these new developments in medical education are still insufficient to convey the necessary psycho/social knowledge and skills. From a literature survey concerning the first echelon (Beek, 1973), it becomes apparent that the strongest emphasis is rather put on co-operation of the family doctor with other professionals and agencies than on his own psycho-social potential.

To sum up, mental health service in the Netherlands is momentarily in a transitory phase; the population-centered movement (shift of emphasis from curative work to preventive care) becomes gradually more remarkable and attracts many sympathizers, also from the governmental authorities. (The obvious difference between Nota 1970 and Nota 1974 shows the altered attitude towards mental health). However, as far as actual projects are considered, changes are rather restricted to mental health services and do not comprehend mental health care as a whole.

[1]The so-called 'Balint group' is a group of family doctors and a (psychiatrist) counsellor, meeting approximately once a week to deal with psychic problems with which the family doctors are confronted through their patients

A typical example of the (existing) contradiction between (expressed) wishes and (existing) facts can be seen in the guiding report published by the Ministry of Public Health (1972), where mental health care is said to be very important, however primary emphasis is put on the patient (the sick) and prevention is merely defined as a decrease in the extent of hospitalization.

Serious accusations are raised in various publications (Beek & Hak, 1973), viz. that insufficient attention is paid to clients' needs; that most services, projects and programs originate from the workers' needs, (implicitly) assuming that they correspond with those of the clients. All this can indicate a sensitivity and possible capacity among the already functioning individuals within the mental health, to bring about the desired changes; however, the great majority of those individuals who are not registered within the service, yet come in frequent contact with other people's problems, (paraprofessionals), are still neglected to a too great extent when actual programs of change are considered. A striking situation is thus created: in spite of the increased recognition of the possible contribution of paraprofessionals to mental health care, the concept of paraprofessionalism (rather than the individual persons) has not yet attained its appropriate status in the structural organization of the service. Though the concept is common enough in Dutch literature concerning mental health, no explicit definition is generally given, thus leaving the reader to his own interpretation.

New kinds of workers are gradually incorporated, yet the concealed possibilities to make use of existing agencies, services or individuals in the wider population are still neglected.

All over the country efforts are made to develop various

projects for using para(non)professionals. Some of them gain recognition and support of central agencies and/or governmental authorities, yet most of them remain limited to local initiative only.

Extension of mental health care by including para(non)-professionals means first of all introduction of new (unskilled) workers to the existing (mental health) services. However, hardly any attempt is made to make use of the already existing agencies, not so much as an integral, but rather additional part of mental health service.

3. Interpersonal relationship in a number of different psychotherapeutic schools

> "Unless the receiver of communication has the sensitivity to pick up the signals emitted by others in the network, communication is limited, distorted or lost entirely" (Blocher, 1968)

Though agreement on basic aspects of the therapeutic transaction in different therapeutic schools is far from common, the degree of theoretical and operational convergence is marked on one point, viz. the central position attributed to the interpersonal relationship between therapist and patient.

Since the work of Sullivan (1953), gradually more attention has been paid to interpersonal processes and relationships which nowadays are recognized as prominent factors for any professional in mental health, clinician or researcher.

Already before relationship variable became popular, Seeman (1949), in his study of clients' reactions, undergoing either directive or non-directive counselling, concluded that some factor other than the therapeutic method produced differences in clients' reactions. Fiedler (1953) affirmed this conclusion, stating that the therapeutic relationship is the critical variable in a successful therapy: "all psychotherapies have as their effective core the interpersonal relationship rather than the specific methods of treatment; the relationship is created by the therapist who must convey feelings to the client rather

than concentrate on methods".
With Snyder (1961) as well interpersonal communication between therapist and patient is greatly emphasized; in his terms, the therapeutic relationship must be seen as the reciprocity of various sets of affective attitudes which two or more persons hold toward each other. Various other authors put a similarly strong emphasis on interpersonal relationships; Bordin's comment (1959) could be representative for many of them: "The key to the influence of psychotherapy on the patient is in his relationship with his therapist. Virtually all efforts to theorize about psychotherapy are intended to describe and explain what attributes of the interactions between the therapist and the patient will account for whatever behavior change results".

While some writers on the subject of psychotherapy focus on differential aspects between the various therapeutic techniques (being more or less beneficial), others stress the fact that psychotherapy is a relationship, where factors directly associated with this variable contribute significantly to success or failure of the therapeutic process.
Strupp (1971) states that psychotherapy consists of a human relationship which serves as a vehicle for producing changes in the client's personality or behavior. "It is very likely that the effective principles in therapeutic work rest on processes that are more general than the specific principles advanced by different schools - psychotherapy is essentially a situation where two or more individuals behave together and affect each other through mutual exchange of information" (Beier, 1966). Shoben (1953) defined the therapeutic situation as a warm, permissive, safe, understanding but limited social

relationship within which therapist and patient discuss the affective behavior of the latter.
Truax (1963) gives a long list of various authors (including, inter alia, the psychoanalysts Alexander and Schafer, the client-centered Rogers and the eclectics Goldin and Strupp) who emphasize the importance of the therapist's maturity, integration and genuineness within the relationship, his ability to understand sensitively and accurately the patient's inner experience, giving warmth and showing acceptance of the patient. Truax concluded that these characteristics (of the therapist) cut across the various theories and can thus be considered common elements in a wide variety of approaches to psychotherapy.
Goldstein (1966) points rightly at an existing discrepancy: "We find wide agreement on the centrality to be accorded to the therapist-patient relationship in the overall therapeutic process, yet there is much definition diversity and lack of agreement concerning the specific nature and implications of this relationship".

Kanfer and Marston (1964), in their study of the characteristics of interactional behavior in a psychotherapeutic conversation, found that the nature of the interviewer's comments affects both interviewee's attitudes towards him and the particular way in which he expresses himself. The attitudes towards interviewer vary as a function of his own behavior and do not always correlate with interviewee's attempts to engage him in more extensive communication exchanges. It was further found that a therapist's support or avoidance of threatening material may increase his patient's dependence on him as well as the patient's tendency to elicit advice or information. On the basis of their findings they underline the impor-

tance of structuring the therapeutic relationship.
In this context Goldstein's recognition of the importance of increasing interpersonal attraction could be significant; according to him, manipulation of a major component of the therapeutic relationship, viz. patient attraction to the therapist, is a primary means for increasing the level of therapist influence; "by heightening the favourableness of patient attraction toward his therapist, the patient becomes more receptive to therapist influence attempts". Coons (1966), assuming insight not to be the crucial condition for change in behavior, found that in group psychotherapy, greater improvement resulted from a technique which stressed interaction than from a technique which stressed insight.

Dealing with the work of the psychotherapist, Strupp (1971) refers to him as 'a specialist in human communication'. According to him, the psychotherapist's goal is the client's authonomy and independence, his growing up to a mature adult who takes care of himself. An important aspect of the psychotherapist's task is to determine the nature of the patient's program, and to bring it to his attention in the hope that greater self awareness will lead to the kind of changes he desires.
Strupp groups the psychotherapist's activities into three areas: engaging in an interpersonal relationship with the patient; getting into verbal and nonverbal communication; conveying understanding to the patient, in the attempt to influence his believes, attitudes, feelings and actions.
Ullmann and Krasner (1969) state as well that communication is basic to the process of influence; from psychotherapeutic protocols, studies in verbal conditioning and in experimental bias they conclude that communication

involves far more than what is conveyed in words. "Almost all human communication includes subtle hidden cues" (Beier, 1966).

The central position of relationship between therapist and client has been generally recognized during the last few years and resulted in a new trend within the psychotherapeutic work, viz. the so-called 'relation therapy'. It conceives the therapist and his direct and confronting (personal though formal) attitude towards the client as a central pillar to the therapeutic situation.
Though various authors have contributed to this new approach[1], unfortunately we are still confronted with the absence of a general theory or even a comprehensive handbook about this last development.

In order to illustrate specific patterns of interpersonal relationships within the psychotherapeutic frame of reference, several prominent psychotherapeutic schools will be discussed briefly, as to their therapist-client relationship.

Psychoanalytic therapy is a causal therapy, attempting to undo the causes of neurosis, resolving the patient's neurotic conflicts[2] (Greenson, 1967).
The procedure that psychoanalysis stimulates the patient to use in order to facilitate communication, is free associations, dreams, slips, symptoms and acting outs. By letting things come to mind the patient moves from strict

[1] e.g. Beier, Haley, Porter, Wazlawick

[2] A neurotic conflict is an unconscious conflict between an id impulse seeking discharge and an ego defense wording off the impulse's direct discharge or access to consciousness. The conflict leads to an abstraction in the discharge of instinctual drives eventuating in a state of being dammed up; the ego becomes progressively less able to cope with the mounting tensions and is ultimately overwhelmed

secondary process in the direction of the primary process.
Since resistance is conceived as a manifestation of defensive and distorting functions of the ego, its analysis is one of the cornerstones of psychoanalytic technique.
Another basic concept is the transference which is one of the most valuable sources of material for the analysis.
The instinctual frustration of the neurotic tends to make him unconsciously seek objects upon which he can displace his libidinal and aggressive impulses. The patient tends to repeat his past in terms of human relations, in order to compensate for lack of satisfaction or belatedly to master some anxiety or guilt. The great importance of the transference reactions is due to the fact that, if properly handled, the patient will experience all the significant human relations of his past which are not consciously accessible to him in the treatment situation (Freud, 1912a).
Besides resistance and transference there are other, relatively non neurotic, rational and realistic attitudes of the patient toward the analyst; it is the working alliance (Greenson, 1965a) in the patient-therapist relationship that enables the patient to identify himself with the analyst's point of view and to work with him.

Client-centered psychotherapy conceives (therapeutic) relationship as central for any personality change; it places primary emphasis on client's moment-to-moment experience within the therapeutic framework.
The client is not a patient who is sick and in need of treatment, but rather a person whose earlier experiences in life have made him defensive, severed him from free and open communication and prevented him from realizing his potential of a fully functioning person.

Client-centered therapy does not consist, therefore, of techniques designed to produce specific changes, but is rather a unified approach to deal with interpersonal experiences, intending to influence them.
An important implication of this approach is that the client is fully responsible of the conduct of his life; therapist's non-interference is dictated from the respect for the client's authonomy and independence. The focus rests on the client's experience; strictly speaking, the only thing that matters is what happens between client and therapist.
According to Rogers (1951), therapist's attitudes are necessary and sufficient conditions for a constructive personality change: "In the broad sense the (therapeutic) process may be described as the client's reciprocation of the therapist's attitudes" (Rogers, 1967).
The prominent requirements of the therapist according to this approach are:
- genuineness, characterized by the therapist's openness to the client's experience and verbal and nonverbal expression of awareness to his own and the client's experience. Relationships between therapist and client are on a person-to-person basis, which permits a reflection of the client's feelings;
- unconditioned positive regard which consists of an ultimate acceptance of the client as a person; the therapist refrains from any judgement of client's feelings and conduct, thus permitting the client to feel secure, protected and respected;
- accurate empathy, which means accurate perception of the client's internal frame of reference (his subjective world) including the emotional components and meanings (as if one were the other person, but without ever losing the 'as if' condition).

According to Carkhuff (1967) the client-centered approach provides the client with an opportunity to find his own mode of expression including an immediate and concrete feed-back of what he has just communicated; the therapist supplies him with the possibility to experience previously denied experiences, to discover and correct faulty generalizations.

In a survey of the status of psychology as a profession, Webb (1962) suggests that contempory psychology, in all its diversity, is bound to one single common principle, viz. that human behavior is lawful. From this assumption follows that understanding of human behavior can best be achieved by a systematic analysis.
According to Ullmann and Krasner (1969), behavior therapy can be summarized as involving many procedures that utilize systematic environmental contingencies to alter directly subject's response to stimuli. This view holds that the symptoms are the neurosis and that there is nothing more to a neurosis than the observed or potentially observable problems of the sufferer. Therefore, while in other psychotherapeutic approaches the treatment tends to consist primarily of verbal interchange between therapist and client, in behavior therapy the tendency is to concentrate on the actual (behavioral) difficulties brought about by the patient (Beech, 1969).
In the behavior therapy approach symptoms are rather conceived as evidence of faulty learning than as connected with any deeply underlying cause; the underlying assumption is that learning of neurotic behavior differs from any other learning only in being inappropriate or maladaptive. Conditioned responses, especially of neurotic persons, are assumed to serve in some way as a reward, arising out of escape from or avoidance of activities

that cause (or are connected with) discomfort.
As behavior therapy is based upon the notion that many psychological abnormalities are the result of an unfortunate conditioning history, it suggests to reverse this trend and either to eliminate some previous learning or to learn some new and better (more adaptive or normal) behavior.
It is recommended to extend an inquiry beyond the obvious scope of the difficulties formulated by the patient, by obtaining as much information as possible and by conducting an intensive interrogation so that no doubt or unclarity about the patient's difficulties remain; when the whole comprehensive information is considered, a more fundamental underlying problem can be discovered.
In this therapeutic situation the patient is supposed to be quickly acquainted with the aims of treatment and with the therapist's generally active role of encouraging and persuading him, attaching relatively little importance to interpersonal relationships.
Wolpe (1966) insists that a warm, trustful, sympathetic attitude of the therapist can help the patient to unburden himself and/or provide him with some reassurance. However, this particular view on the therapeutic relationship is generally not emphasized by behavior therapists, who rather conceive a good contact with the patient as one out of the various available possibilities to reduce anxiety.
Nevertheless, Strupp and Bergin (1969) state explicitly that the relationship factor becomes gradually an integral part of the behavior therapy, although it is not regarded as essential in the traditional behavioral approach.

The different views about the nature of psychotherapy all point out the importance and significance of the relationship between the therapist and his client; however, not all of them agree on the kind of this relationship, neither on the extent of significance attached to it.
The diversity among the different psychotherapeutic schools ranges from stating it central and primary (client-centered therapy), through recognizing its basical usefulness in the therapeutic process (psychoanalytic therapy) to defining it merely as one of the important facilitating aspects useful to therapeutic work (behavior therapy).
In spite of the existing controversity among the different schools, they agree unanimously that this factor has obviously gained an important place and can not be omitted when considering psychotherapy in general, therapeutic conduct or therapeutic outcomes.
A common conception found in all (mentioned) therapeutic approaches refers to the importance attached to the client's own participation in (and his active contribution to) the therapeutic process.
Prominent variables of (therapeutic) interpersonal relationship, recognized in the various approaches to psychotherapy, can be grouped into three clusters:
- warmth, acceptance, patience and flexibility in order to enable the client to attain a feeling of security and willingness in the therapeutic situation;
- empathy, recognition of evasion and sensitivity to verbal expressions, slips of the tongue or 'by the way' utterances as well as non-verbal gestures, in order to attain more information than the one brought in explicitly and directly;
- looking for underlying (specific) factors, differentiating among their background (origin) and structuring them

in order to receive an clear(er) sketch of the client's situation.

Besides the relationship between therapist and client, a factor that is unanimously considered primary in any therapeutic process is clearness of the client's situation; "the effectiveness of any therapeutic intervention is limited by the degree of understanding of the nature and source of the client's problem" (Stephens, 1970). However, a controversy exists as to the nature and extent of this clearness; the dilemma formulated by Goldstein, referring there to the centrality of the relationship within the psychotherapeutic process, could be stated here as well: There is wide agreement on the needed clearness in the client's situation, yet there is a wide diversity in definitions and lack of agreement concerning the specific nature of that clearness.

4. Consequences for mental health of extending the interpersonal ability of the paraprofessional

My definition of paraprofessionals refers to individuals who function already in the community; in this train of thought any critical reference to their existence in the field of mental health seems to me superfluous as they exist almost any time and everywhere.
This interpersonal contact has no doubt consequences - better or worse, efficient or not - for the entire mental health care.

The most important contribution paraprofessionals can offer to mental health is their possibility to place care rather within the community than outside it. A new approach is thus being formed: Both care and principles of mental health are brought closer to the public, compensating for the limited (physical) existence of formal mental health services. In this sense paraprofessionals could serve as indirect agents to supply a form of mental health care in the different societal units, which are not explicitly included and/or identified with any formal and specialized (mental) service.
This contribution could be further explained and specified by making a (sub)division between several aspects:
- the paraprofessional can have a prominent preventive role; since he comes into daily contact with community members he is able to supply an immediate intervention in the natural environment before any escalation occurs.
- the paraprofessional can have a helping function which can, to some extent, be conceived as a kind of therapeutic work (in the very wide meaning of the word). Mostly

neither the helper nor the helpee is conscious of this possible interpretation of their relationship, which has important social and psychological advantages (lack of stigma and/or self conception of being under treatment). Besides, this kind of relationship can be useful as a preparatory phase in case of further professional treatment.
- the paraprofessional can also deal with difficulties and problems that are beyond the specific and specialized scope of mental health services; in this sense he contributes to the enlargement of mental health care and helps the services to cope with the increased demand for help.

In order to make optimal use of their potential contribution they should be supplied with some program to improve (or extend) their function in dealing with other people's personal problems or difficulties.
Basic concepts of psychotherapeutic relationship seem to me most appropriate to serve as starting point for any suggested project of this kind. Psychotherapy is a specialized profession of making and maintaining contact with the fellow human being; like any other specialization it has, theoretically and practically, been developed to such a degree that it is impossible for an arbitrary paraprofessional to make direct use of its concepts and techniques.
An operationalization of basic therapeutic notions to a common level of understanding should take place in order to incorporate them in such a project.
No effort is made to develop subtherapists whatsoever; the purpose is rather to supply common skills (based on more sophisticated models and theories) leading to better and more efficient manners of handling other persons.
Survey of the psychotherapeutic literature shows that

almost all psychotherapeutic schools share several principal points of view, differentiating in the emphasis put on some (favorite) aspect(s).
The suggested project could be based on a synthesis between the common principles combined with some prominent aspects of specific therapeutic approaches where the relationship factor is strongly accentuated; in this way paraprofessionals could derive benefit from the psychotherapeutic frame of reference.

Acquisition of cognitive information, practical skills and feedback would lead the paraprofessional to more specified and purpose-directed relationships with others; this in turn is generally conceived as a possible answer to the existing increasing need for mental help in the community.
After participation in the suggested project he should be able to attain more detailed and profound information concerning the (applying) person and to sketch a clearly structured picture of the global situation.
Clearness[1] of the general situation is in my opinion a necessary facilitating factor at every level of help possibly offered by the paraprofessional, whether merely at the stage of discussing the other's difficulties, in an attempt to guide him to a solution or in referring him to a professional helper.
- Already by discussing the applicant's difficulties, the paraprofessional helps him to structure the different factors which are of influence on the situation; this in turn may prove to be sufficient for finding an appropriate solution to the (present) problems on his own.

[1] Presentation of the entire situation, resulting from structuring (grouping) the different factors which are of influence on the situation of the applying person

- By discussing and structuring the applicant's situation, it can become apparent to one (or both) of them that the applying person, missing the suitable (subjective and/or objective) capabilities, would not be able to proceed with his difficulties on his own. At this moment the paraprofessional's abilities to make efficient use of the obtained clearness of the situation, can possibly lead to a solution of the (present) problems.
- Either during presentation of the difficulties or in the actual process of help, the paraprofessional (or the applying person) may realize that this relationship is not sufficient to bring about the necessary change. Further reference to professional treatment is then indicated. If the paraprofessional has at his disposal a clear sketch of the entire situation, much time and effort can be saved both during the reference procedure itself as well as in the initial contacts with the professional. In this sense, attaining clearness in the client's situation at an initial phase, therefore, means speeding up fluency of clients within the referable agencies.

Considering the potential significance and contribution of paraprofessionals to mental health, it seemed that any program enabling them to attain clearness in the situation presented by the other would improve their present functioning. Programs aimed at acquirement of clearness seemed to be based most appropriately on common concepts of the psychotherapeutic frame of reference.
In the following report, a training procedure is suggested tending to improve the paraprofessional's skills in interpersonal contacts.

III CONSTRUCTION OF A TRAINING PROCEDURE

This chapter will start with theoretical argumentation and background of the training, followed by the global research design.
After reporting the preliminary study and the pre-treatment measurement, a detailed account of the training procedure will follow.
Reports of post-treatment and follow up measurements will be completed by final conclusions.

1. Theoretical argumentation and background of the training

As already stated in the previous chapter, various psychotherapeutic schools agree on the expectancy and/or necessity of a (potential) clearness about situations presented by persons.
On the basis of this general agreement, I consider clearness an important factor in the way first echelon workers deal with their clients. In order to attain clearness one should be able to focus on the principal problem(s); this, by differentiating among the various implicit factors that make up the explicit claim brought in by the client.
I consider thus distinguishing among and mapping of the various factors which are not explicitly mentioned by the client, the significant tasks of first echelon workers. These two steps are vital since they enable the helper to focus on the essential basic problem(s) necessary to attain some clearness in the situation described

by the client. Without such clearness no significant step can be taken towards the solution of clients' problems.

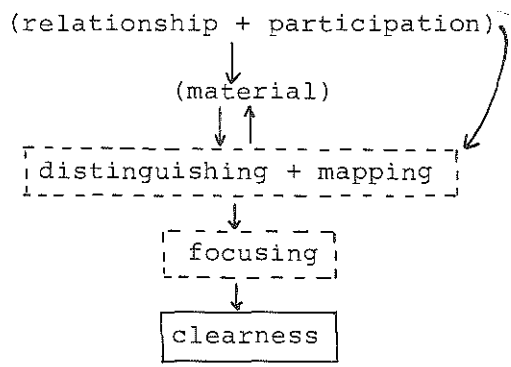
Any interpersonal relationship can be characterized and analyzed according to three factors: How (is negotiated)?
Who (negotiates)?
What (is negotiated)?

In a situation where one of the participants tries (and is expected) to direct mutual behavior, these factors could be stated as follows:

- Handling the relationship
- Handling other's participation
- Handling the material

Skill in handling the material is the ultimate goal of the training whereas the other two can be looked upon as necessary pre-conditions: Focus on the underlying implicit problem(s) demands a special way of dealing with explicitly stated facts made possible by optimal situational sphere and client's participation.

Mutual behavior could be sketched as follows:



Main aspects of relationship with the other as found in psychotherapeutic literature (see p. 42) were presented to various persons working either in the mental health

sector or in educational institutions dealing with future mental health workers.
Based on their considerations, a list of 15 categories[1], divided into three subgroups (corresponding with the handling concepts mentioned above), was constructed:

(A) Handling the relationship

1) Personal interest in the other - Indifference towards the other.
(The helper is interested in the other, his difficulties and their solution. His interest remains unchanged also in case of necessary relegation).

2) Acceptance of the other - Leaving the other with his difficulties.
(The helper tries to face the other unbiassed, also when he feels ill at ease because of the other's difficulties; he realizes that whatever the other may be, he has the right to be helped).

3) Flexibility in the relation with the other - Rigidity in the relation.
(The helper is able to adapt himself to unexpected changes in the conversation, in spite of an existing plan or process).

4) Allowing the other complete freedom of expression - Reacting only from the point of view of one's specific profession.
(The helper asks the other some general questions (concerning the other's social, familial, occupational area etc.) which are not directly connected with the helper's own profession).

[1] In order to clarify the categories as much as possible, each of them is described by defining both the desired direction and its opposite extreme; an operationalization is given to the desired extreme only

5) Taking up other's reaction to the helper's remarks - Ignore other's reactions to the helper's remarks.
(Incorporate in the following conversation any verbal or non-verbal sign of the client made in reaction to a remark of the helper).

(B) Handling other's participation

6) Reaction to changes in non-verbal expressions of the other - Ignore other's non-verbal expressions.
(Awareness of non-verbal expression and react accordingly).

7) Reaction to other's remarks which are beside the point - Exclusive reaction to utterances concerning the main problem.
(Awareness of remarks made by the way, using them in order to improve understanding of client's situation and/or to help him to express his real problem).

8) Prevention of evasion from an important problem - Enable other's (psychological) escape.
(The helper tries to bring back into the conversation aspects which seemed to be important for the other but were evaded by him. If necessary, the helper confronts the other with his evasion).

9) Encouragement of reports of experiences beyond the complaint - Being content with utterances concerning the complaint in question.
(Ask for further report of experiences beyond the problem in question. If necessary, by means of eliciting some general remarks).

10) Encouragement to participate in the search for reasons and explanations of his complaint and/or difficulties, and their solution - Non-observance of active participation.

(Ask the other to try to look for the reasons of his difficulties; help him to form a total picture out of the various sources of information and experiences; help him to reach a suitable solution).

(C) Handling the material

11) Explanation of the given advice - Giving advice without any explanation.
(Give any suggested advice in understandable terms for the other, provided with the underlying reasons and possible consequences).

12) Taking up aspects of the complaint unknown to the other - Leaving unknown aspects unexplained.
(Give the other the necessary explanation as to the possibly unknown background of his difficulties).

13) Active search for general psychological reasons and ability to relate them to the complaint - Remain only in the helper's own specific frame of reference.
(Attention to any - direct or indirect - mentioning of mental factors, which can possibly supply further explanation of the problem in question).

14) Active search for environmental influences and ability to relate them to the complaint - Remain in the helper's own specific frame of reference.
(Attention to any - direct or indirect - mentioning of milieu factors which can possibly supply further explanation of the problem in question).

15) Differentiation between psychological and social factors - No differentiation between psychological and social factors.
(Ability to see whether a given factor is a psychological or social one. If both factors are involved, select the more prominent).

This list of categories, which is based on the frame of reference of psychotherapeutic relationship and contains a detailed operationalization of the above mentioned three main aspects of inter-personal handling, formed the central pillar for the construction of the training. No claim is made to attain a psychotherapeutic level of functioning though this may be possibly assumed on ground of the (professional) formulation of these categories.

2. Global research design

Survey of research literature in psychotherapy points at three important factors that have to be taken into account in experimental designs concerning effects of psychotherapeutic treatment:

client variables - characteristics of the person who seeks help.

agent variables - characteristics of the person who supplies help.

method variables - characteristics of the manner in which help is given.

These three factors and their mutual relationships are considered in the literature (e.g. Stollak et al.(1966); Strupp (1971); Strupp and Bergin (1969); Wijngaarden and Petrie (1972)) important experimental variables referring to measurement and evaluation of treatment effects.

However, bearing in mind the essence of my definition of paraprofessionals, a complete reference to these variables is impossible: Stating that everyone functioning formally or informally in the field of mental hygiene has to deal with any arbitrary applying person means that the client factor remains unmanipulated. Any manipulation of the client variables was conceived to be in contradiction to the stated definition, and could not be taken into consideration in the research design.

The agent, though taken into account (e.g. by taking a representative sample of various potential paraprofessionals) could be partially manipulated only, being dependent on the actual research situation.

The only one left to be fully controlled is, therefore, the method factor.

Any group of formal or informal[1] paraprofessionals of the first echelon, interested in a training for improvement in their daily activity, was regarded a suitable research subject. With a view to generalization of obtained results beyond the specific research sample, as well as to prevention of bias of attitude contamination and resistance to change, it seemed most appropriate to choose a group (subjects) as neutral as possible (without specific frame of reference, prejudices or specific past experience).

Whenever construction of a training procedure is considered, two prevailing inter-dependent aspects should be taken into account:
- the training procedure
- instrumentation of measurement and evaluation

The inter-dependence between these two aspects necessarily implies the existence of some plausible accordance between the stated final aim of the training and the evaluation criteria making up the given instrument. This (necessary) accordance between the final aim of the training and the evaluation criteria implies, in its turn, that there is little chance to find an (existing) suitable instrument for immediate evaluation of a constructed (specific) training procedure.
Since a parallel incorporation of these two dimensions seemed to widen the research far beyond its intended scope, and since I consider a practical 'help-instrument' of importance for possible solutions to problems arising in the field, I decided to put stronger emphasis on the

[1] By formal paraprofessionals we understand individuals functioning within a given community owing to their (original) professions, whereas the term informal paraprofessionals used to designate individuals functioning rather owing to their social roles and not necessarily related to any profession

training procedure than on the evaluation instrument(s).

The above mentioned list of categories shows the intention to develop a structured training procedure.
My underlying assumption is that a structured training for paraprofessionals is preferable to an unstructured one. However, this assumption has to be checked up, bearing in mind that an obtained behavioral change, following a given treatment[1], might be influenced by the situation (of group meetings) rather than by the material (transferred during the meetings).
I decided, therefore, to set up a pretest-post test control group design[2] where three groups are parallely manipulated, viz. two experimental groups and a control group:
experimental group I - undergoing a structured training procedure;
experimental group II - undergoing unstructured meetings, corresponding in all the other aspects to experimental group I;
control group - undergoing no treatment at all.
Comparison between obtained results of the experimental groups and the control group shows (general) obtained effects of treatment; however, further exploration of the differential influence of the suggested kind of treatment (structured vs. unstructured) can be carried out by comparing the results of the two experimental groups.

[1] By treatment is understood the specific manipulation each of the participating groups obtained; in this context it is rather a methodological than a clinical concept

[2] Campbell and Stanley (1963)

Measurement was planned at three different moments:
before treatment
after treatment
follow up
Effects of treatment are stated on basis of comparison between results obtained at the first measurement moment and those obtained at the second one. As a certain amount of effect is hypothesised, a difference between the two measurement moments is expected.
The situation is different for the third measurement moment, since in the case of comparison between obtained results at second and third measurement moment a certain extent of stability is assumed and no differences are expected to be found.

Measurement has been carried out not only at three different moments, but also on three different levels:
- evaluation by outsiders (judges)
- evaluation by superiors
- evaluation by subjects

These three levels were introduced in order to obtain a description of treatment effects as detailed as possible.

A suggested procedure for each of the experimental groups as well as the various measuring devices were developed and set up during the preliminary study.

3. Preliminary study

The preliminary study was carried out with a group of twelve undergraduate students of clinical psychology; (they were considered near laymen).

The study concerned three main aspects:

A. a general inventory of formal and informal sources of help in the town where research took place.
B. preparation of treatment procedures.
C. preparation of devices to assess the effects of the given treatment.

All group members dealt with the first aspect while two different subgroups were formed to deal with one of the other two aspects each.

A. A general inventory

Each member of the group was asked to prepare a list of all formal and informal help sources known to him. The final list (including inter alia, volunteer help service, relief work club, police etc.), completed with official information from local publications, was distributed among the group members who had to carry out an interview of the various listed help sources.

For this purpose a detailed interview was constructed concerning (1) the kind of the service, the kind of the helpees and the problems the service is confronted with and (2) expressed needs with regard to a possible training, the actual readiness to undergo a training and the practical possibilities. After an initial selection (among the listed help sources) made on basis of the readiness to participate in the inventory, interviews with approximately 20 services were held and reported in detail.

An analysis of the different aspects on which information was gathered brought about three services[1] as potential subjects for the training. These three services were interviewed for a second time by a different person.
On the basis of the conclusions drawn from both interviews, concerning the motivation of the workers, the actual possibilities and a possible justification for generalization beyond the specific group, the 'Home-Help-Service' was finally chosen to participate in the research.

This service, defined as working curatively as well as preventively, aims at keeping and/or restoring the normal (usual) family life, mostly by replacing or assisting the house wife who is (fully or partially) prevented from doing her duties. The applying persons come from all social classes. Definitely no selection of applicants is made which means that any family (including the 'problem families') receives the needed help.
The 'Home-Help-Service' located in a town of about 150.000 citizens, consists of approximately 200 workers, in the sectors of family care and care for the aged.
Most of the engaged persons, especially those charged with field-work, have no specific educational background; selection is made on the basis of personal suitability.
Supervision is continuously given by a social worker[2].
The personal shortcomings of the workers consisting of both lack of(specific) knowledge and (some) deficiency in dealing with the other is one of the principal problems with which the service is confronted.

[1]Hulpdienst/Nijmegen
Nederlands Katholiek Vakverbond (afd. Nijmegen)
Stichting Gezinsverzorging Nijmegen

[2]The social worker in the Netherlands does not obtain an academic degree

Several meetings with the employed personnel were organized in order to enhance their motivation to take part in the project.
From those (paraprofessionals) who expressed their readiness to participate, thirty female subjects were chosen at random with due regard to the general variables of age, education, formal function and experience[1]. These thirty subjects were spread over the two experimental groups and the control group, with observance of the above mentioned variables.
Twenty subjects were called up for a meeting, whereas ten subjects were told to wait for a later call since it was impossible to absorb all the applicants in the present project.

B. Preparation of treatment procedures

1. training: A group of seven students - a subgroup of the students' project group - was charged with the preparation of the training procedure.
The purpose of the training was not to supply candidates with theoretical knowledge but rather with some practical interactional skills; therefore, aspects of relationship were considered the essential items of the program.
The students' group was regarded as a judging organ dealing with a. filmed material
b. written material
c. tentative procedure

[1]The subjects were spread over the different variables as follows:
age: 18 to 22 years: 11; 25 to 35 years: 7; 37 to 44 years: 6; 48 to 53 years: 6;
education: elementary school: 17; care diploma: 6; secondary education: 5; continued education: 2;
formal function: helper: 21; provider: 9;
experience: till 1 year: 8; 1 to 2 years: 7; 2 to 4 years: 8; 4 to 7 years: 5; more than 7 years: 1; unknown: 1

a. The (Dutch) film material concerning inter-personal relationships where one of the persons involved is in a problematic situation, was projected before the students. They were instructed (1) to choose those categories of the list which they thought to appear in each of the screened items and (2) to indicate the extent to which each of the categories appears in the given item. Basing on this judgement, certain film items were chosen to represent specific categories[1] and to serve as their modelling[2].

b. Written material was collected (if necessary translated) or constructed, consisting of either vignettes, parts of conversations or fragments of case studies and reports concerning inter-personal relationships where one of the persons involved is in a problematic situation. The written material - either left in its written form (items to be answered in writing) or transferred into a role-play - served as working exercise for the students in order to enhance understanding and eliminate difficulties and problems cropping out during its performance. The items found to be most suitable for use in the training, were chosen; in addition, a decision was made concerning the form of every item: written item vs. role-play. When transferring some of the items into role-plays, efforts were made to imitate as much as possible the actual situations (e.g. using specific jargon, presenting

[1]most of the chosen film material was prepared by Drs. M. Höweler and Drs. A. Vrolijk, staff members of the Department of Conflictuology at the Free University of Amsterdam (headed by Prof.Dr.H.R. Wijngaarden) and copied (with the author's permission) from the library of the "Stichting Film en Wetenschap", Utrecht

[2]This concept was introduced by behavior therapy (included within the vicarious learning model) hypothesizing that demonstration of segments of preselected 'good' behavior would facilitate learning

patients' data cards) in order to facilitate identification with the played roles.
Besides dealing with the form of the items (clearness, possible difficulties), the relation to each of the categories was examined in order to determine the suitable moment of incorporation.
From experience during this stage we decided to treat some of the categories in pairs of two in one single session.

c. The potential material thus having been sorted out and matched to the respective categories, we had sufficient basis for allotment to the various training sessions (including determination of rank order). At this stage the (tentative) training procedure was set up and put before the students' group in order to receive feedback and suggestions, on basis of which the definite procedure was constructed.
A complete description of the definite procedure will be given on p. 75.

2. unstructured meetings: As to the other treatment group, it was decided that the treatment will consist of meetings with discussions about any arbitrary subject which is thought to be of influence on participants' daily functioning.
No structured formula was suggested beforehand; however, the global form of these meetings was decided on: The course of the discussion was left to the participants; the leader was expected not to interfere in this course but rather follow it and confront the participants with relationship patterns appearing during the group meeting and/or help them to solve actual field problems.(use of a bandrecorder, for confrontation of group members with their own behavioral patterns was allowed).

It was decided to instruct the group on their first meeting about the desired way of discussing, viz. exposition of questions, difficulties and actual (field) problems to each other than to the leader. It was decided to explicitly state the position of the leader within the group. As to the leader, it was decided that he should be a psychologist (or another social studies professional) with some experience in psychotherapeutic treatment and group work.

C. Preparation of devices to assess the effects of the given treatment

A group of five students (another subgroup of the students' project group) was charged with the preparation of assessing devices.
From survey of the literature concerned both with evaluation of psychotherapeutic effects and evaluation of paraprofessionals at work, it became apparent that no (existing) suitable assessing device could be found for our case: neither the conditions of the subjects' population and the (planned) treatment nor the formulated theoretical considerations and the final treatment aim were in accordance.
Since no existing valid tests or measurements could be found to suit the specific purpose stated in the research design, the construction of some assessing devices seemed unavoidable.
Bearing in mind the decision to let the development of a training procedure prevail over the construction of an evaluation instrument (see page 55), construction of assessment devices was considered a necessary condition in the process of developing a training procedure, without pretention to attain a completely independent value.
Considering the theoretical background of the research,

the following devices were found to be most suitable for assessment of treatment effects:

1. role-play
2. questionnaire
3. report (written reaction to given material)

1. Role-play: two different yet as parallel as possible situations were constructed, exercised and reconstructed. Each of them consisted of two written roles - one for the paraprofessional, the other for an actor.

Role-play I (before treatment):

I.1 The Volunteer

You care for the aged and thus visit Mrs. Bos weekly. Mrs. Bos is a pleasant woman who is able to manage herself, but is, nevertheless, very happy to attain your help and advice. A very good relationship exists between the two of you.

While drinking a cup of coffee, Mrs. Bos mentions that she is a bit worried about her neighbour Mrs. van Veen who - in spite of her young age - often suffers from pain and tiredness; she then gets into difficulties with her household and the care for her two little children (she refuses to consult the family doctor). Mr. van Veen is a truck driver, with a good income.

Mrs. Bos asks you to visit the v. Veen family; you agree and are told, the week after, that the v. Veen family (Mr. v.Veen has occasionally been at home) would be glad to meet you - an appointment is unnecessary.

You come along and speak now with Mr. or Mrs.v.Veen.

I.2 Mr. or Mrs. van Veen

Both Mr. and Mrs. v. Veen have difficulties to tell about their respective troubles: Mr.v.Veen has the tendency to make long drives including overnight stays; as a consequence Mrs.v.Veen feels herself neglected.

Mr. v. Veen, when informed by phone about his wife's 'fit of illness', is in the habit of returning home immediately, giving up his planned extra work.

Role-play II (after treatment):

II.1 The family provider

You care for the v. Eijk family. Although Mrs. v. Eijk is an invalid, she manages quite well and you have only to coach her. You admire her thoroughness and like to visit this family. Accidentally you met there her sister Mrs. Baas, her husband and the children Jaap (2) and Marijke (3½). You talked only superficially with them.
One day Mrs. van Eijk asked you to visit her sister or her brother-in-law who claims that when he comes home from work his wife is still busy preparing the parents' dinner in the kitchen, although she did not have anything else to do all day long. Mrs. van Eijk had already spoken with her sister who is aware of the problem but cannot help it; she tries, but fails.
You decided to speak with Mr. or Mrs. Baas and went there.

II.2 Family Baas

Mr. Baas is accustomed to read the newspaper as soon as he comes home. The children, who have had their meal already, try to draw his attention but usually in vain. While Mrs. Baas is busy in the kitchen, Mr. Baas plays with the children and puts them to bed.
None of them thinks that the details mentioned above have any connection with the fact that Mrs. Baas is often late with dinner.

Due to practical reasons (length of introduction phase and schedule of the studio), role-play had to be performed simultaneously with other subjects; three students, two male and a female, served as actors, playing respectively

the husband role and the wife role.
Each of the written role-plays was discussed and exercised by the actors in order to obtain the necessary uniform standard; questions which were thought to possibly crop up during the actual role-play were discussed and a decision was made.
During the actors' training, efforts were made to keep the two different role-plays as parallel as possible: although the emerging problems were different, the family constellation and the nature of the conflict were kept equal.
The actors were instructed (and trained) to stick to their formal role until an attempt was made by the subject to go beyond the given information. In this case the actors were expected to follow the new course.

Each member of the students' group was asked to prepare some items analogously to the theoretical argumentation and the stated goal of the training to be used for evaluation of functioning in role-play. The suggested proposals were discussed in the group, as to their practical advantages and shortcomings.
The following variables were finally decided on for evaluation of subjects' performance in role-play:

1. stimulation of the other's active participation in clarifying his difficulties;
2. expression of interest and respect causing a sphere of trust and the development of a relationship;
3. differentiation among the various factors in the situation of the other;
4. distillation of the problem;
5. insight in the situation of the other.

These five variables were presented on a five point continuum moving between the variable as stated above and its opposite. (Appendix A)

2. Questionnaire: Every member of the students' subgroup prepared some evaluation-descriptive statements concerning the relationship between the paraprofessional and helpee in line with the theoretical argumentation (consisting of the intermediate variables stated above and the final goal).

All the suggested statements were discussed in the group as to their suitability to assess possible improvement in the paraprofessionals' activities. On basis of feed-back and suggestions given during the discussion, the definite list of variables, used for construction of the questionnaire, was set up:

1. being interested and involved in the problem of the other;
2. respecting and accepting the other in a way that attention and willingness remain unchanged whatever he may tell;
3. being able to experience the problem of the other;
4. trying to adapt oneself to any change in the situation and to look at the problem from different points of view;
5. being able to obtain the other's trust by giving a feeling of security and calmness;
6. perceiving different nuances in the other's way of mentioning small details;
7. encouraging the other to express his opinion and feelings about the discussed subjects;
8. letting the other determine the course of the conversation;
9. being able to listen patiently to the other;
10. encouraging the other to look for a solution to his difficulties;
11. being able to consider (possibly together with a superior) any possible support aimed at improving the situation;

12. explaining to the other the processes preceding any given idea or advice;
13. observing the other to obtain distinction between psychic disturbances and problematic relationships; herewith clearness in the situation can be obtained;
14. giving the other emotional support and warmth;
15. obtaining a clear view of the situation through the contact with the other, resulting in a feeling of ability to differentiate between personal and environmental factors.

Based on this list of variables two different yet parallel questionnaires were set up; one of them was intended to be completed by all subjects whereas the other was intended to be completed by superiors.
Each of the variables was set on a 5-point continuum moving between positive assertion to its opposite. (Appendix B)

3. Report: An (existing) French film for training in observation was suggested to be used in order to obtain observational (written) reports from subjects.
The film (non-speaking) consisted of three very short independent parts, each of which supplied a description of an interactional scene.

Part 1 - The baby:
A young woman is dressing a crying baby. An older woman comes in and helps her. When the baby is dressed, the young woman puts it to bed, while the older one is watching. The older woman turns the baby while the younger one is watching.

Part 2 - The triade:
A young man and a young woman are sitting embraced on a couch, looking at a photo-album. Another young woman leafes through a book, while

watching them. The young man leaves the woman on the sofa, goes to the other one and embraces her, while the woman on the sofa watches them.

Part 3 - The breakfast:
A young man, sitting at a table, notices that there is no butter. An older woman comes in with the butter; the young man smiles at her. He wants to use the butter but she takes the bread and smears it. While he is eating, the woman drinks a cup of tea sitting behind him.

The formulated instruction was, after each part to write down what has been seen.

The students were asked to prepare some criteria according to which the observational reports could be evaluated.
During the discussion of the criteria it was found that evaluation could better be done on basis of one variable: the proportion of the actual reproduction of the film to interactional and/or emotional reflection. This variable was operationalized in three different questions; two of them were further divided into two sub-questions. (Appendix C)

As stated above, the research was designed to include a manipulation of three groups, measured at three different moments and on three different levels.
The developed (evaluation) devices were conceived as follows:

1. the role-play and report, evaluated by judges were considered relatively objective.
2. the questionnaire, filled in by superiors, was also considered relatively objective, however, of a slightly lower level of objectivity than that of the defi-

nitely outsider's judgement.

3. the questionnaire, filled in by subjects, was considered subjective.

All the (evaluating) devices were planned to be applied before and after treatment on each of the three groups. However, since the readiness of the subjects of the control group to participate actively in a measurement procedure was found to be very limited, restriction of their participation to home activities only was unavoidable. The questionnaires (completed both by subjects and superiors) were the only ones planned to be used at the follow-up measuring moment.

The preliminary study was concluded with setting up the design - combining the different groups, evaluation devices and measuring moments - as follows:

group	experimental I and II			control		
moment / device	before	after	follow-up	before	after	follow-up
role-play	x	x				
report	x	x				
questionnaire comp.by superior	x	x	x	x	x	x
questionnaire comp.by subject	x	x	x	x	x	x

4. First measurement moment

All subjects and their superiors participated in the first measurement moment: experimental subjects were asked at the introduction meeting to carry out three different measurable tasks; control subjects and superiors were requested to fill in questionnaires.
In each of the two experimental groups an introduction meeting was held before their program started. Besides making acquaintance, expressing wishes and discussing work style (and program, within experimental group I) all trainees were asked:
1) to complete a questionnaire, concerning their own ideas about their present functioning in contacts with helpees. They were given instructions including some clear examples of filling in the questionnaire.
2) to carry out an observational excercise, where written reactions (report), to three short film fragments were required.
3) to perform a role-play (in the helper role) according to a given written text. They were asked to talk with the person who seeks help and waits in another room. The conversation - with an upper limit of 30 min. - was video-recorded. (Some subjects cut down the duration of their performance).
Since the helpee's role was performed by two male actors and one actress, attempts were made to prevent a possible bias (caused by sex differences) by a random division of trainees to either the role of husband or wife; the trainees knew beforehand with whom conversation would be held.

The same questionnaire was given to subjects of the control group with identical instructions. Subjects were required to complete the questionnaire according to their own views only.

Questionnaires were also sent to (four) superiors of all the subjects who were asked to complete one questionnaire for each of the subjects they guide personally. They were instructed to complete the questionnaires independently of each other, referring to the functioning of the worker with helpees. They were expected to implicate any source of information (as conversations with the worker, with the helpees or with outsiders) in order to attain a view as complete as possible of the relationship between the worker and the helpee. The questionnaires were supplied with an instruction-sheet, including some examples of how to fill them in.
The superiors were neither acquainted with the nature of the treatment, research design or final aim, nor informed about the division of the subjects into the various subgroups.

Questionnaires were worked out immediately after measurement.
Material obtained from both role-play and report was not worked on until second measurement took place. Besides for technical and economical reasons, a random presentation of (role-play/report) items as to both measurement moments was suggested to decrease bias of judgement.
Role-play and report are evaluated according to variables stated independently of their contents; evaluation can, therefore, be carried out before setting up the variables. The questionnaire can be looked at as a list of such variables; since there is no distinction between evaluation

variables and questionnaire items, immediate analysation of the completed questionnaires was considered necessary to carry out possible changes for improving evaluation procedure before the next measurement.

Before analysing the questionnaire, an interdependence among the different variables was assumed in the sense of various nuances and aspects of one global factor; however, all of the variables were maintained on the evaluation list in order to obtain a view as comprehensive as possible of subjects' functioning.

1) questionnaire, completed by superior:

An intercorrelation matrix and a factor analysis (upon level .300) were made according to the (computer) program ASTER 01[1]. Three clusters were found; two of them relatively strong (reliability coefficient .75 and .74), whereas the third one was weaker (reliability coefficient .53).

It was suggested to neglect the third factor since apart from its low reliability coefficient the correlation between its variables was not higher than .36.

Factor I (variables 2, 4, 5, 7, 8, 11, 15) was suggested to be named 'client-directed reference', with emphasis on the contact with the other.

Factor II (variables 3, 9, 12, 13, 14) was suggested to be named 'self-directed reference', with emphasis on internal and external reactions of the paraprofessional towards the other (see page 67).

2) questionnaire, completed by subject:

An intercorrelation matrix and a factor analysis (level .300) were made. Most variables (14) were found to be

[1]Graauw, C. de, Programma ASTER 01. Nijmegen, Programma Bulletin nr. 24, 1972

intercorrelated within one cluster (reliability coefficient .89) which was suggested to be named 'relationship with the client'; however, the different variables were used as operationalization of various dependent aspects of one global factor.
The one variable excluded from the cluster (8) was dropped out (see page 67).

The items of both questionnaires were put together in one global correlation matrix. Factor analysis of this matrix showed that 14 items of the questionnaire completed by subjects formed one separate factor, whereas the items of the questionnaire completed by superiors formed three other separate factors.
Though both questionnaires' items were verbally the same, they probably got different significance: It might thus be concluded that the two questionnaires can be considered quite different from each other and it is no wonder, therefore, that they show a different internal interdependence.
Basing on the factor analysis some non significant items could be excluded.

5. The training procedure

Bearing in mind the actual difficulties institutes and workers have in meeting the various practical conditions connected with training of any kind, efforts were made to limit both the duration of the training sessions and the total number of the meetings.
The training was, therefore, planned to last approximately three months, with one meeting of about three hours a week.

The first and last meetings served respectively as an introduction and a round off session ; ten sessions were planned as active training sessions.
Each of the training sessions referred to one or two categories explained and configured by means of one (film) modeling (per category) and either a role-play or a written item.
The sessions were held independently of each other. Though a reciprocal influence was not excluded, the total program was not based on an explicit incorporation of the foregoing sessions.

At the introduction meeting each of the trainees received a program sheet called 'course in relief work'. It consisted of a detailed program of the training, the category(ies) to be treated, and some information about the modeling(s) and either role-play or written item.

All (training) sessions began with reading a category, explaining and discussing it until the trainees understood its meaning and were able to reformulate it in their own words.

When this was attained the corresponding modeling was projected, after a short introduction as to its contents and the different participating roles. The trainees were asked to observe the helper with special attention to the category discussed before. The modeling was followed by a group discussion.
If a second category was treated in the same session, an identical procedure followed concerning the second category.

As mentioned above each of the sessions included besides the modeling either a role-play or a written item.
(1) role-play: Besides the work style discussed during the introduction meeting, no additional information referring to the specific role-play was given.
After receiving (written) instructions referring to the role(s) to be performed, questions were answered individually to prevent any possible inter-personal influence.
Two persons carried out the role-play in one corner of the room while the rest of the group was required to observe them and write down general notes referring to the helper, with special attention to the category(ies) just treated. A time limit of 30 min. was stated for each play.
After carrying out the role-play a group discussion was held, referring to the helper's functioning: the helpee was the first to give his feed-back, the helper the second followed by the rest of the group; the trainer was the last to give his feed-back.
The same procedure was carried out three times per session.
All trainees participated to an equal extent in the role-plays; they were equally divided, taking into consideration the kind of played role (helper/helpee).
After performance of the three role-plays by trainees, the trainer performed the helper role on the understanding that the underlying problem had been changed by the group

in the trainer's absence. This role-play was followed by a group discussion as well. The trainer's role-play also served as a modeling, yet the term modeling is used here exclusively to designate the film material belonging to each of the categories.
Some of the role-plays were supplied with additional (written) material, aimed to bring about more intensive tackling of the specific situation. This material consisted of fragments of authentic conversations, directly connected with the contents of the play and thus making possible a deeper understanding of the underlying problems. Trainer's feed-back to this additional material was always given after the trainees' discussion had come to an end.

(2) written item(s): All the trainees got the same item (either vignettes, parts of conversations or fragments of case-studies and reports) and question(s) belonging to the given item. The questions were to be answered in writing; the trainees were asked to work individually and simultaneously. After having answered the question(s), each trainee read out his reactions followed immediately by a group discussion. Trainees were required to pay special attention to the stated category(ies).
As in the foregoing cases, the trainer gave his own feedback when the trainees had finished their discussion.
The written items were supplied with additional material as well, including various answers given (elsewhere) by other persons. This in order to widen the range of possible approaches to the given problem and to enable them to deal in extenso with each item.

After role-playing or dealing with the written material the session was rounded off.

This seems to me the suitable moment to give a detailed description of the training sessions.

First training session

Category 1: Personal interest in the other - Indifference towards the other.
(The helper is interested in the other, his difficulties and their solution. His interest remains unchanged also in case of necessary relegation).

Modeling: The heart complaint (Höweler, M. and Vrolijk, A.) ca. 20 min.

A young man tells an older one that he is afraid his heart would suddenly stop working and he'll die. Though he tries not to think about it he cannot help his continuous anxiety.

In the course of their conversation, he admits that however hard he tries to overcome his anxiety he is probably, unconsciously looking for new symptoms known from literature; he recognizes,thus, an inner conflict between leaving the medical care and looking for it.

The helper listens with interest and warmth: inclining towards the client, he gives signs of understanding and empathy and clearly expresses acceptance.

Category 2: Acceptance of the other - Leaving the other with his difficulties.
(The helper tries to face the other unbiassed, also when he feels ill at ease because of the other's difficulties; he realizes that whatever the other may be, he has the right to be helped).

Modeling: The institute (a) (Höweler, M. and Vrolijk, A.) ca. 8 min.

A young girl (a volunteer in an institute for helping young people in stress situtations) tells a (male) interviewer about the financial problems of the institute resulting in limits of the help facilities and departure of workers.
The interviewer obviously seems to accept the girl and the policy of the institute. In order to get some more precise information he asks the girl directly about the meaning of the given treatment ("You conceive the treatment as good but what does it really mean?").
In her answer, describing the phase of helping the youth in renewal of contacts with their homes, she briefly refers to her own experience and the way she came - as a client - to the institute.

Role-play: Mrs. Otte (given to all group members)
A lady of about 75 years old, whose eyesight gradually deteriorates. However, being mentally still fit she wants to live as independently as possible. She seems to be a lonely woman; although her three sons do not live far away they never come to see her for longer than an hour weekly and even that is considered a necessary commitment. Her problem is that she is bored; her activities are restricted to observing the street and going for short walks, both of which are difficult because of the considerable distance of her house from the street. She looks for another house in the same neighbourhood but her request is not granted - a fact that causes her to mistrust the caring nurses.
The reporter doubts whether the essence of her problem really lies in the location of the house and whether, considering her worsening eyesight the advantages of a new house would last longer than another few months.
You are going to talk now to this lady keeping in mind

her request to move to another house.

Second training session

Category 3: Flexibility in the relation with the other - Rigidity in the relation.
(The helper is able to adapt himself to unexpected changes in the conversation, in spite of an existing plan or process).

Modeling: The sportsman (Höweler, M. and Vrolijk, A.) ca. 5 min.

I. Client begins the session by saying: "before we start I would like to tell you something pleasant: Last weekend I saw you exercising some sport. You fell and looked ashamed and fearful lest someone would see you".
The helper smiles perplexedly and suggests to follow the usual line of therapy, concerning the client's problems.
II. Identical beginning by client.
The helper smiles freely, saying: "you were probably amused to see me in another role, as another person".
Client reacts: "I had the opportunity to see you as an ordinary human being in contrast to my usual dependency on you".

Category 4: Allowing the other complete freedom of expression - Reacting only from the point of view of one's specific profession.
(The helper asks the other some general questions (concerning the other's social, familial, occupational area, etc.) which are not directly connected with the helper's own profession).

Modeling: The employees' organization (Höweler, M. and Vrolijk, A.) ca. 10 min.

A young man intending to deal with matters of personnel

is interested in the employees' organization, in connection with his future frequent contact with it.
The interviewer who does not know much about this area, asks questions in a way that their answers give him insight in the other's world.

Role-play: Miss v.d. Ben (given to all group members)
You are 29 years old, working since two years in a pharmacy; you enjoy your work and your studies for a chemist's assistant. Before that you were working in your parents' shop, and in spite of their wish to stay there you left for the pharmacy. An operation your father has recently undergone results in speaking difficulties and interferes with his contact with clients; this is the reason your parents insist on your coming back to their shop. Your brother, who has already a profession, refuses to assist them.
You are in a conflict: on the one hand you understand your parents' difficulties, on the other hand you would not like to abandon your present job.
On a late duty you talk with your colleague about your problem.

Third training session

Category 5: Taking up other's reaction to the helper's remarks - Ignore other's reactions to the helper's remarks.
(Incorporate in the following conversation any verbal or non verbal sign of the client made in reaction to a remark of the helper).

Modeling: Falling in love (Höweler, M. and Vrolijk, A.)
ca. 5 min.
I. A young lady tells the therapist how much she enjoys their conversations; they keep her thinking all day long

and as a matter of fact she thinks about him.
The therapist states that their contact has indeed become different from a merely therapeutic one. She reacts by saying that she is in love with him, guessing he likes her as well. Therapist (does not react directly): "You fell in love ...", whereupon the client says: "I guess you love me as well". The therapist, again: "You appreciate my feeling towards you ..."
II. A young lady begins in the same way.
The therapist reacts: "You wish to know my feelings towards you. In order to avoid any misunderstandings you'd better know right away that I'm not in love with you". The lady, though being very disappointed, follows the session and becomes aware of her inclinations to develop unreal expectations.

Written item: An anecdote (given to all group members) "He came to me - for the second time on the same duty - asking an aspirin against his headache ..." (taken from an attendant report).
Write down your own reaction to such a situation.

The trainees are given the original attendant report after having read out and discussed their own versions: "He came to me - for the second time on the same duty - asking an aspirin against his headache. To my question concerning his general feeling he answered he could hardly bear his headache; he mentioned a conversation with X earlier this morning where he had difficulties in expressing himself, a fact that brought about misunderstandings and inter-personal frictions. I suggested to take up contact with X and to clear up the misunderstandings. He was enthusiastic about the idea and reacted immediately. When he came back he was relaxed and smiled. He did not take the aspirin."

Additional material:
Existing reactions to this written item.

Fourth training session

Category 6: Reaction to changes in non-verbal expressions of the other - Ignore other's non-verbal expression.
(Awareness of non-verbal expression and react accordingly).

Modeling: Spontaneous gestures (v. Beek) ca. 20 min.
Communication is held between two couples of older mutes. After a while, the camera is fixed on each of the participants separately, examining closely their particular mimicry.

Category 7: Reaction to other's remarks which are besides the point - Exclusive reaction to utterances concerning the main problem.
(Awareness of remarks made by the way, using them in order to improve understanding of client's situation and/or to help him to express his real problem).

Modeling: The institute (b) (Höweler, M. and Vrolijk, A.) ca. 8 min.
A girl gives some general information about her work; the interviewer tries to focus the conversation on the significance the work has for her personally. She tells him that she likes the work although only ten percent of the people appreciate the given help. By the way she mentions that it is important for her to be thanked for. By entering into this matter he succeeds in bringing about a more personal conversation concerning her own contact problems which result from the way she was educated.

Role-play: Dr. Groen, the family doctor (text given to all group members)
A young woman (24 years old) showing symptoms of sleeplessness and nervousness got into contact with you after having discovered that her seven months old son suffers from his heart. The cardiologist told the parents that the cause of the trouble was a functional deficiency and wished to see the baby again after six months.
When you repeated the specialist's answer, trying to reassure her on the medical aspects, you realized that she (still) reacted very nervously. You decided to have another, longer conversation with her.
She comes at the time fixed for this consultative conversation.

Mrs. Blauw (given only to those group members supposed to play the patient's role)
A fact unknown to the family doctor (which you prefer not to tell spontaneously as you consider it a delicate subject) is that you have undergone an abortion when you were 17 years old.

Additional material:
several authentic fragments of conversations held between family doctors and a (played) patient, in connection with the contents of the role-play.

Fifth training session

Category 8: Prevention of evasion from an important problem - Enable other's (psychological) escape. (The helper tries to bring back into the conversation aspects which seemed to be important for the other but were evaded by him. If necessary, the helper confronts the other with his evasion).

Modeling: Commune (Höweler, M. and Vrolijk, A.) ca. 3 min.

I. Interviewer: "I would like to ask your opinion about the commune".

Interviewee: "Commune ..? It is difficult, what is your opinion, you probably know more about it."

Interviewer gives his own opinion.

II. Begins in the same way.

Interviewer: "I'll tell you my opinion after you have given yours, otherwise your own answer could be influenced."

Role-play: Dr. Jansen, the family doctor (text given to all group members)

Patient has since short contact with you because of her continuous headache. Before that she was a patient of Dr. X's who sent her to an internist two months ago. The internist stated a high blood pressure and advised a period of hospitalization. The patient refused admission to a hospital, preferring pills against the high blood pressure.

You suggested to first ask doctor X for further information before making any decision. Colleague X told you the following details about the family: the husband has been hospitalized for appendicitis and is completely cured in the meanwhile; the son (ten years old) suffers from serious visible epileptic attacks, as a result from a concussion of the brain; he is controlled and treated at the neurological clinic.

With this data at hand you decided that the woman should be hospitalized. She comes to see you at the appointed time.

Mrs. de Vries (given only to those group members who had to play the patient's role)

A fact that the family doctor does not know (and you do not want to reveal) is that your son had always been a healthy and normal child up to his street accident, which occurred once when you took him on your bicycle. You consider the child in constant need of attention and feel yourself obliged to give him your full amount of it.
In the meanwhile you still resist the suggested hospitalization, but do not reveal your real reason.

Additional material:
Several authentic fragments of conversations held between family doctors and a (played) patient, chosen because of their connection with the matter discussed in the role-play.

Sixth training session

Category 9: Encouragement of reports of experiences beyond the complaint - Being content with utterances concerning the complaint in question. (Ask for further report of experiences beyond the problem in question. If necessary by means of eliciting some general remarks).

Modeling: The bus driver (Höweler, M. and Vrolijk, A.)
ca. 10 min.
I. A traffic manager talks about changes in the daily routes to one of his drivers, who is willing to accept the change only on condition that the (appointed) time table is kept the same. When it becomes apparent that the change means a late duty consisting of a special route with children, the driver refuses, mentioning some other program together with his wife.
The manager does not accept this as a reason and says that he only tries to avoid a route with children. Further explanation of the driver's refusal - an appointment at the doctor's - does not prevent the manager from as-

serting his views and eventually sending the driver to the head of the personnel.
II. Begins in the same way.
The manager pays attention to the driver's refusal and asks him for a more detailed explanation. When the driver tells about the appointment at the doctor's the manager shows interest in the (personal) problem of his driver and pays less attention to the working schedule.

Category 10: Encouragement to participate in the search for reasons and explanations of his complaint and/or difficulties and their solution - Non-observance of active participation.
(Ask the other to try to look for the reasons of his difficulties; help him to form a total picture out of the various sources of information and experiences; help him to reach a suitable solution).

Modeling: The organizational adviser (Höweler, M. and Vrolijk, A.) ca. 13 min.
In a conversation between an organizational adviser and a head of a department, the adviser begins and says that he has observed the department in order to track down the existing difficulties; at this moment he would like to hear the head of the department's opinion about the situation and its specific problems.
The manager tries to explain the situation, assisted by the adviser, who reinforces the efforts to attain some clarity. In the course of their discussion the manager mentions his uncertainty about the two solutions, but eventually succeeds in making up his mind and choosing one of them.

Written items: vignettes (given to all group members)
How would you react as a family doctor?

1) patient: I guess that my nervousness and tiredness are caused by my husband.
   doctor:
2) patient: I don't believe in taking pills.
   doctor:
3) patient: Good morning doctor, I haven't been feeling well of late and I constantly suffer from headache. Could you prescribe me some pills, aspirin or something else?
   doctor:

Additional material:
Suggested suitable reactions to patients' complaints supplied with several examples of actual reactions as given separately to each of these three vignettes.

Seventh training session

Category 11: Explanation of the given advice - Giving advice without any explanation.
(Give any suggested advice, in understandable terms for the other, provided with the underlying reasons and possible consequences).

Modeling: The married (female) employee (Höweler, M. and Vrolijk, A.) ca. 9 min.
A manager asks the organizational adviser for suggestions concerning the problem of low production.
The adviser gives some practical possibilities to solve the problem. He does not pay any attention to the manager's arguments concerning his bad experience with some of these suggestions or other reasons against them, but interrupts him constantly.

Role-play: Mrs. Thiel (text given to those group members who had to play the role of the woman)
You are 41 years old, married with 4 children. Your son started his study at the university immediately after having taken his final examination at the age of seventeen. So far he has always been an industrious and serious student; however, recent changes in his behavior make you anxious about his studies and future: he frequently goes out to have a good time and neglects his studies; you can hardly talk with him any more - he does not tell you anything and obviously avoids any meaningful answer to your questions about his studies. Your husband shares your care and anxiety.
Because of your enforced marriage - at a young age - your husband had to give up his university studies and although he is a very successful businessman, you'd rather he were a lawyer.
You apply to the new priest to talk with him about your son.

Eighth training session

Category 12: Taking up aspects of the complaint unknown to the other - Leaving unknown aspects unexplained.
(Give the other the necessary explanation as to the possibly unknown background of his difficulties).

Modeling: A cloud of dust (Höweler, M. and Vrolijk, A.) ca. 5 min.
I. A (female) client glibly relates the events of the last few days without paying attention to any thematic order in the flow of her speech.
The therapist does not try to stop the flow nor to structure the conversation, but merely asks some questions concerning minor details.

II. The client begins in the same way.
The therapist calls her attention to her behavior without referring to the contents of her stories.
Client: "Indeed .., it happens frequently when I'm nervous, as if I tried to conceal something personal .. I've got a new boy-friend .."

Role-play: The consultant (text given only to those group members who had to play the role of the helper)
You work on an advisory board for alcohol and drug users. Mr. de W. asked by phone for an appointment. He told you that he is 25 years old, unskilled labourer and married without children. The couple lives with the wife's parents. He often takes to alcohol. He came to the advisory board on another person's advice; he himself considers his living arrangements the principal problem, but wishes to talk with you all the same.
This is your first meeting with him.

Mr. de W. (text given to those group members who had to play the helpee's role)
You are 25 years old, an unskilled labourer, married without children. You live with your wife's parents. You often take to alcohol and, therefore, friends advised you to get into contact with the advisory board for alcohol users. You have had telephonic contact with someone of the board and gave him some initial data about yourself. You made an appointment for further discussion of the matter.
You come at the appointed time and (continuously) ask to take up contact with official agencies for housing arrangements.

Ninth training session

Category 13: Active search for general psychological reasons and ability to relate them to the complaint - Remain only in the helper's own specific frame of reference.
(Attention to any - direct or indirect - mentioning of mental factors, which can possibly supply further explanation of the problem in question).

Modeling: The nurse (Höweler, M. and Vrolijk, A.) ca. 15 min.

In a conversation between the manager of a hospital and a nurse who applies for the job of the head of a new department, the manager tells the nurse that he has to reject her application because of her young age. In the course of their further discussion, the nurse underlies the advantage of her being familiar with such a situation. The manager, however, continues talking about the high organizational demands of this job though she argues that one gets quickly accustomed to this kind of work.
Finally, the manager changes his course, leaves the formal argumentations and considers the difficulties she has had with colleagues as temporary head of the department. By this direct approach, his argumentations for rejecting her applications become clearer and more reasonable.

Category 14: Active search for environmental influences and ability to relate them to the complaint - Remain in the helper's own specific frame of reference.
(Attention to any - direct or indirect - mentioning of milieu factors which can possibly supply further explanation of the problem in question).

Modeling: The office manager (Höweler, M. and Vrolijk, A.) ca. 10 min.
A conversation between an efficiency adviser and an office manager, concerns the suggestion to place all employees in one hall in order to save on expenses.
The adviser takes up the manager's objections. He underlines the possible advantages of the suggestion, relating them to his objections. The manager, convinced of the possible advantages brings up another suggestion which eliminates his earlier objections but keeps the previous advantages.

Role-play: Mr. Snoeren (text given in two different forms, one to those who had to play Mr. S., the other to those who had to play the physician)
Married, with three children, two of them study and do not live at their parents' home. After 29 years of engine driving you (he) gave up your (his) job because of an hernia. For four years you have (he has) been engaged as a door-keeper in a big factory. Since about a 1½ year you (he) suffer(s) from depressions coupled with a permanent feeling of being unwell, which has nothing to do with the previous illness.
You (he) decided to apply to the factory doctor.

Tenth training session

Category 15: Differentiation between psychological and social factors - No differentiation between psychological and social factors.
(Ability to see whether a given factor is a psychological or social one. If both factors are involved, select the more prominent).

Modeling: The man with an eye-glass (Höweler, M. and Vrolijk, A.) ca. 16 min.
In the course of an interview in a crisis center, a worker

is asked about his work and motivation. He tells about his interest in people who get into unbearable situations. He prefers helping people in their own milieu to being a mere agent of an hierarchical-bureaucratic structure. The work is for him "a way of life rather than a mere job".
Further inquiry into the personal motives of the worker in question reveals that he has chosen the present work cadre because it meets his needs, although he realizes that it might lead him to a certain isolation.

Written items: Mrs. de Bruin (text given to all group members)
Mrs. de Bruin, having difficulties at home, turns for help to the 'Home-Help-Service' with which she had got into contact once when she was sick.
The following fragments (listed in arbitrary order) are instances of their conversation:

- My parents in law have been living with me, I mean with me and my husband of course; for quite a long time - several years already, but the situation gradually gets more and more difficult.
- Yes, though it may sound very strange, I feel that he neglects me in comparison with his parents.
- I never discussed it sincerely with him because one can always, I could always guess his views. Since I believe to know his opinion it is very difficult for me to talk with hime about this subject.
- Occasionally I get the feeling that I exaggerate, that I'm too impatient with them and indirectly cause harm to my husband. On the other hand I think I do feel that way, because I'm hardly able to bear it any more. I have to do something about it. However, it is difficult for me to discuss it with my husband and, therefore, I turn

to you for help.

- Yes, I believe it could have been different if I had really good contacts with them; but now they are old, and I still have the feeling that if they were healthy and strong they would not be kind with me at all. However, since they are dependent on me, I am considered good enough.
- Yes, as a matter of fact the whole situation is highly irritating, especially for my parents in law of course, and the fact that everyone accepts things simply as they are, does not lead to any improvement.
- My husband is convinced that we have to care for them; I agree with him but I cannot accept his lack of understanding for my own difficulties and the way he solves the problem, by simply stating that it is our obligation and that I have to make the best of it.
- Of course something has to be done for these people, but we should find another solution; the problem is that my husband hardly makes any effort to look for other possibilities, because he thinks that the best solution is the present one.

(a) What is (are) the problem(s) with which Mrs. de Bruin is confronted?

(b) What could you suggest to do about it?

Additional material:

Several examples of possible answers to both questions.

6. Second measurement moment

All subjects and their superiors participated in the second measuring moment as well, consisting of the same devices as the first.

Each of the two experimental groups ended its program with an evaluation meeting including, besides a discussion based on trainees' general feed-back to the given treatment, fulfilment of the three measurable tasks given at the introduction meeting:

1. the questionnaire was given (after its elaboration) to the subjects to be completed again. It was assumed that the subjects would not be able to remeber their answers of the first time, considering the number and length of the variables. This assumption was affirmed during an earlier discussion about the contents of the questionnaire.
2. observational exercise (written reaction to each of the same three film fragments screened during the introduction meeting); it was assumed (and affirmed by the trainees) that although most of them could remember the general theme of the films, not a single one could repeat his own previous impressions.
3. role-play (subjects received the text of the role of a helper, different from the one at the introduction); the conversation with the person who seeks help was video-recorded. In order to prevent possible influences of personal differences among the actors, trainees talked with the same actor they met at the introduction meeting.

The feed-back discussion was held after the three tasks were carried out; it considered the activities of the meetings (and the program within experimental group I), the trainer, trainees' own functioning during treatment and the

usefulness of the given treatment for their daily field activity.

The same (elaborated) questionnaire (provided with the same instructions) was sent to the subjects of the control group for a second time. They were explicitly asked to complete the questionnaire according to their present activities and by no means to refer it to previous (or desired) activities.

Also superiors were sent questionnaires for a second time with the explicit request to complete them (for each subject separately) exclusively according to their present activities.

Results

Three students of different branches of social studies were chosen as judges to carry out evaluation of the performance in role-play and the written reports. They were familiar with interview techniques and judging procedures, but had no experience in dealing with other people's problems. They were considered suitable to comprehend and apply the given operationalizations (of the evaluation variables), however, it was expected that they would not be oversophisticated as to psychotherapeutic relationship.

Each of the measuring devices could have been statistically manipulated by a pretentious formula as e.g. a co-discriminant analysis; however, this seemed exaggerated considering (1) the low number of subjects making up each of the three groups and (2) the nature of the evaluation variables, viz. qualitative rather than quantitative; though they were operationalized as objectively as possible, personal impressions could not be completely avoided as a factor of influence on the evaluation.

Bearing this in mind it was decided to use less pretentious statistical manipulations:

- The Pearson product-moment coefficient of correlation which is, according to Freund "the most widely used measure of the strength of the linear relationship between two variables"; it indicates the goodness of the fit of a line fitted by the method of least squares and this, in turn, tells us whether or not it is reasonable to say that there exists a linear relationship (correlation) betweem x and y.
- Factor analysis, carried out with a computer program as developed and published by de Graauw[1], in order to find the clusters making up each of the devices used in the evaluating moments.
- t-test could be used because the conditions which must be satisfied, in order to make the t-test powerful, were met: it was assumed that the observations were independent and drawn from normally distributed populations; the populations had the same variance; the variables involved were measured in an interval scale (so that it was possible to use the operations of arithmetic on the scores).

(1) Role-play:

Since all the role-plays were videorecorded they could be given in radom order as to the groups (experimental I/experimental II) and the rank order (before/after), for an independent judgement.

According to the decision taken during the preliminary study, evaluation of subjects' performance in the role-play, was carried out on the basis of the following variables:

1. stimulation of the other's active participation in clarifying his difficulties.
2. expression of interest and respect causing a sphere

[1] ASTER 01 (Nijmegen, Programma Bulletin nr. 24, 1972)

of trust and the development of a relationship.
3. differentiation among the various factors in the situation of the other.
4. distillation of the problem.
5. insight in the situation of the other.

The evaluation sheet consisted of these five items. Judgement was given on a 5-point scale with the extremes of accepting the statement (referring to the given subject) or rejecting it.

A certain interdependence among the variables was expected, as they were supposed to represent intermediate stages of one process. It was assumed that two subgroups were formed: (1) consisting of the first two variables;
(2) consisting of the remaining three variables.

All the same it was decided to use all five variables in the evaluation procedure, in order to get information on the process as a whole.

The obtained overall intercorrelations among the three independent judges were: 1-2 .77
1-3 .67
2-3 .74

These high correlations suggested that the judgements could be considered reliable and thus be used for an evaluation of change.

The underlying assumption concerning the existence of two subgroups, within the list of variables, was statistically checked; the obtained matrix of intercorrelations among the five variables was the following:

	1	2	3	4	5
1	1.00	.71	.64	.57	.58
2	.71	1.00	.49	.30	.42
3	.64	.49	1.00	.61	.71
4	.57	.30	.61	1.00	.82
5	.58	.42	.71	.82	1.00

Analysation of the matrix showed that variable (1) intercorrelated - not only with variable (2) as assumed, but also with each of the other four variables. It seemed, therefore, better to cancel this variable from the list in order to avoid a possible bias in the results.
Variable (2) showed a low correlation with each of the other three variables and could thus remain as a separate factor, representing 'the relationship of the paraprofessional with the helpee'.
According to our expectations, a relatively high intercorrleation was found among variables (3), (4), and (5). These variables, as mentioned above, were assumed to form a sequential interdependence where two variables were considered antecedents to the third one: 'differentiation among factors' (3) and 'distillation of the problem' (4) make possible 'insight in the situation'(5). This way of formulation does not mean that variables (3) and (4) were considered necessary conditions for variable (5). Conceiving variable (5) as the principal one, within its subgroup, it was suggested to represent 'the functioning of the paraprofessional in confrontation with the helpee'.

A t-test on the two sets of obtained results did not show a significant difference (.05) between experimental group I and experimental group II before treatment. As the beginning levels of both groups were identical, any differ-

ence found later could be ascribed to the effects of the treatment.
The scores of experimental group I after treatment on the two chosen variables, were significantly higher (.05) than those of experimental group II.
Whereas a significant improvement (.05) was found within experimental group I, there was no (significant) improvement within experiment group II.

Table of Results

	Variable 2			Variable 5		
	t	$\bar{x}$	$\bar{y}$	t	$\bar{x}$	$\bar{y}$
Diff.between exp.I(x) and exp.II(y), before	0.88	3.38	3.04	-0.89	2.19	2.52
Diff.between exp.I(x) and exp.II(y), after	3.81	4.09	2.61	3.95	2.90	1.59
Diff.between before (x) and after (y), exp.I	4.18	10.00	12.50	-4.04	6.57	8.85
Diff.between before (x) and after (y), exp.II	0.89	9.14	7.85	2.11	7.57	4.71
Diff.between improvement I(x) and improvement II(y)	2.59	4.71	3.57	5.09	4.80	3.04

We can conclude, therefore, that the administered training caused a significant improvement in the actual functioning as a helper.

(2) Report:

Film reports were given in random order as to groups (experimental I/experimental II) and the rank order (before/after) for an independent judgement.
Reports of film 2 had to be omitted in the analysis of results since technical problems prevented its presentation to experimental group II. Only reports about the other two films were, therefore, analyzed.
Regarding the decision taken during the preliminary study,

evaluation of the reports was carried out according to the proportion of the actual reproduction of the film, to the interactional and/or emotional reflection; this evaluation criterium was operationalized in three different questions (two of them further divided into 3 subquestions) before being given to the judges.

High intercorrelations were found among the three independent judges: 1-2 .78
1-3 .82
2-3 .82
The high reliability justified further use of the judgements.

Surprisingly a comparison between the two experimental groups before treatment did not reveal a complete accordance in their respective report scores. This means that the skill to perceive and/or express in writing was not evenly spread. However, as to reports on film 1, an accordance between both experimental groups was found; this opened the possibility of partial use of the material for assessment of the effects of the treatment.
Although the improvement found in experimental group I was significantly higher (.05) than in experimental group II, I do not consider this significant difference a direct effect of the treatment: an inclination to give high scores, observed for the first measurement moment in experimental group II, most probably decreased the measuring power of the device; the greater improvement found with experimental group I could thus be ascribed to this artefact rather than to actual improvement.
Neither was there a significant difference between both experimental groups after treatment, nor a significant difference within each of the two experimental groups.

Table of Results

	t	$\bar{x}$	$\bar{y}$
Diff. between exp.I(x) and exp. II (y), before	-0.44	6.42	7.42
Diff. between improvement I(x) and improvement II(y)	2.60	3.38	2.42
Diff. between exp.I(x) and exp.II(y), after	0.08	6.90	6.85
Diff. between before (x) and after (y), exp.I	-0.62	19.68	20.71
Diff. between before (x) and after (y), exp.II	0.73	20.28	22.28

We thus concluded that no real improvement in reporting screened material has occurred in experimental group I; the training could probably have no influence on the specific skill of perceiving, and expressing in writing film material, whereas some by-effects of the unstructured situation may cause a decrease (though not a significant one) in this skill.

(3) Questionnaire, completed by superior:

An analysis of the obtained scores on the questionnaire was carried out, for each of the (left) variables (separately) as well as for the total scores.
No significant difference (.05) was found between the three different groups before treatment; all of them were evaluated in an equal way and, therefore, any significant difference found in the second measurement moment could be ascribed to treatment effects.
Significant difference (.05) was found after treatment between experimental group I and each of the other two groups (experimental II and control). No difference was found between experimental group II and the control group. Although no difference was found, between the two measurement moments, within each of the three groups, a signifi-

cant difference (.05) was found between the improvement of the two experimental groups. The fact that no difference was found with experimental group I can possibly be explained by the observed inclination to give high scores in the first measurement moment resulting in a decrease of the measuring power of the device.

Table of Results

	t	$\bar{x}$	$\bar{y}$
Diff. between exp.I(x) and exp.II(y), before	0.24	64.33	65.12
Diff.between exp.I (x) and control(y), before	0.84	66.28	61.71
Diff.between exp.II (x) and control(y), before	0.50	64.33	61.71
Diff.between exp.I(x) and exp.II(y), after	2.79	72.57	58.00
Diff.between exp.I(x) and control(y), after	2.67	72.57	59.00
Diff.between exp.II(x) and control(y), after	-0.13	58.00	59.00
Diff.between before(x) and after(y), exp.I	-1.64	66.28	72.57
Diff.between before(x) and after(y), exp.II	0.99	64.33	58.00
Diff.between before(x) and after(y), control	0.42	61.71	59.00
Diff.between improvemen+ I(x) and improvement II(y)	2.31	6.28	-6.33

According to the superiors, a significant improvement was found in the functioning of the subjects who had got the training whereas no improvement could be observed in the other two groups.

(4) Questionnaire, completed by subject:

An analysis of the obtained scores was carried out for each of the variables separately as well as for the total scores.

No significant difference (.05) was found among the three different groups, before treatment; any significant difference found in the second measurement moment could, therefore, be ascribed to treatment effects.

A significant difference (.05) was found after treatment between the two experimental groups but no difference was found between experimental group I and the control group.

A significant negative difference (.05) was found between experimental group II and the control group.

This unexpected result can be explained by the nature of the treatment given in experimental group II, where subjects were confronted with their mistakes and failures without receiving any clear instructions as to how to overcome them; as a result they might have lost their self-confidence, which appears in a lower self rating than that of the control group (who were not confronted with any criticism at all). (For Table of Results see page 105)

The observed significant difference between both experimental groups after treatment, concerning their own opinion on their way of talking with helpees was found to be mainly due both to some insignificant differences in the expected direction and a significant decline in the self estimation of experimental group II.

Summing up the second measurement moment, we can state that a significant improvement in the actual functioning as a helper was found with the subjects who received the training.

This improvement was recorded by means of two measuring

devices (role-play and questionnaire completed by superiors), both at relatively objective measuring levels. Opposite to the researcher's expectation, no real improvement was found on the third device (report); this could be explained by the fact that the specific (measured) skill in question was probably not connected with the (expected) effects of training.

No improvement was found on the subjective measuring level (questionnaire completed by subjects) either; in the training group this could be due to a higher level of self criticism of the subjects rather than to an actual lack of improvement.

The decrease in self estimation found with the subjects who got the unstructured treatment should not be neglected - it could probably indicate a negative influence of the confronting yet not always constructive nature of the unstructured situation on the self confidence of the subjects which in turn could have an undesired influence on their personal image as well as on their functioning with helpees.

Table of Results

	t	$\bar{x}$	$\bar{y}$
Diff.between exp.I(x) and exp.II(y), before	0.43	60.00	58.00
Diff.between exp.I(x) and control(y), before	-0.96	60.00	63.44
Diff.between exp.II(x) and control(y), before	-1.24	58.00	63.44
Diff.between exp.I(x) and exp.II(y), after	3.19	64.71	53.57
Diff.between exp.I(x) and control(y), after	-0.21	64.71	65.42
Diff.between exp.II(x) and control(y), after	-7.09	53.57	65.42
Diff.between before(x) and after(y), exp.I	-1.82	60.00	64.71
Diff.between before(x) and after(y), exp.II	1.09	58.00	53.57
Diff.between before(x) and after(y), control	-0.54	63.85	65.42

7. Follow up

The follow up moment was held three months after the end of the treatment. It consisted of the two questionnaires, to be completed by all subjects and their superiors.

(1) questionnaire, completed by superior:

An analysis of the obtained scores was carried out for each of the variables separately as well as for the total scores.

The results obtained on this moment confirmed those obtained after the experimental phase: a significant difference (.05) was found between experimental group I and each of the other two groups. No difference was found between experimental group II and the control group. No difference was found either within each of the three groups, between first and second measurement moment and the follow up (see a suggested explanation given on page 103). (For Table of Results see page 107)

It could thus be concluded that, according to the superiors, the already found significant improvement in the functioning of the subjects who had received the training, remained unchanged during the follow up period.

(2) questionnaire, completed by subject:

An analysis of the obtained scores was carried out for each of the variables separately as well as for the total scores.

The new results of this questionnaire confirmed those obtained after the experimental phase as well: a significant difference (.05) was found between both experimental groups, but no difference was found between experimental group I and the control group (see a suggested

explanation on page 104). No difference was found within each of the three groups between first and second measurement moment and the follow up. (For Table of Results see page 108)

Table of Results

	t	$\bar{x}$	$\bar{y}$
Diff.between exp.I(x) and exp.II(y), follow up	2.51	61.71	52.80
Diff.between exp.I(x) and control(y), follow up	2.99	61.71	53.66
Diff.between exp.II(x) and control(y), follow up	-0.20	52.80	53.66
Diff.between before(x) and follow up (y), exp.I	2.05	55.58	61.71
Diff.between before(x) and follow up (y), exp.II	0.98	57.40	52.80
Diff.between before(x) and follow up (y), control	0.13	53.66	54.33
Diff.between after(x) and follow up (y), exp.I	0.59	62.12	63.12
Diff.between after(x) and follow up (y), exp. II	0.14	53.60	52.80
Diff.between after(x) and follow up (y), control	0.24	54.50	53.66

Table of Results

	t	$\bar{x}$	$\bar{y}$
Diff.between exp.I(x) and exp.II(y), follow up	5.62	61.28	48.66
Diff.between exp.I(x) and control(y), follow up	1.46	61.28	57.14
Diff.between exp.II(x) and control(y), follow up	-3.34	48.66	57.14
Diff.between before(x) and follow up (y), exp.I	-1.67	56.14	61.28
Diff.between before(x) and follow up (y), exp.II	0.91	51.65	48.66
Diff.between before(x) and follow up (y), control	0.04	57.28	57.14
Diff.between after(x) and follow up(y), exp.I	-0.11	61.28	60.85
Diff.between after(x) and follow up (y), exp. II	0.35	49.33	48.65
Diff.between after(x) and follow up (y), control	1.24	61.50	58.33

It seemed that the significant differences found in the follow up between both experimental groups concerning their self estimation, could be due to some insignificant differences in the expected direction and some decrease found in experimental group II, rather than to a real global improvement in self estimation of experimental group I.

The results obtained after treatment remained unchanged during the 3 months period of the follow up, which implies that the effects of the given training were of a considerably continuous nature.

The obtained average scores (on this moment) of the control group were assumed to be equal to the obtained averages of all three groups before treatment; affirmation

of this assumption could serve as an indication of reliability of the questionnaire.

No significant difference (.05) was found between 'after' and 'follow up' scores of the control group and 'before' scores of both experimental groups, in any possible combination.

1. Questionnaire completed by superior:

	t	$\bar{x}$	$\bar{y}$
Diff.between control group follow up(x) and exp.group I before(y)	0.96	57.57	53.66
Diff.between control group follow up(x) and exp.group II before(y)	0.76	56.33	53.66
Diff.between control group follow up(x) and control group before(y)	0.13	53.66	54.33
Diff.between control group after(x) and exp.group I before(y)	1.27	57.57	50.71
Diff.between control group after(x) and exp.group II before(y)	1.05	56.33	50.71
Diff.between control group after(x) and control group before(y)	0.42	61.71	59.00
Diff.between control group after(x) and control group follow up(y)	0.24	54.50	53.66

2. Questionnaire completed by trainee:

	t	$\bar{x}$	$\bar{y}$
Diff.between control group follow up(x) and exp.I before(y)	-0.30	56.14	57.14
Diff.between control group follow up(x) and exp.II before(y)	-0.66	54.28	57.14
Diff.between control group follow up(x) and control group before(y)	0.04	57.28	57.14
Diff.between control group after(x) and exp.I before(y)	-1.98	56.14	61.57
Diff.between control group after(x) and exp.II before(y)	-1.87	54.28	61.57
Diff.between control group after(x) and control gr. before(y)	-0.54	63.85	65.42
Diff.between control group after(x) and control group follow up(y)	1.24	61.50	58.33

The confirmation of our assumption implies the acquirement of a reliability indicator for the questionnaire.

Apart from completion of the questionnaires, the follow up measurement moment included an additional feed-back conversation, with both subjects and superiors.
Subjects of both experimental groups evaluated the obtained treatment and its influence on their daily work in the field by answering a few questions. Their written answers were not statistically analyzed but served rather as an example of personal feed-backs.
In an unstructured conversation the superiors of all subjects discussed the possible changes of the participants. This served as additional information to the completed questionnaires.

8. Conclusions

In line with the argumentations on basis of which this research had been planned, a design consisting of two experimental groups and one control group, to be evaluated on three different measurement moments, was set up. Considering the results obtained after treatment as well as at the end of the follow up, the structured training procedure was found to be more effective, in comparison with both the unstructured and the control situations, in bringing about the (stated) expected changes.
The accordance between the results obtained with the two relatively objective devices (role-play and questionnaire completed by superior) can be interpreted to mean that the information given by superiors attains a higher level of objectivity than often is considered. This means that more use can be made of superiors' evaluation, as a (single) information source, whenever feed-back to such a treatment is needed.
The obvious lack of accordance between self estimation and outside evaluation calls attention to a careful manipulation of information given by subjects. A continuous confrontation with an unproportional amount of criticism, inherent to such a treatment, prevents the subjects from being able to properly perceive their real abilities, leading to a low self estimation.
The subjects of the training group, though having achieved an obvious improvement in their functioning, with helpees, did not rate themselves higher at the end of the treatment (and after follow up) than before. During the training they learned to look at their own functioning more critically and, therefore, together with factual improve-

ment, they realized what still has to be improved; the self estimation was thus greatly influenced by their increased self-criticism.
The subjects of the unstructured treatment, undergoing a process where criticism was mostly not accompanied by direct guidance to improve the criticized behavior, learned to recognize their various shortcomings rather than to overcome them; this contradictory situation probably brought about the observed decrease in self estimation. However, although failing to meet the formulated criteria of the study, the unstructured situation was found to have some specific influence on the participants; it could thus (probably) be used for other aims than those of this research.

As to the training procedure itself, facilitating aspects (of the material) were found to be of importance; illustration of a given situation with various examples (items) made the imitated situation as real as possible, enabling the trainees to experience their roles personally and react in their (own) usual way.
The additional material, though merely planned as complementation, was found to be very important for challenging the trainees to improvise beyond the requested program. This improvisation was considered a necessary condition for the introduction of new aspects in any hypothetical relationship with another person.
Deviating from the conclusion in the preliminary study, category 11 (explaining a given advice) proved to provide some problems in the training. The category was meant to refer only to those situations where giving an advice is considered necessary. However, in practice, it became apparent that trainees had the tendency to look for solutions, probably in order to give an advice, instead of

applying this category in its limited sense (only when an advice is strictly needed). The category was, therefore, not in line with the rest of the categories, where an attempt is made to eliminate or decrease the (existing) tendency of paraprofessionals, to look for solutions and give advice.

Summping up, we can say that, though each of the two treatments had an influence on the functioning of the paraprofessionals, only those subjects who got the structured training showed an obvious improvement in the stated criteria.
Superiors' evaluation was found to be objective enough to supply clear information whenever effects of such a treatment are considered.
The subjective evaluation was found to be too much affected by by-effects of the treatment and is thus considered inappropriate to reflect changes referring to the criterium; however, the information it supplies is important for gauging the extent of influence of the treatments on the individual participants.

IV DISCUSSION

In this chapter attention will be paid to some additional feed-back received from group members and superiors. As it was decided that this information would not undergo any statistical operation, it was considered inappropriate to be dealt with while reporting the research results. However, it should not be neglected as a certain contribution to the entire project.
Moreover, some considerations will be given referring to the existing controversy between structured and unstructured (training) group situations in general, and in connection with this project in particular.
The chapter will be concluded with some research considerations and suggestions referring to the possibilities of using the constructed training procedure for the improvement of mental health care.

(1) Additional (unmeasured) evaluation of the project

Evaluation of the project was carried out only in regard to the (potential) expected level of functioning of the paraprofessional which, per definition, lies far below any acceptable functioning level of a psychotherapist. The reader should, therefore, bear in mind that although the project originated theoretically from the psychotherapeutic frame of reference, the target level of the subjects was rather intended to enable them to deal optimally with the client and by no means to reach the professional level of the psychotherapist.

In order to gain some more informative feed-back about (direct) effects of the project[1] on the participants, an unstructured conversation was held with all subjects' superiors within a month after the follow up period (held three months after treatment was ended). The superiors were not familiar with the subdivision of the subjects into different groups nor with the nature and/or goals of the (project) groups.
The evaluative description (given originally per subject) could be summarized as follows:
- Members of the training group were generally conceived as showing more acceptance of other persons and being more careful in forming their (final) opinion about helpees; as showing more self criticism about their own functioning (with helpees) and being more critical during the superiors' supervision (on the job). Besides, more understanding in both interpersonal and personal experiences was observed. No signs of any increased personal inconvenience were observed.
- Members of the meeting (unstructured) group did not show any common effect: several of them became more sensitive to their work situation (were able to signalize things earlier than before the meetings) but on the other hand the superiors noticed an increase in expression of personal problems, connected either with an increase in awareness of own (private) contacts resulting sometimes in disappointments or with a failure to cope with situations which were interpreted differently than before.
- With members of the control group no change at all was observed.
From this additional informative feed-back, it became

[1] beyond the obtained (measured) results

thus apparent that both structured and unstructured programs are of influence on the functioning of paraprofessionals; however, the structured program can be conceived as more effective in bringing about the (specific) desired improvement in their functioning as 'helpers' in the first echelon.

Another informative feed-back was obtained from the (actively participating) subjects themselves in an unstructured conversation held with them at the end of the follow up period. On this occasion they were also asked to complete an open-question-sheet[1].
- Members of the training group noticed that their way of talking with helpees had changed; they marked a tendency to investigate deeper into the problem in question, which mostly resulted in helpees' appreciation, which in turn brought about free and open conversations. The involvement of the background of the presented complaints made the helpees (themselves) deal with the underlying difficulties. Their more accurate observation of the helpee and more careful handling of the problem led to an increased trust and sincere relationship.
They also made some critical remarks, especially about the (almost complete) lack of basic education concerning interpersonal contacts, which made it difficult for them to absorb the newly obtained skills and place them in their proper frame of reference. Some of the difficulties resulted from their experience that people sometimes tend to conceal the truth. A (professional) psychotherapist has a wide theoretical background which supplies him with a (sympathetic) explanation to the human phenomenon of ten-

[1]As no statistical operation was performed on this information, it can serve rather as some further illustration than as an independent proof

ding to conceal a personal (intimate) truth. Members of the training group, lacking the necessary skills and background could hardly accept such an explanation and had, therefore, at times difficulties in maintaining their confidence in the applying person.
- Members of the meeting group showed a diversity in their own experiences which spread from a strong feeling of deterioration (in their daily functioning) to an expression of having attained the (expected) improvement. The feeling of deterioration was mostly due to inconvenient personal discoveries and new experiences and/or to a feeling of uncertainty caused by the (negative) feedback from the group. Although some subjects experienced an improvement in their daily functioning, their experience was coupled with a feeling of unsatisfaction deriving from difficulties to use the newly obtained insight either in their work situation or in their personal life. Some of the members complained about the way some themes were dealt with, such as being insistently busy with subjects' personal problems not explicitly related to their daily work. They experienced a tendency to attach too much importance to situations which in fact did not correspond with the actual reality in the field.
Some of the advantages expressed by the meeting group referred to expression of personal problems and to the recognition of the possibility that there are different points of view and interpretations of interpersonal contacts. The idea that personal problems can much better be revealed was for most of them completely new.
Most of the participants experienced an improvement in their capacity to listen to another person and to keep enough psychological distance for maintaining a more critical/objective view of the entire situation. As disadvantages of the program they mentioned feelings of anxi-

ety connected with the meetings, mistrust in each other and anger when they could not manage the situation (and on the other hand were tired of repeating again and again their personal problems).

Members of the training group were asked to give additional (critical) feed-back referring to the (specific) training procedure they had undergone.
The idea to present the (training) program to the participants at the very first meeting was unanimously approved of by all subjects. However, some of them suggested that the program-sheet should have been provided with a detailed explanation (instead of containing a global sketch of the main facets of interpersonal relationship). They emphasised the fact that a detailed explanation can supply the participants with knowledge about the course of the training and thus enable them to meet the expectations. Other members who were content with the global program-sheet, accentuated the relative importance of the personal acquaintance with the underlying/central ideas (revealed in the course of the training by the participants themselves); they believed that a too detailed explanation could decrease participants' curiosity which is important in any learning process.
Role-play (during the first training sessions) was found to be difficult for most participants because both method and intention were unknown to them; however, the role-play performed at the very first (pre training) meeting[1] was conceived as a kind of preparatory (individual) experience and in this sense facilitated further role-plays (in group connection) in the course of the training; the first, generally most difficult and frightening experience, was carried

[1] to be later used as measurement material

out outside the group preventing thus the additional (threatening) aspect of group criticism.
They suggested that the trainer should perform the first role-play so that the participants could get acquainted with their task. However, role-play as such should not be given as first task in the training since it may frighten the trainees and evoke anxiety concerning their ability to cope with this requirement.
Examples derived from psychotherapeutic experience and given during the training by the trainer, were positively accepted by the trainees.
The subjects expressed their preference for written items to role-play, both because of the (satisfying) immediate feed-back and the fine feeling of being busy all together on a common task.
The following discussions and the trainer's feed-back were considered of great importance, serving as direct and immediate reaction to participants' functioning. They accentuated the importance of the trainer's task to watch the general course of the discussion.
Although reformulation of the categories in their own words was found to be difficult (the words used in the categories were not always clear to them) most of the trainees expressed their agreement on the importance of this (re)formulation of every new segment of the material.
Sociability and contact among the group members were by all subjects conceived to be of crucial importance, causing a free and relaxed atmosphere. Though the (structured) situation was not explicitly aimed at developing social contacts, the atmosphere of confidence prevented an interpersonal tension and resulted in a slow yet steady process of interest in and acquaintance with each other.

2. Structured vs. unstructured training groups

Among the ideas about trainings in interpersonal contacts, a controversy exists as to the best way of transferring relational skills and conceptions. The diversity of opinions spreads from the extreme belief in personal experience as necessary and sufficient condition for successful help-relations, to the belief that nothing but planned teaching can be useful for attaining the desired goal.
This kind of controversy cannot be solved by means of obtained (exact) research results as it principally concerns the frame of reference and the explicitly formulated (and operationalized) training goals. Usually, most initiators and/or trainers in this area fall on some point between these two extremes.

Most paraprofessionals have no previous experience in training of this kind. As they are mostly not acquainted with methods of training, it seems to me that the initial (training) phase should be devoted to the development of a suitable working alliance, necessary for the course to be followed.
In unstructured trainings the desired direction is often clear enough, however the operationalizations for a working-alliance are sometimes so vague that trainees are forced to make them up by themselves. They are, for example, told that they can use the available time for discussion of fundamental problems of their work situation, yet no instructions are given concerning the course of the discussion nor are there examples supplied to explain the kind of subjects to be discussed.
No doubt, training participants can get acquainted with

the stated working alliance of unstructured groups (as in encounter groups for example), however some (later) facilitating conditions are still necessary in order to bring about an appropriate process of work relationship within the group. One of these conditions is previous experience in dealing with (personal) problems in group connection, which means besides experience in dealing with problems in general, the ability to formulate a specific problem of the field. Another important condition is the time factor, since both duration and intensity of the group meetings have direct influence on what happens in the group and, therefore, on the time needed for acquaintance with the desired working alliance.

In structured trainings both the objective of the training and the operationalized working alliance are stated as clearly as possible at the initial training meeting. In addition, clearly formulated instructions are given to the trainees with each task they have to perform.

The conditions stated above as necessary in any unstructured program, cannot be met for paraprofessionals, who mostly lack any profound experience in dealing with problems. The factor of time planning (duration of each meeting as well as the global program) can neither theoretically nor practically be introduced: no long-term training can be suggested since this will probably result in an undesired shift in the subjects' occupational (professional) identification; as the training is rather intended to improve the paraprofessional's functioning (and not to change it fundamentally) and as they can hardly meet the practical conditions connected with an intensive program, we do not recommend to plan a training which is very intensive and/or of a too long duration.

Since previous experience and the factor of time planning were not considered necessary (or important) conditions

for the structured training program, it was regarded in case of paraprofessionals, as having the advantage over the unstructured program.

The results obtained in this research obviously indicate that structured training is preferable to an unstructured program when paraprofessionals are involved. Members of both groups had some (adjustment) difficulties, but whereas these difficulties were solved after a short initial phase, in the structured training, with members of the unstructured situation, they actually lasted during the entire program.
The instructions helped the training subjects to discover quite quickly the underlying intentions and the purpose of the different tasks, which in turn enabled them to feel secure and relaxed. Presentation of a clear plan (including the role participants were expected to fulfil) and a program perspective were found, both by participants and researcher, to be a crucial factor contributing to the success of the training.
Unclarity in the unstructured situation was by most subjects experienced as too difficult to be coped with; lack of operationalizations of the (globally) stated purpose and absence of a (detailed) plan caused an increasing stress, uncertainty and anxiety, which resulted in mutual accusation and distrust. In absence of an obvious program, the group members permanently looked for possible subjects of discussion with the result of repeating over and again the same things, accompanied by a lot of critical (reciprocal) feed-back mostly with little (or no) constructive reflection. Subjects could hardly give any constructive idea or suggestion to their fellow participants; this resulted in a decrease of their self confidence, which could be harmful both to their field functioning with helpees

as well as to their own well-being[1].

I would not state any preference as to the issue of structured vs. unstructured (training) situation in general, yet considering the results of this research it can be assumed that in the case of short-term trainings for individuals without any previous similar experience (in training), the structured program is preferable.

[1] It may be that in a long-term program (e.g. a year long) no by-effects of this kind will occur; yet a long-term program does not meet the practical possibilities nor the stated theoretical considerations

3. Considerations for further elaboration and possible application of the training within the field of mental health

The program as carried out was intended to supply a positive contribution to the growing need of (qualitative and quantitative) extension of mental health care.
Since more effective use of paraprofessionals has been suggested, a change in their present (inter)personal handling and conception is strongly recommended. This means, in other words, that if the use of paraprofessionals is actually anticipated as a possible extension of mental health care, the constructed training procedure should be widely introduced.
It is completely impossible to expect from the (restricted) local agencies to initiate a program of this kind on a wide scale. Since they can hardly cope with the difficulties in completing their own (service) duties it will be unreasonable to charge them with additional new obligations, which although no doubt will be of importance for the future community mental health (resulting, inter alia, in a probable decrease in applications), have no direct and immediate facilitating consequences.
Extension of mental health care (rather than mental health service) is in fact a typical task for a national organ (governmental or other) which can initiate a national project with the existing (paraprofessional) helpers in the field without employing new workers[1].

[1] It is suggested that use of the existing potential of manpower prevents a further extension of the functioning personnel in formal (mental health) services; in this sense it can have a positive influence on the minimalization of negative by-effects of bureaucracy within the system of mental health

A project of this kind makes evidently use of professionals; however, since the suggested training procedure is neither intensive nor long-termed, there is no reason to believe that their contribution to this project will result in decrease in their available treatment time.
It is assumed that any professional with some knowledge and experience in therapeutic contacts and group work can give (lead) the suggested training. A necessary condition for the trainer is his positive attitude towards paraprofessionals (both as individuals and as a group)[1] and their possible contribution to mental health care.

A training project on a wide scale (spread over various professional groups (e.g. teachers, clergymen, nurses) and different geographical districts) can serve, besides the stated goal of more extensive use of paraprofessionals, for further elaboration of the constructed procedure: A cross validation can be made of the program in general as well as of its (supposed) suitability to various groups of trainees. By means of a parallel application of the training on different subjects' groups, the possibility to influence the functioning of paraprofessionals within mental health care (in general) can be affirmed. Any variety in results, supposed to be dependent on the combination between the given training and the specific paraprofessionals, can be analyzed as well. Adjustment of the procedure to particular subjects will probably involve the introduction of some new items.

The training seems to be more complete with the addition of three complementary parts: a theoretical background

[1] In regard to the maintained definition of paraprofessionals no resistance to the concept of paraprofessionalism is expected as it will cause no feeling of rivalry with the professional

(before the training), some guidance in mental health services (after the training) and some kind of mental health consultation.
(1) By theoretical background we mean informative material about (inter)personal relationships which could connect the educational background of the trainees with the material used in the training and evoke a tendency to relate the different ideas and approaches, bringing about a desired extent of flexibility.
The theoretical background is suggested to be specified for each of the paraprofessional groups according to their previous education.
It should not be given either during the training nor by the trainer, in order to keep a clear differentiation between its possible (negative) by-effects and the ones of the training.
(2) By guidance in mental health services we mean a detailed scheme of all existing services in the district which can be taken into consideration for further reference or in case of a necessary professional advice.
This detailed scheme should be given as clearly as possible (in written form) including in addition to a list of the available services, description of aims, significance, admission criteria and manner of appliance.
(3) By mental health consultation we mean an advising organ of professionals to which the paraprofessionals can turn for support in specific problems with which they are confronted.

As this training was constructed as an initial basis, a possible extension of the program in the future can be considered; however, it should be kept in mind that the paraprofessionals have to be trained to improve their original tasks and by no means to attain a new profession

and/or another job.
Another possibility to extend the effects of the training is the involvement of trainees' superiors; their acquaintance with the underlying concepts and the attained skills enables them to give (field) coaching in the form of group meetings with practical goals (known to the trainees). The trainees are supposed to have attained a sufficient basis in the training for independent management of a productive discussion and (reciprocal) direct feedback to problems arising in their daily work.

Although this training procedure can be used to bring about a change in the use of paraprofessionals on a local level, for a substantial improvement of mental health care, a project on a wide scale should be developed, either on national (or regional) level or on basis of the occupation of the paraprofessionals.
Concerning the results of this study it can be stated that the training, constructed and accomplished with the given proposals, can contribute to the improvement of mental health care.

SUMMARY

The increased standard of living and other developments in the last decade brought about a greater sensitivity to and awareness of anything that concerns personal difficulties, yet mental health services have not been able to stand up to the growing requirements of this development.
An improvement of the activities of the already functioning paraprofessionals and involvement of new paraprofessionals were suggested to decrease the gap between demand and offer.
Paraprofessionals were defined in this study as individuals with an arbitrary first echelon function, who come in contact with other persons without having been trained to deal with personal difficulties.
It was stated that these first echelon workers have to be equipped with more appropriate skills in order to optimalize their contribution to mental health care, and since no available program suited the maintained definition of paraprofessionals the construction of a new training procedure was considered necessary.
Construction of a training procedure for paraprofessionals in mental health was stated therefore as the research goal.

Review of the (American) literature concerning paraprofessionals in mental health brought two main approaches into light: the middle class and the indigenous paraprofessional. Yet, fundamental differences between central concepts of these two approaches and my own definition of paraprofessionals made a direct use of the available material impossible.

A survey of the Dutch literature about mental health services indicated that the services are in a transitory phase, with their emphasis shifting towards preventive care; yet changes are rather restricted to the (separate) services, and do not comprehend mental health care as a whole.
The thus created situation is quite remarkable: in spite of the increased recognition of the potential contribution of paraprofessionals, the concept of paraprofessionalism has not yet attained an appropriate status within the services. New kinds of workers have been gradually incorporated while the hidden possibilities of existing sources within the community are still not enough exhausted.

Psychotherapy, as a specialized profession of making and maintaining contacts with the fellow-being was conceived to be an appropriate frame of reference to supply basic concepts and a starting point for a training project for paraprofessionals defined as agents of human contacts, who are expected to effectively maintain interpersonal relationships.
From psychotherapeutic literature it could be concluded that most of the psychotherapeutic schools share several common, yet differently accentuated, principal points of view. All of them point at the importance of both the relationship between therapist and client and clearness in the client's situation.
A synthesis of the common principles together with some prominent aspects of specific approaches, led to an analysis of interpersonal relationship according to three factors: handling the relationship, handling other's participation, handling the material - the first two were considered necessary conditions for the third.

Distinguishing and mapping among the basic factors in the client's situation were considered the significant tasks of first echelon workers; these two tasks are necessary antecedents to clearness in the situation attained by focusing on the essential underlying problems.
A list of (15) categories was set up as a detailed operationalization of the three main aspects of interpersonal (psychotherapeutic) relationship, to serve as a central pillar for the training.

A pretest - post test control group design was set up including, besides the control group, two experimental groups undergoing respectively a structured training and unstructured meetings.
Three measurement moments were designed (before treatment, after treatment, follow up), carried out on three different levels (relatively objective evaluation by judges, relatively objective evaluation by superiors, subjective evaluation).
The preliminary study concerned primarily a general inventory of the help sources in the district, preparation of treatment procedures and assessment devices. The study was rounded off by setting up a design, applying the evaluation devices (role-play, report, questionnaire completed by superiors, questionnaire completed by subjects) and measurement moments (before, after, follow up) for each of the different groups (experimental I, experimental II, control).

The training consisted of ten sessions (the duration of each was three hours at the utmost), planned to last (with an introduction and a round off meetings) approximately three months.
Every session handled one (or two) category(ies), provided

with the corresponding modeling and followed by a group discussion. Besides, each of the sessions included either a structured role-play, followed by a group discussion (carried out several times) or a written item completed simultaneously by all trainees, followed as well by a group discussion and accomplished with additional material[1].

A significant improvement - recorded on two of the measuring devices - in the actual functioning as helper was found with the subjects who received the (structured) training.
With the subjects who got the unstructured treatment a decrease in self estimation was observed.
Follow up results affirmed the results obtained immediately after treatment.
Information given by superiors attained a higher level of objectivity than often is considered; this means that in general more use can be made of superiors' evaluation.
Attention was called to careful dealing with information given by subjects, as the criticism, inherent to such a project, prevents them from a proper perception of their real abilities.

On basis of the research results and the obtained additional (unmeasured) evaluation of the project, it was suggested that for paraprofessionals a structured project is preferable to an unstructured one.
A plea was made to use this training procedure on a wide scale, if an extension of community mental health is desired.

[1]A complete description of the material used in the training sessions is given in the chapter 'The training procedure'

It seemed insufficient to initiate such a project on a local level, since its results would then merely affect local (mental health) services.
This wide-scale project was suggested to be used as well for further elaboration of the constructed training.
Concerning the new developments in mental health care, this study emphasises the supplementary - educative - role professionals should have, viz. the training and coaching of individuals of the first echelon whose vital contribution might be of minor significance without sufficient guidance.

SAMENVATTING

Het gestegen welvaartspeil en andere ontwikkelingen in de afgelopen jaren hebben geleid tot een verhoogde gevoeligheid en bewustwording voor allerlei vormen van persoonlijke moeilijkheden; de dienstverlening op het gebied van de geestelijke volksgezondheid is echter niet op tijd in staat gebleken om te voldoen aan de eisen die deze ontwikkeling stelt.

Om het verschil tussen vraag en aanbod te verkleinen werden voorstellen gedaan tot verbetering van de wijze van functioneren van die 'paraprofessionele' werkers die reeds actief zijn op het terrein van de geestelijke gezondheidszorg en werd gepleit voor het intensiever betrekken van 'paraprofessionele' krachten bij dit werk.

Paraprofessionele werkers werden in deze studie gedefinieerd als personen die een of andere functie vervullen in het eerste echelon en met anderen in contact komen zonder getraind te zijn in het opvangen van hun persoonlijke moeilijkheden.

Gesteld werd dat deze werkers in de eerste lijn zich meer bekwaamheden eigen moeten maken om een optimale bijdrage te kunnen leveren aan de geestelijke gezondheidszorg.

Omdat er geen programma bereikbaar was dat aansloot bij de gebruikte definitie van paraprofessioneel werker, werd de constructie van een nieuwe trainingsprocedure noodzakelijk geacht.

De constructie van een trainingsprocedure voor paraprofessionele werkers in de geestelijke gezondheidszorg werd daarom gekozen als doel van dit onderzoek.

Uit bestudering van de (Amerikaanse) literatuur over paraprofessionele werkers in de geestelijke gezondheidszorg kwamen twee benaderingswijzen als de belangrijkste naar voren: de ene wordt aangeduid als de 'middle class paraprofessional', de andere als de 'indigeneous paraprofessional'. Fundamentele verschillen tussen de voornaamste opvattingen omtrent deze twee benaderingswijzen en mijn eigen begripsbepaling van paraprofessionele werkers maakten het echter onmogelijk het beschikbare materiaal rechtstreeks te gebruiken.
Bestudering van Nederlandse publicaties op het gebied van de geestelijke gezondheidszorg maakte duidelijk dat de dienstverlening in een overgangsfase verkeert en sterker de nadruk begint te leggen op de preventie; tot nog toe bleven deze veranderingen echter beperkt tot afzonderlijke diensten en betreffen zij niet de geestelijke gezondheidszorg als geheel.
Het is opmerkelijk om te constateren dat, ondanks een groeiende erkenning van de mogelijke bijdragen van paraprofessionele werkers, het begrip paraprofessionalisme binnen de officiële dienstverlening niet de waardering krijgt die haar toekomt. Geleidelijk aan is men gebruik gaan maken van een nieuw soort medewerkers maar de mogelijkheden om van bestaande bronnen in de samenleving profijt te trekken worden nog niet voldoende benut.

Psychotherapie, als gespecialiseerde en professionele manier van contact leggen en onderhouden met anderen, werd opgevat als een geschikt referentiekader voor de vorming van een aantal basisbegrippen en als startpunt voor een trainingsprocedure voor paraprofessionele werkers; deze laatsten werden verder gedefinieerd als (tussen)personen van wie verwacht wordt dat zij op effectieve wijze een interpersoonlijke relatie kunnen aangaan en

verder kunnen hanteren.
Uit de literatuur over psychotherapie kon de conclusie worden getrokken dat de meeste psychotherapeutische richtingen meerdere belangrijke gezichtspunten, ondanks het feit dat er sprake is van accentverschillen, met elkaar delen. Alle wijzen zowel op het belang van de relatie tussen therapeut en client als op de wens van duidelijkheid in de situatie van de client.
Samenvoeging van deze gemeenschappelijke beginselen, aangevuld met enkele belangrijke aspecten van meer specifieke benaderingswijzen, bracht onstot een analyse van het interpersoonlijke handelen volgens drie factoren: het hanteren van de relatie; het hanteren van de participatie van de ander; het hanteren van het materiaal - waarbij vervulling van de eerste twee voorwaarden als noodzakelijk werd beschouwd om aan de derde te kunnen voldoen.
Het vermogen om onderscheid te maken tussen de voornaamste factoren die de situatie van de client bepalen en deze in kaart te brengen werd gezien als de belangrijkste taak van de werkers in het eerste echelon; deze twee taken gaan noodzakelijk vooraf aan het scheppen van duidelijkheid in de situatie en het scherp stellen van de problemen die aan die situatie ten grondslag liggen.
Om te komen tot een verfijnde operationalisatie van de drie belangrijkste aspecten van het interpersoonlijke (psychotherapeutische) handelen werd een lijst van (15) categorieën opgesteld die diende als voornaamste steunpilaar voor de ontwikkeling van het trainingsproject.

Er werd gebruik gemaakt van een 'pretest - post test control group design': naast een controlegroep waren er twee experimentele groepen die deelnamen aan bijeenkomsten met een gestructureerd respectievelijk ongestructureerd karakter.

Metingen werden gepland op drie verschillende momenten (voor de behandeling, na de behandeling, in het kader van de follow-up) en op drie verschillende niveau's (een relatief objectieve evaluatie door onafhankelijke beoordelaars, een relatief objectieve evaluatie door superieuren, een subjectieve evaluatie).
Ter inleiding werd een studie gemaakt die zich primair bezig hield met het inventariseren van de hulpbronnen in de regio, de voorbereiding van de behandelingsprocedures en de meetmethoden. Deze studie werd besloten met het opstellen van een onderzoekplan, toepassing van de evaluatiemethoden (rollenspel, verslag, vragenlijst ingevuld door superieuren, vragenlijst ingevuld door de deelnemers) en de metingen (ervoor, erna en tijdens de follow-up) bij elk van de verschillende groepen (experimentele groep I, experimentele groep II, controlegroep).

De training bestond uit tien sessies (elk van drie uur) en zou volgens plan (met een inleiding en een slotbijeenkomst) ongeveer drie maanden duren.
Elke sessie had betrekking op een of twee categorieën die telkens werden aangevuld met communicatiefragmenten op filmband en gevolgd door een groepsdiscussie. Daarnaast bestond elke sessie uit een gestructureerd rollenspel, gevolgd door een groepsdiscussie (verschillende keren uitgevoerd) of uit een schriftelijk onderwerp waaraan door allen gelijktijdig werd deel genomen, gevolgd door een groepsdiscussie en enig aanvullend materiaal[1].

Een significante verbetering - door twee meetinstrumenten geregistreerd - in het werkelijke functioneren als

[1]Een volledige beschrijving van het materiaal dat tijdens de sessies werd gebruikt treft men aan in het hoofdstuk "The training procedure"

hulpverlener werd gevonden bij diegenen die de (gestructueerde) training ondergingen.
Bij diegenen die aan de ongestructureerde behandeling deelnamen was een afname waar te nemen van de waardering die zij voor zichzelf hadden.
Follow-up resultaten gaven een bevestiging te zien van de resultaten die direct na de behandeling werden verkregen.
Informatie die door superieuren werd gegeven bereikte een hoger niveau van objectiviteit dan vaak wordt gedacht; dat betekent dat er in het algemeen meer gebruik gemaakt kan worden van evaluatie door superieuren.
Er werd aandacht gevraagd voor een zorgvuldig omgaan met informatie die van de deelnemers zelf afkomstig is, aangezien de kritiek die bij een dergelijk project naar voren komt hen verhindert een goed oog te hebben voor hun werkelijke bekwaamheden.

Uitgaande van de onderzoekresultaten en de verkregen aanvullende (niet gemeten) evaluatie van het project werd gesteld dat voor paraprofessionele werkers een gestructureerd project de voorkeur verdient boven een ongestructureerd project.
Gepleit werd voor toepassing van deze trainingsprocedure op ruimere schaal, indien uitbreiding van de geestelijke volksgezondheid wenselijk wordt geacht.
Het schijnt onvoldoende om een dergelijk project te beperken tot locaal niveau omdat dit meestal alleen resulteert in een verbetering van de plaatselijke dienstverlening.
Voorgesteld werd om dat 'wide scale' project ook te gebruiken voor een verdere uitwerking van de ontworpen trainingsprocedure.
Wat betreft de nieuwe ontwikkelingen op het gebied van de geestelijke gezondheidszorg, onderstreept deze studie de aanvullende - educatieve - rol die professionele werkers

zouden moeten hebben, een rol die bestaat uit het trainen en begeleiden van die personen uit het eerste echelon die zonder voldoende leiding hun vitale bijdrage niet zouden kunnen leveren.

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APPENDIX A: Evaluation scales (role-play)

No.: .....

For each of the following statements you have to sign the extent to which you agree with it. These statements refer to the functioning of the helper in the projected conversation.

1. Her behavior stimulates him/her to deal with his/her own problems and to seek some clarity in it.

agree |_|_|_|_|_| disagree

2. Expression of interest and respect enhances the other's trust in a way that makes the development of a relationship possible.

agree |_|_|_|_|_| disagree

3. From the course of the conversation it seems that she is able to differentiate among various factors in the situation of the other.

agree |_|_|_|_|_| disagree

4. She is able to conceive the essence of the problem.

agree |_|_|_|_|_| disagree

5. It seems that she has obtained insight in the situation (and problem) of the other.

agree |_|_|_|_|_| disagree

Name: .....

APPENDIX B: Questionnaire (completed by subject)[1]

completed by Mrs./Miss ..... date: .....

I generally keep aloof from the problems of the other.	☐☐☐☐☐	I am generally interested and involved in the other and his/her problem.
My attention and willingness are influenced by what the other tells me.	☐☐☐☐☐	I respect the other and accept him as he is; my attention and willingness are influenced by this attitude rather than by what he says.
I am generally sensitive to the problem of the other	☐☐☐☐☐	I generally stick to my own suppositions.
I try to adjust myself to different situations and to consider the problem from different points of view.	☐☐☐☐☐	It is difficult for me to be flexible; I generally stick to a specific solution.
I do not generally succeed in gaining the trust of the other	☐☐☐☐☐	Generally I can gain the other's trust by giving a feeling of security
I am interested only in the essence of the story and do not pay attention to details mentioned by the other.	☐☐☐☐☐	I pay attention to nuances in the other's way of mentioning small details.

[1] Questionnaire completed by superior consisted of the same items, given in the third pronoun form

Generally I do not ask the other to give his own opinions or experiences.		I use to ask the other his own opinions and experiences referring to the subject in question.
I let the other determine the course of the conversation, and react to it.		I try to indicate the course of the conversation.
Generally I can patiently listen to the other.		It is sometimes difficult for me to listen to the other; it depends on my own mood.
Before supplying a possible solution, I try to simulate the other to seek it himself.		I try to find a solution on my own as soon as possible.
I am able to consider (together with my superior) possibilities of improvement in the other's situation.		I generally wait for suggestions of my superior as I am hardly able to consider possibilities of improvement.
I explain how I have reached a certain idea or advice.		Generally I do not explain how I have reached certain ideas or advices.
I am able to observe the other in a way that enables me to recognize psychic disturbances and/or problematic relationships, enabling me to obtain more clearness in the situation.		I cannot obtain clearness in the situation.
I suppose that I can supply emotional support and warmth.		I can hardly supply emotional support and warmth.
In the contact I have with the other I can hardly differentiate among personal and environmental factors.		In the contact I have with the other I can generally differentiate among personal and environmental factors.

APPENDIX C: Evaluation sheet (report)

No.: ....

The accessory observational report has to be evaluated on this sheet:

1. A mere factual reflection (of the situation) is given.
   - o yes
   - o no

2. Reflections and/or suggestions referring to the interactional activities are given.
   - o yes
   - o no

   if yes, 2a. Comparing with the factual reflection, the interactional reflection is:
   - o minimal
   - o similar
   - o much greater

3. Suggestions of emotional expressions and/or feelings are given as well.
   - o yes
   - o no

   if yes, 3a. Comparing with the factual reflection, the emotional reflection is:
   - o minimal
   - o similar
   - o much greater

Name: .....

CURRICULUM VITAE

Oded Oren, born on May 25 1943 in Affula, Israel.

1961 Final examination of High School, Israel.

1964-1967 Study of Psychology and Special Education at the Hebrew University of Jerusalem (Israel), attaining a B.A. in Psychology and Special Education.

1967-1968 Working in a psychiatric hospital (Jerusalem) as a nurses' adviser, participating in organization of in-service training.

1968/69 Working as psychologist in a Day Hospital and Psychiatric Hostel (Jerusalem), for psychotherapeutic consultations.

1969-1971 Study of Clinical Psychology at the State University of Utrecht, attaining a Drs. degree in Psychology (main subject Clinical Psychology).

1970 Student-assistant participating in research projects on a psychiatric setting, Utrecht.

Summer '70 Post-Graduate course in Behavior Therapy, Amsterdam.

1972-1973 Participation in three seminars, which form part of an educational program in psychotherapy at the Institute of Medical Psychotherapy (Utrecht).

1972-1974 Engaged in academic (graduate) teaching at the Department of Clinical Psychology at the Catholic University of Nijmegen.

1973 Engaged (on a free-lance basis) in psychotherapeutic work for the Psychological Student Service of the State University of Utrecht.

1971- Clinical psychologist in a Psychiatric Observation Clinic (Utrecht), Department of Justice.

1972- Individual psychotherapeutic work with private clients.