

**Exploring the dynamics of telephone counselling:
A qualitative study of Lifeline, Melbourne**

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Dedication

This thesis is dedicated to all those people I lost over the four-year course of this project. In particular, my mother, whose drive, ambition and tenacity never ceased to amaze, my father, whose steadfast ability to adapt and accept life's challenges with grace and fortitude both humble and inspire, and my soul mate and best friend, who taught me how to love and be loved.

This thesis is also dedicated to my son, my brothers and my sisters whose love, support and constancy carry me through the good times and the bad. And to my beautiful sister, whose courage and spirit shine ever brighter through her ongoing battle with cancer.

Candidate's Declaration

I, Heather Young, declare that the PhD thesis entitled "Exploring the dynamics of telephone counselling: A qualitative study of Lifeline, Melbourne" is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature

Date

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Abstract

Telephone counselling plays an important role within the mental health service context. This study explores, describes and analyses the dynamics of crisis telephone counselling provided by Lifeline Melbourne. The study is important as there is limited empirical research on the processes and outcomes of telephone counselling.

Elements of a constructivist Grounded Theory Approach guided the inquiry. Methods of data collection included observation, document and database analysis, reviews of telephone counselling sessions and analysis of caller and telephone counsellor follow-up interviews.

A number of tensions in the telephone counselling process were identified. These tensions were associated with the integration of face-to-face counselling models within the parameters of Lifeline's intended function as a crisis service. The dynamics that these tensions created were evident in the content and quality of counselling interactions and the counselling relationship, callers' utilisation of the service, perceptions of outcomes and Lifeline's perception and management of callers.

The research findings indicate that recurrent callers are aware of the crisis service philosophy yet manage these tensions in an attempt to maintain a connection with the service. The study identifies the implications of the Lifeline service model for provision of counselling services that are appropriate to the Lifeline context and address client needs.

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Chapter 1 Introduction

Mental disorders represent four of the ten leading causes of disability worldwide with major depression ranked fourth in the ten leading causes of the global burden of disease. If projections are correct, within the next 20 years, depression will have the dubious distinction of becoming the second cause of the global disease burden (World Health Organization, 2001b). Estimates are that, in Australia, mental disorders represent 30% of the non-fatal disease burden (World Health Organization, 2001b). However, while there is a growing understanding of the importance of mental health and its influence on physical and social wellbeing and health outcomes there remains an enormous treatment gap between the need for treatment and available resources (World Health Organization, 2003b).

Reviews and meta-analyses of counselling and psychotherapy practice provide evidence for the effectiveness of interventions across a range of counselling approaches for a variety of mental health problems (Elkins, 2007; M J Lambert & Ogles, 2004; Wampold, et al., 1997). Psychotherapy has been found to facilitate remission of symptoms, improve functioning, accelerate the natural healing process and provide additional coping strategies and methods for future problems (M J Lambert & Ogles, 2004). Research that has compared psychosocial interventions with medication has also found that while medication was equally effective and less expensive in the short term, psychosocial treatment was more acceptable and continued to have preventative effects even after treatment ceased (Victorian Government Department of Human Services, 2002). These same benefits are reflected in research that has explored the impact of ongoing telephone counselling. Such counselling is not only effective in the reduction of depression and anxiety but its benefits are sustained even after treatment is discontinued. Furthermore, augmentation of traditional medication

treatment with telephone counselling resulted in greater improvements in depression scores than medication alone (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004).

Telephone counselling has the potential to play an increasingly important role in the delivery of mental health services and to become an integral part of a community mental health response. Telephone counselling and crisis line services have been in existence since the 1950s, in particular the Samaritans established in London in 1953 and Lifeline established in Sydney in 1963, and they continue to be an expanding component of the mental health industry, often supported by government and community resources.

Telephone counselling services operate throughout the world, providing a broad range of specialist and generalist services. Often they are established in response to a specific need and thus target a particular problem, such as smoking cessation, or segment of society, such as children. Other telephone counselling services, such as Lifeline's, offer a broader more generalist service available to everyone that aims to respond to a comprehensive range of issues. The need for such services can be demonstrated by documented public demand. Lifeline reports that on average they receive 450,000 calls across Australia every year (Lifeline International, 2006).

In addition to being readily available, telephone counselling offers a number of advantages over traditional face-to-face counselling, including convenience, accessibility and affordability. These aspects are particularly important for those who are housebound, in rural or underserved areas or struggling with financial difficulties. They may also assist those suffering the effects of depression such as low motivation and lack of energy. Perhaps as a result of the advantages that telephone counselling offers, continuing participation rates have been reported as much higher than are usually observed in face-to-face counselling (Ludman, Simon, Tutty, & Von Korff, 2007). For instance, nearly 80% of depressed patients that were part of a phone therapy group completed 8 or more telephone sessions (Ludman, et al., 2007), while suggestions are that fewer than 30% of adults suffering depression continue face-to-face therapy beyond four sessions (Horvitz-Lennon, Normand, Frank, & Goldman, 2003).

Telephone counselling services are positioned to play an integral role in the provision of comprehensive treatment and care. Lifeline in Australia is staffed by volunteers, has their telephone counselling infrastructure provided to them free of charge by Telstra and may also receive assistance with costs such as property rental and insurance (Urbis Keys Young, 2002). While it is not possible to determine the cost effectiveness of telephone counselling services, as there is no standardised effectiveness data for face-to-face counselling or telephone counselling, the benefits of a largely voluntary workforce represent significant economic savings.

From a public health perspective, Lifeline's telephone counselling service has the potential to deliver a range of assessments, interventions and outcomes across a number of domains at both population and individual levels. For instance, the Lifeline service is in the position to provide services to a large number of people, is available to all ages across the lifespan, is low cost, and, across the spectrum of interventions, has the capacity to work on prevention, treatment and maintenance. This is likely to be particularly important for low income, rural and remote communities. In addition, ease of access and affordability positions Lifeline's telephone counselling service to provide primary mental health care, which has the capacity to reduce the impact of mental health disorders at both individual and population levels. The service also has the capacity to collaborate with and support other agencies or mental health practitioners in the provision of secondary or specialist mental health care. This may be particularly important in the face of continuing efforts to move inpatient places from psychiatric hospitals to general hospitals and provide mental health treatment in the community (World Health Organization, 2001a, 2001b). The availability of the Lifeline service, which operates 24 hours a day seven days a week and every day of the year, provides timely access to support and is an essential resource. Many community services and mental health practitioners are unable to provide this degree of service access.

In the current environment, where the demand for evidence based practice is increasing and funding limited, it is important that telephone counselling services fully understand their role and are able to enhance their service delivery. A successful public health intervention relies increasingly on the ability to identify

the key components of effectiveness (Linnan & Steckler, 2002). However, despite the increasing demand for services, telephone counselling is still a relatively young field and as a result research in the area is limited. The available research and literature on telephone counselling reflects the increasing diversity of the field and studies often focus on a specific problem, particular sub-population or on ongoing telephone counselling. Where the generic single session telephone crisis counselling intervention model is concerned, there is a paucity of research. The majority of studies have utilised a quantitative research design that, by its nature, imposes a priori hypotheses and seeks precise measurement and analysis of target concepts. While these studies provide important information, they are limited in their capacity to explore in depth the complexities involved, such as the processes, experiences and interactions between caller and counsellor and the context within which they are occurring.

This study represents the first in-depth exploration of the processes and dynamics of telephone counselling in the context of the provision of services offered by Lifeline Melbourne, Victoria's largest provider of generalist telephone crisis counselling.

Aims of the study

The qualitative research design adopted in this study was based on a constructionist epistemology and drew on a number of the principles and techniques of Grounded Theory. The study explored perceptions of telephone counsellors and callers and examined single session telephone counselling interactions. It was framed within an understanding of components identified in research as effective for face-to-face counselling. For example, relationship factors, including therapist related variables such as accurate empathy, congruence and unconditional positive regard (Orlinsky, Grawe, & Parks, 1994; Orlinsky & Howard, 1986; C. R. Rogers, 1957), placebo, hope and expectancy (Frank, 1968; Goldstein, 1962; M J Lambert, 1992), and the facility to talk freely and openly express feelings (D. Howe, 1993; McLeod, 1997; A. L. Mishara, 1995). These aspects will be discussed in greater depth in chapter three and

provide a basis for discussion pertaining to the relationship between face-to-face counselling practices and telephone crisis counselling practices.

The focus on one particular agency offered the potential to extend the discourse on telephone counselling and illustrate the importance of context and its impact on counselling practice. The final chapter outlines a number of recommendations for telephone counselling practice based on the identification of inconsistencies and the tensions these create.

More specifically, the study aimed to:

- Explore how traditional counselling theories are applied in the telephone counselling context;
- Describe telephone counselling interactions and identify how context shapes telephone counselling practice and individual interactions;
- Explore how telephone counsellors and callers perceive and experience telephone counselling;
- Identify implications for practice of providing counselling by telephone.

It was envisaged that an additional by-product of the research would be the provision of baseline criteria against which the effectiveness of telephone counselling could begin to be measured and any harmful effects minimised as well as providing information that could facilitate Lifeline's shaping of policy and procedure to ensure more effective outcomes. The importance of this study is highlighted by the community's increasing reliance on Lifeline's service in the event of potentially distressing incidents, the knowledge that almost all mental health and community health services (public and private) rely on Lifeline to respond to client needs out of hours, and that Lifeline Melbourne responds to approximately 37,000 calls every year.

Overview of chapters

Chapter 2 provides a context for the research beginning with a brief review of some of the core theoretical frameworks that underpin therapeutic practice and the current trend towards integration. This chapter illustrates the diversity in counselling theory, the implications that theory holds for counselling practice and the challenges associated with the integration of counselling models that adhere to different theories and practices. Chapter 3 discusses the research and literature relevant to face-to-face counselling practice and the current discourse around the importance of specific versus common factors. This chapter highlights the challenges of discovering, exploring, understanding or increasing the effects of the key ingredients of psychotherapy practice and intervention and touches on the current tension between knowledge and practice in the field and external demands and political pressures. Chapter 4 contextualises the growth and evolution of telephone counselling, provides a review of relevant research and literature and situates the significance of this study. Chapter 5 provides information about the environment in which telephone counselling interactions occur in the Lifeline context and distinguished this form of counselling from more generic models of face-to-face counselling practice. This chapter also provides specific information and data about Lifeline, Melbourne and the functioning of the service.

Later chapters present information relevant to the study design, data analysis and findings. Chapter 6 provides an explanation of the research design, including a description of the participants, the collection and management of data and data analysis procedures and a discussion of validity and reliability issues arising from the study. This chapter concludes with the researcher biography and entry into the setting. Chapter 7 considers the features and conditions of telephone counselling in the context of Lifeline Melbourne's service as they emerged from the data and reports on telephone counsellor and caller perceptions, including reasons for calling and the emergence of 'connecting' as a central theme. Chapter 8 offers an analysis of the telephone counselling interaction and identifies key components and processes of the telephone counselling interaction and the influence of context and conditions on these. Chapter 9 presents an

overview of the caller typologies that emerge from the data as a result of the tensions created by inconsistencies between the models adopted, the adaptation of these to the telephone counselling setting and associated conditions, and the mismatch between these and caller needs. This chapter provides an illustration of two caller typologies, positioned at either end of the caller typology continuum, in the form of two case studies that interweave description and interpretation. Finally, Chapter ten provides a synthesis of the major findings, discusses the limitations and implications of the study and provides recommendations for telephone counselling practice and training.

Chapter 2 Counselling Theories

The previous chapter highlighted the growing need for mental health services and the role played by telephone counselling, in particular, services such as Lifeline's. This chapter presents an overview of the core theoretical frameworks underpinning different schools of therapy. It presents these frameworks in sequential stages of development from the early psychodynamic approaches through to current post modern practices. This phasing illustrates theoretical shifts and the diversity in theory and the implications of choice of orientation to therapeutic practice. An understanding of theoretical approaches, and the associated implications for therapeutic practice, is important for situating therapy models that have been adopted and adapted for use in the telephone counselling context. The presentation of approaches in phases is for clarity of communication; there is considerable slippage between and within the phases, which reflects the growth and diversity of counselling approaches and practices.

Although some attempt to distinguish between 'counselling' and 'psychotherapy' these terms are frequently used interchangeably (Nelson-Jones, 2006). For the sake of consistency, the term therapy, therapist and client are used when referring to face-to-face models of practice. Counselling, counsellor and caller are adopted later in the thesis when referring to telephone counselling.

The historical context of contemporary counselling theory

The field of psychotherapy is characterised by a diverse range of therapeutic models and new approaches are continually being developed. Many of these approaches have their origins in different strands or schools of psychology, such as psychodynamic, behavioural, humanistic, family systems and post-modern.

Phase 1: Psychodynamic therapies

Freud developed the idea of psychoanalysis in the mid to late 1890s and is commonly referred to as "the father of psychoanalysis". Instincts are central to the Freudian approach and human nature is viewed as biologically determined. That is, behaviour is determined by unconscious motivations and biological and instinctual drives. Freudian theory and practice focuses on early childhood experiences as determinants of later psychopathology and views the client as a separate, individual entity that can be systematically and objectively observed (Sommers-Flanagan & Sommers-Flanagan, 2004). Classical analysts typically assume an anonymous stance and maintain a sense of neutrality in interactions with their clients. The goals of therapy are to make the unconscious conscious and to strengthen the ego so that behaviour is based less on instinctual drives and more on reality.

Freud's work has been highly influential and many of his basic concepts form the foundations of other theorists' work, including psychodynamic approaches. However, alternative theories of therapeutic practice have emerged as a reaction to the psychoanalytic model, such as behaviourist approaches, person-centred counselling and some forms of feminist therapy (Corey, 2005; Nelson-Jones, 2006; Sommers-Flanagan & Sommers-Flanagan, 2004).

Phase 2: Behaviourist Approaches

The behavioural approach was a radical departure from the psychoanalytic perspective (Corey, 2005). This approach sprang from efforts to describe, predict and control observable behaviour and is often considered a reaction against the psychoanalytic approach that was seen as unscientific (Nelson-Jones, 2006). Largely developed in the 1950s the behavioural approach in clinical practice evolved from Ivan Pavlov's work with the conditioned reflex. Other early pioneers of behavioural therapy include Hans Eysenck, who coined the term 'behaviour therapy' towards the end of the 1950s (Eysenck, 1972), Watson, who developed the idea of the conditioned response, and Skinner, who stressed the role of the environment and the importance of consequences in reinforcing behaviour

(Nelson-Jones, 2006). Later called the science of behaviour, behaviourist approaches are based on the premise that all behaviours are learned and that all things that organisms do, including acting, thinking and feeling, should be regarded as behaviours. Behaviourism places a distinct emphasis on the role of environmental contingencies in influencing the acquisition and maintenance of behaviours (Nelson-Jones, 2006).

Behaviour therapy, rational emotive behaviour therapy and cognitive therapy have a common foundation in behaviourism. These approaches are largely action-focused and aim to assist people to challenge their faulty assumptions and develop new patterns of behaviour. While behaviour therapy places a focus on clients' current behaviour and on taking steps to develop new behaviours, rational emotive behaviour therapy and cognitive therapy place the emphasis on learning how to challenge automatic thoughts and dysfunctional beliefs. In the second half of the 20th century, behaviour therapy was coupled with cognitive therapy to form cognitive behaviour therapy (Corey, 2005).

Cognitive behaviour therapy combines both cognitive and behavioural principles and methods. Although many, quite diverse, approaches fall under the umbrella of cognitive behaviour therapy, they share common elements. The central premise of these approaches is that psychological distress is largely a function of disturbances in the cognitive processes and the focus is on changing these cognitions to produce the desired changes in behaviour and affect. Usually time limited, they are based on a structured psycho-educational model that tends to target specific problems. Therapists assess client behaviours and formulate treatment plans that specify and define goals and interventions (Nelson-Jones, 2006). Although behaviour therapists attempt to form a good working relationship with clients, traditionally, the emphasis of this approach was on the importance of technical skills with less emphasis placed on the quality of the therapeutic relationship (Safren, Heimberg, & Juster, 1997).

Phase 3: Humanistic Therapies

Person-centered therapy, founded by Carl Rogers and developed during the 1940s, emerged as a reaction to both analytic therapy and behaviourism, as did gestalt therapy. These approaches fall within the Humanistic school of psychology and can be categorised as relationship-oriented and experiential therapies (Corey, 2005; Sommers-Flanagan & Sommers-Flanagan, 2004). Early humanistic psychologists offered a more holistic view of human experience and sought to restore the importance of consciousness. In their view psychoanalysis relegated the conscious mind to relative unimportance with its emphasis on unconscious drives, and behaviourism neglected crucial subjective data through the application of physical science methods to human behaviour. Humanistic psychology tended to look beyond the medical model of psychology in order to open up a non-pathologising view of the person (Nelson-Jones, 2006). From the Person-centered perspective, psychopathology is a failure to learn from experiences (Sommers-Flanagan & Sommers-Flanagan, 2004).

Person-centered therapy is considered a founding work within the humanistic school of psychotherapies. Philosophically, this approach assumes the client's capacity for self-direction, and their ability to set goals for therapy, with little active intervention on the therapist's part. The emphasis is on the therapist's attitudes, including empathy, congruence and unconditional positive regard, and the prime determinant of the outcome of the therapeutic process is believed to be the quality of the interpersonal encounter between client and therapist (C. R. Rogers, 1962). Humanistic therapists focus on the importance of emotional processing and the client's ability to experience their feelings and think and act in harmony. The aim is to help the client develop a stronger and healthier sense of self, also called self-actualization (Nelson-Jones, 2006; Sommers-Flanagan & Sommers-Flanagan, 2004).

Phase 4: Systems Approaches

While many of the earlier models of counselling were predicated on concepts taken from intrapsychic theories, family therapies represented a paradigm shift from psyche to system that was considered revolutionary during the early years of its development (Corey, 2005). The "systems" perspective stresses the importance of understanding individuals in the context of their surroundings, relationships and systems of interactions. Therapists who adhere to this school attend to interactions or connectedness between people and the context within which they interact. The present is more important than the past and treatment is focused on both verbal and nonverbal communication patterns within the family unit. This holistic view takes into account the individual's psychosocial, socioeconomic as well as psychological worlds. System theory proposes that change in one part of the system affects all other parts (Skyttner, 2001).

Phase 5: Postmodernist Therapies

Therapy within a postmodern context does not represent a single school of thought, rather it encompasses several schools of thought that share a common philosophical and epistemological position. Emerging during the 1970s, this movement questioned the nature of knowledge and challenged the positivist epistemology that supposes the existence of a reality independent of the observer that can be known objectively (Tarragona, 2008). Postmodern therapies take a constructivist approach and hold a firm belief that there is no such thing as objective fact (Sommers-Flanagan & Sommers-Flanagan, 2004). Constructivist theory does not support traditional models of psychopathology and views diagnosis as an unhelpful procedure. Instead, therapists emphasise clients' unique strengths and collaborate with them in identifying goals, strategies and the overall direction of therapy (Sommers-Flanagan & Sommers-Flanagan, 2004).

Among the most widely known postmodern perspectives on therapy practice are solution-oriented therapy and narrative therapy (Corey, 2005; Sommers-

Flanagan & Sommers-Flanagan, 2004; Strong, 2000; Tarragona, 2008). Solution-oriented therapy, initiated by Steve de Shazer in the late 1970s, pays little attention to the past, knowing the cause of the problem, or in gaining an understanding of the problem. There is no assessment in the traditional sense; instead the therapist focuses on both the present and the future and on searching for the 'right' solution for that particular client. Therapists believe that clients are resourceful and have the capacity to construct solutions. The client establishes goals and the role of the therapist is to help clients recognise their competencies, create solutions and write a different story with the possibility of a new ending (Corey, 2005; Sommers-Flanagan & Sommers-Flanagan, 2004; Tarragona, 2008).

The stories that clients bring to therapy and the creation of alternative preferred stories are also the focus of narrative therapy. Developed initially by Michael White and David Epston during the 1970s and 1980s, this approach holds that narratives or stories shape identities, whether uniquely personal or culturally general. Like Person-centered therapy, narrative therapy stresses the importance of the therapist's attitude and personal characteristics in creating a climate that encourages the client to reconstruct or re-story their lives in more adaptive ways (Sommers-Flanagan & Sommers-Flanagan, 2004; Tarragona, 2008). The role of the therapist is to externalise and deconstruct problem-saturated stories by separating the person from the problem, objectifying the problem and searching for moments of success regarding the problem (Corey, 2005; McLeod, 1997; Tarragona, 2008).

Phase 6: Integration

Over the past four decades there has been a trend towards the proliferation of types and numbers of psychotherapies (M J Lambert, Bergin, & Garfield, 2004). Perhaps dissatisfaction with existing models has been the catalyst that has generated so many new approaches (Feixas & Botella, 2004). This same catalyst has, in more recent times, advanced the movement towards integration based on combining the best of differing orientations in an effort to articulate more

complete theoretical models and develop more efficient treatments (Goldfried & Castonguay, 1992; M J Lambert & Ogles, 2004).

In practice while therapists may be strongly influenced by a particular approach, many do not subscribe to only one model. Rather they tend to synthesise various approaches by integrating concepts and drawing on the techniques of different approaches, so that the majority of therapists have become eclectic in orientation (M J Lambert & Ogles, 2004). Suggestions are that practising therapists, in recognising the complexity of the human form and attempting to meet the individual, diverse needs and preferences of their clients, have naturally always drawn on their knowledge and experience in this way (S. D. Miller, Duncan, & Hubble, 2004).

The literature highlights the importance of distinguishing between integration and eclecticism, the first being a 'bringing together' or amalgamation of different theories and models into a new theory or model, and the second being the 'selecting out' or separating and utilising of ideas and techniques from a range of theories and models (Lees, 2004). Theoretical integration is an entirely new form of psychotherapy and is the most complicated and sophisticated mode of psychotherapy integration, whilst technical eclecticism is the least complex and most common form of psychotherapy integration (Strieker & Gold, 2008).

Technical eclecticism refers to the use of a variety of techniques from different therapeutic approaches and the blending of these together to better provide the most useful formula for any given individual. This approach to integration is the most popular amongst practicing therapists (S. D. Miller, et al., 2004). Often techniques are drawn from therapies that have a strong family resemblance; however, there are concerns associated with the blending of philosophically incompatible ideas as this has the potential to create a variety of tensions and may result in confusion (Sommers-Flanagan & Sommers-Flanagan, 2004; Watson, 2006).

Commentary

There is now an array of distinct theoretical approaches to counselling and psychotherapy that represent a diversity of perspectives and practices. An understanding of the origins and theoretical underpinnings of counselling models is important, because these orient practice and inform the way a counsellor approaches a problem presented by the client. This précis of the history, theory and practice of counselling and psychotherapy highlights the wide range of ideas and reflects significant contradictions in thought and practice. For example, different psychotherapy theories have incompatible philosophical assumptions, which influence the way 'reality' is perceived and, therefore, differ in what they define as being valid forms of knowledge (Corey, 2005; Goldfried & Castonguay, 1992; Sommers-Flanagan & Sommers-Flanagan, 2004).

Traditional counselling theories were conceived in what has been termed a modernist epistemic context, which posits that true knowledge of phenomena can be discovered through objective observation and measurement (J. T. Hansen, 2006). However, postmodern or constructivist theory, in offering differing versions of the nature of 'reality' and the existence of multiple 'truths', challenges the notion of a singular, universal truth that can explain human beings and the systems within which they live. McLeod (1997) suggests that this shift, and the move towards eclecticism or integration, reflects the erosion of the influence of major schools of counselling and psychotherapy and the gradual replacement of these with a practitioner's own personal *bricolage*.

In addition to this movement, and despite epistemological and theoretical differences, principles that exist across diverse theoretical perspective and therapeutic practices have also been conceptualised and articulated over the years and are now accepted as common factors (Sommers-Flanagan & Sommers-Flanagan, 2004). A primary point of connection is that the therapy process can be seen as a series of conversations, during which clients tell and retell their story, and emphasis on the spoken word in the therapeutic interaction is one element shared by all of the major therapy orientations (McLeod, 1997; Sommers-Flanagan & Sommers-Flanagan, 2004). Therapeutic approaches are

usually described in terms of appropriate therapist responses to client discourse and speech is functional in terms of psychotherapy training and research. As both theory and practice emphasise the spoken aspects of therapy, some consider narrative psychotherapy a meta-theoretical orientation that entails the voicing and shaping of client stories (Levitt, 2002). Other common factors include a safe therapeutic environment and an emotionally charged, confiding therapeutic relationship, with the main task of the therapist being to facilitate disclosure and help the client find meaning in what is said (M J Lambert, 1992; Levitt, 2002; C. R. Rogers, 1957).

Chapter 3

The Therapeutic Endeavour

‘Accept me, understand me and talk with me’
(D. Howe, 1993, p. 139)

The previous chapter provided a framework for understanding the diversity of counselling theory and the implications of choice of orientation to therapeutic practice. This chapter presents a broad overview of some of the central elements relevant to psychotherapy. In addition, it considers the question of specific versus common factors and explores the challenges involved in discovering the key ingredients and measuring their effectiveness. It argues for an awareness of the complex, interactional and dynamic nature of psychotherapy and the need to consider both client and therapist and the unique intersubjective space they create and inhabit during the therapeutic encounter.

Psychotherapy practice

The experience of talking about one’s problems, receiving empathic communication and feeling “better” can be considered a fundamental component of the therapeutic process. In general, talk is the medium in which therapy takes place. Therapy then is largely about ‘telling’, the experience of telling and the giving ‘voice’ to experiences, perhaps particularly to those experiences that have been silenced (McLeod, 1997). Clients’ stories not only help practitioners understand clients’ complaints they are also believed to be an integral part of the healing process (A. L. Mishara, 1995; Rennie, 1994). According to Berry and Pennebaker (1993) memory of an experience is changed through the act of putting it into words. Mishara (1995) posits that this is because by telling our story we are able to obtain some distance, “open up” and organise our experiences, so that we are able to transcend the prior suffering self. This means

that the person changes their relationship to past experiences and what it means in their present by talking about them.

We all have a need to talk, particularly if we are worried, anxious, confused, upset or excited. Indeed, the opportunity to talk is often what clients most value (D. Howe, 1993). In times of high emotion giving voice to feelings seems a natural thing to do. Clients experience relief from being able to talk freely and release pent up feelings and usually the intention of psychotherapy is to provide conditions of sufficient safety that allow the opening up of previously undisclosed feelings (McLeod, 1997). Feelings are an essential part of the counselling experience and once recognised can be explored, understood and validated. Suggestions are that through the act of telling we translate experience from the emotional to the cognitive-linguistic and that talking cures by way of the cognitive reorganising that this entails (Pennebaker, Colder, & Sharp, 1990). In addition, emotion is thought to play a key role in learning with stronger physiological markers of an emotional response having a significant positive correlation with more successful learning (Carter, 2003). A good counsellor works to accurately hear feelings, even when they are not overtly expressed through content or expression, recognise them, facilitate their expression and disentangle emotional confusions (D. Howe, 1993). A safe therapeutic atmosphere is essential grounding for this process (Wolfe, 2005).

In his review of studies into clients' reports of their experience of therapy Howe (1993) concluded that there were three broad stages that clients pass through, being accepted, being heard and being understood. Acceptance and understanding provides a holding environment within which clients are able to be vulnerable and is the basis for the therapeutic relationship. The quality of the therapeutic relationship is a central concern and in many instances it is believed to be the most valuable part of the experience (D. Howe, 1993). Therapist's personal attributes, for instance being warm, supportive, open, honest, accepting and affirming, promotes the formation of the therapeutic relationship and encourages and strengthens clients (Ackerman & Hilsenroth, 2003). From this secure base clients are able to begin the process of exploration, discovery and change.

Story telling as a meta-theoretical approach in understanding the therapeutic process

In the process of the telling, stories are described and meaning assigned, giving form and content to experience, thoughts and feelings and beginning the process of understanding (Tarragona, 2008). Experiences are structured around a story and stories help to organise experience, creating connections between events and people. Narratives are natural vehicles for the exploration and understanding of the meaning of experiences in context (McLeod, 1997). Each retelling of the story enables a revisiting of the experience and the opportunity to assimilate previously unnamed elements into the narrative (McLeod, 1997). In endeavouring to make sense of and link together disparate experiences, events are reconstructed (D. Howe, 1993; Tarragona, 2008). In this way clients are seen as reconstructing rather than recovering past experiences. This represents a shift from recovery of experiences to creation so that 'reality' is reorganised and given meaning rather than passively received (D. Howe, 1993).

According to Howe (1993) this continual reconstruction of the way we understand ourselves, and hence the need to talk and tell one's story, is the reason clients seek therapy. Storytelling, however, can be both helpful and unhelpful. While helping clients connect with their inner disturbance and increasing feeling and self-understanding, storytelling can also be used to avoid discussing struggles, problematic issues, and disturbing feelings (Rennie, 1994). For example, in the case of PTSD, avoidance reduces the threat or anxiety arising from the trauma but, therefore, fails to process it. Therapists listen and encourage clients to talk, express and reflect; seeking clarification and understanding, as well as questioning and challenging the client in an attempt to help the client make sense of the experience, understand the meaning of their experience, develop new meanings and discover more effective understandings.

Story telling in therapy is primarily a way of dealing with inner disturbance (Rennie, 1994). The work of deconstructing stories with the goal of discovering and rewriting better narratives is a major difference between every day storytelling, when people might tell and retell the same story for years, and therapeutic storytelling, where the expectation is that the story will change

(McLeod, 1997). Therapy then becomes a process of co-creating and of empowering clients to be authors of their lives (Kellogg & Young, 2008).

Practising therapy

While change and the change process is the major focus of therapy, the therapeutic endeavour, to facilitate change, is practiced within complex and dynamic systems. Within these systems therapeutic practice is influenced by therapist individuality and characteristic work practices.

In addition to factors that impact their individual practice, such as training, experience, discipline and attitude, therapists deliver treatment within complex and dynamic systems that incorporates health care policies, such as financing, organisational influences, such as culture and case load, treatment approaches, such as orientation, strategies and dose and duration, and client factors, such as symptoms, functioning and expectations to name a few. Each of these multiple layers, and the numerous features they incorporate, plays some part in influencing the therapeutic endeavour and its outcomes.

Therapists practise within this intricate living system with the ultimate goal of achieving client change. Change, its mechanisms and its process, are presumably the primary concern of any therapeutic endeavour and conceptualising, understanding and measuring change continues to be a major focus of psychotherapy research (Carey, et al., 2007; Murray, 2002). Given the complex and multifaceted nature of the therapeutic endeavour these are not simple tasks. As a result there is a mass of research and literature that explores, examines and considers these concerns with the aim of developing and enhancing the effectiveness of therapeutic practice.

Effectiveness

In essence, all of the research and discourse regarding psychotherapy is about discovering, exploring, understanding or increasing the effects of the key ingredients of psychotherapy practice and intervention. The history of psychotherapy can be characterised as the search for the processes or the specific ingredients that reliably produce change (S. D. Miller, Duncan, & Hubble, 2005). Now, more than ever, with the increasing demand for empirically supported interventions and accountability, the issue of treatment effectiveness is at the forefront of professional discourse and clinical research (M J Lambert & Ogles, 2004).

The gold standard for establishing the intrinsic efficacy of any treatment is the randomised controlled trial that is usually carried out in a defined environment by trained clinical investigators. In an effort to detect the effect of treatments, researchers try to eliminate, or hold constant, any factors that might obscure treatment effects (Norquist, Lebowitz, & Hyman, 1999). Efficacy studies also employ strict inclusion and exclusion criteria for participant selection. They involve the random allocation of different treatments or conditions to ensure that both known and unknown confounding factors are evenly distributed between treatment groups and include measures of outcomes that are usually limited to symptom reduction based on well-validated rating scales (Norquist, et al., 1999). In this way efficacy trials are designed to optimise the internal validity of findings, that is, the ability to attribute the changes observed with a particular causal factor (M J Lambert & Ogles, 2004).

While such "efficacy" trials are essential, the testing of an intervention in this context is limited and fails to be generalisable or transferable to the real life setting where routine encounters of consumers with mental health care providers rarely meets the standard of classic clinical trials. This lack of external validity has led to a shift towards conducting research in the real life setting that includes typical patients who suffer from various forms of co-morbid health conditions, with treatment delivered by typical staff and measures including a broad spectrum of functional as well as symptomatic outcomes (M J Lambert &

Ogles, 2004; Niederehe, Street, & Lebowitz, 1999). This type of study that focuses more on whether an intervention works as it is practiced in the field in its unaltered state is referred to as an "effectiveness" study.

Although psychotherapy process and outcome research methods and methodology are becoming increasingly more sophisticated there remains little agreement among researchers about the targets of investigation, assessment procedures and measurement instruments (Hill & Lambert, 2004). Process research, what happens in psychotherapy sessions, and outcome research, the changes that occur as a result of the therapy, can each be assessed utilising either quantitative or qualitative means. Each of these approaches can be further delineated methodologically. Researchers are able to focus on a particular target, for instance the client, therapist, dyad or system, examine a number of dimensions, such as therapists technique, client reactions, reduction of symptoms and satisfaction, as well as utilise a variety of tools, for example self report rating scales, interview and transcript analysis (Hill & Lambert, 2004). This overview identifies only a fraction of the possible variables and their assorted elements. As a result reconciling conclusions drawn from the psychotherapy research literature is difficult.

Although a variety of methods, measures, data sources and sampling domains are utilised, many of the measures used in research do not directly access stakeholder perspectives. Studies that do try to include stakeholders' evaluation more commonly focus on measures of client satisfaction with the interaction and outcome as indicators of effectiveness (Bowling, 2002). However, satisfaction may constitute a number of different dimensions including adequacy, suitability and the fulfilment of an objective. Few studies actually define client satisfaction therefore limiting the ability to form a clear or comprehensive understanding of how it relates to effectiveness.

Similarly, stakeholder perceptions of what defines effectiveness are rarely explored (Wadsworth, 1998). There is a tendency to focus on various predetermined constructs that are deemed to be of value or that are perceived as representing success. Often, in the cases when both client and counsellor perspectives are considered, important differences are apparent, for instance,

one study that considered client and counsellor perceptions of effectiveness found that overall levels of client satisfaction with the number of sessions was higher than counsellors, who more often rated the number of sessions as inadequate (D. Rogers & McLeod, 1995). These results prompted the author to comment that counsellors and clients appear to have different criteria for success, different objectives for counselling, and different agendas (D. Rogers & McLeod, 1995). In addition, and importantly, answers to questions relating to possible negative processes and outcomes from stakeholders' perspectives are typically absent from effectiveness research.

Nevertheless, overall meta-analytic studies have found comparable positive treatment effects across a range of treatments for a variety of disorders (M J Lambert & Cattani-Thompson, 1996; M J Lambert & Ogles, 2004; Wampold, 2001). While routine practice does not reflect the substantial benefit attained in clinical trials, psychotherapy has been found to facilitate remission of symptoms, improve functioning, speed up the natural healing process and provide additional coping strategies and methods for dealing with future problems (M J Lambert & Ogles, 2004). Exactly what the active ingredients are though in this process remains in question (Sparks, Duncan, & Miller, 2008).

Structure, model and technique

There are a variety of different psychological treatments employing diverse techniques, activities, processes and interventions in an attempt to facilitate client change (Blagys & Hilsenroth, 2000). Some therapeutic approaches emphasise the importance of past experiences and include discussions of childhood and adolescent memories, linking these to the client's current problem, whilst others focus primarily on the present. Others might focus on unconscious processes, such as resistance, and explore them, for instance an interpersonal therapist might point out the client's defensive manoeuvres while a cognitive behavioural therapist would not (Blagys & Hilsenroth, 2000). The identification of patterns in clients' thoughts, feeling, actions and relationships is another difference. Cognitive behavioural therapists attempt to identify long held thought patterns so that they can begin to challenge them and provide alternative

explanations or new perspectives, while interpersonal therapists focus more on identifying patterns in the client's relationships and feelings in order to raise the client's awareness of the core issues (Blagys & Hilsenroth, 2000).

Specific factors

The move towards specificity, or specific approaches for specific disorders, is driven by a number of factors. The number of therapy models has grown exponentially in the past four decades (M J Lambert & Ogles, 2004) and, as a result, the focus of the therapeutic endeavour inevitably shifted onto more specific techniques and interventions that characterised particular therapies. This emphasis on technique, particularly in the case of behavioural or cognitive behaviour therapy that focused on dealing with specifically defined target behaviours, has resulted in a research literature that has demonstrated efficacy for several kinds of problems, such as depression and anxiety disorders, in randomised clinical trials (Goldfried & Davila, 2005; Lebow, 2008; Sparks, et al., 2008; Zinbarg & Griffith, 2008).

The result of this has been a growing movement, particularly in the United States, towards empirically supported treatments. For instance federal funding of psychotherapy research leans strongly towards identifying treatment approaches that are shown to be empirically effective for patients with a specific diagnosis (Kirschenbaum & Jourdan, 2005). This problem-specific approach to intervention received a major impetus from a growing emphasis on DSM based classification, for instance, from insurance companies that required its use for reimbursement purposes and from the National Institute of Mental Health (NIMH) requirement for research funding that patient populations be categorised according to DSM criteria.

In addition, in the United States and Great Britain, psychological associations have engaged in efforts to construct lists of empirically supported, manualised psychological interventions for specific disorders. These are based on randomised controlled studies and have resulted in the creation and publication of guidelines for clinical practice and training (Norcross, 2001). Policymakers and insurance

carriers increasingly turn to such guidelines to determine which therapies to approve and fund, which, in turn, reinforces the movement towards comparative outcome studies on brand-name therapies. Recent developments in Australia, that saw the introduction of Medicare funded psychotherapy, are similarly constrained by conditions associated with the use of particular approaches and a limited number of sessions. Client access to government funded psychotherapy is also linked to DSM defined disorders and accompanying criteria. Only patients assessed by a GP as meeting the criteria for a specific DSM defined psychological disorder are referred for psychological treatment.

The move towards empirically based practice all but ignores the accumulation of a significant body of evidence pointing towards the notion that specific approaches or techniques carry little or no weight where client improvement is concerned (Sparks, et al., 2008). Quantitative reviews and meta-analyses of psychotherapy outcome literature consistently reveal that specific techniques account for only 5% to 15% of the outcome variance (M J Lambert, Shapiro, & Bergin, 1986; Wampold, 2001) or find little or no difference between therapies (Luborsky, et al., 2002; Sparks, et al., 2008; Wampold, 2001). In evaluating "specificity" across 27 studies conducted between 1990 and 1999, Ahn and Wampold (2001) concluded that demonstrated efficacy across studies was unlikely to be due to the specificity of any single treatment component.

It has been argued that reported differences between approaches are no more than would be expected by chance (Sparks, et al., 2008). There are also reports that specific techniques correlate negatively with outcome. A study of 30 depressed clients compared two nonspecific factors and a specific cognitive therapy technique. The two common factors, the therapeutic alliance and the client's emotional involvement with the therapist, were highly related to positive outcome while the technique, correcting distorted cognitions, was negatively related to successful outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). In addition, while manuals may assist in training therapists in particular approaches, there is little evidence to support the use of manualised treatments with reports indicating no improvement in outcome and a strong possibility of negative consequences (Beutler, et al., 2004; M J Lambert & Ogles, 2004).

Such findings have fuelled a growing interest in the notion that diverse therapies have equivalent outcomes (Sparks, et al., 2008) and has led researchers to propose that it is the similarities or “common” factors shared by all therapeutic models, rather than the differences or “unique” factors that account for treatment effectiveness (Ahn & Wampold, 2001; Grencavage & Norcross, 1990; Sparks, et al., 2008; Wampold, 2001). While specific factors refer to the techniques and interventions that characterise particular therapeutic approaches, common factors refer to dimensions shared by most therapeutic approaches, including the therapeutic relationship.

Common factors

The beginnings of the debate about the ‘common factors’ as it is known today began in the mid 1930s and, although the components have been built upon and refined, the concept of a pan-theoretical framework has since been supported by a number of researchers and theorists (Sparks, et al., 2008; Wampold, et al., 1997). Common factors generally fall into four overarching clusters including relationship factors, client and extra therapeutic factors, model techniques and placebo factors.

The influence of other common factors were also included (Grencavage & Norcross, 1990; Wampold, 2001), such as, *client beliefs* about the effectiveness of therapy, the clients *hope and expectation* about getting better and the ability of the therapist and client to establish a treatment contract (Kirschenbaum & Jourdan, 2005; Orlinsky, Ronnestad, & Willutzki, 2004). Others likened the core ingredients, shared goals, consensus on tasks and emotional bond, to the supports of a three legged stool with the seat of the stool, conceived of as the clients theory of change, holding everything together. Any disagreements would destabilise the alliance making the stool uncomfortable or toppling it over. If all were in agreement, however, the client would remain comfortably seated, or engaged, with treatment (S. D. Miller, et al., 2005).

Relationship factors

The therapeutic relationship, or alliance, is the most frequently mentioned common factor in the psychotherapy literature (Grencavage & Norcross, 1990) and a considerable amount of research attention has been focused on it (Kirschenbaum & Jourdan, 2005). The therapeutic relationship can be broadly defined as the thoughts, feelings and behaviours that therapy participants experience and express towards each other in the process of interacting (Gelso & Carter, 1985). References to the therapeutic relationship can be found in Freud's (1912) early writings about the value of the analyst maintaining 'serious interest' in and 'sympathetic understanding' of the client to enable the client to form a positive attachment to the analyst.

Freud believed that this supportive attitude would allow the patient to form a positive transference, which was the source of the client's confidence or 'belief' in the analyst's explanations or communications. The emphasis, however, was on technique with the therapeutic change process occurring through the development of the transference reactions of the client to the silent analyst. The transference process, the core of the psychoanalytic approach, is the client's unconscious shifting to the analyst of fantasies and feelings that are attached to significant others in the client's past (Corey, 2005). The primary curative element was in the difficult work of transference interpretation, which included the therapist's feelings or countertransference reaction to the client, and psychoanalysts argued that the relationship simply moderated the association between the transference and treatment effectiveness (Saunders, 2000).

In later years Carl Rogers rejected the psychoanalytic position and posited that the therapeutic relationship was curative in and of itself. He argued for the importance of the relationship over technique suggesting that it comprises the very heart of the change process (C. R. Rogers, 1957). According to the client-centered perspective the therapist's ability to demonstrate "core conditions", to be empathic and congruent and to assume a stance of unconditional positive regard towards the client, influenced the development of a relationship characterised by these conditions (Corey, 2005). The hypothesis was that the

nature of this relationship would inevitably promote a positive response and was all that was necessary for the client's improvement. In this way the relationship was seen as mediating the therapeutic benefits (Saunders, 2000). Roger's position on changing human behaviour was contrasted most dramatically with Skinner's, whose contention was that human behaviour was under the control of external forces and that it was these external conditions that brought about change (Goldfried & Davila, 2005).

Consistent with Skinner's position, behaviour therapy began by placing the primary emphasis on techniques and viewed the relationship as less important as a primary vehicle of change. In this context the therapist's function was that of a "social reinforcement machine" (Goldfried & Davila, 2005) and the relationship was viewed as necessary, for the development of trust, rapport and collaboration, which in turn would facilitate the therapeutic interventions, but was insufficient for change to occur. This perspective places the emphasis on the moderating aspects of the therapeutic relationship, that is, on its influence on causal associations between treatment interventions and outcomes (Saunders, 2000).

Gestalt therapy had a similar beginning and indeed Perls was known for being quite blunt when providing clients with interpersonal feedback. Perls' approach clearly placed the primary emphasis on technique whereby experiential exploration occurred through the use of the empty chair, to assist clients in achieving resolution of internal conflict, or by having clients enact various elements of a dream, as a form of dream interpretation (Goldfried & Davila, 2005). Solution-Focused Therapy also focused on techniques, principally those that revolved around a particular style of questioning, including solution building and miracle questions, to help clients paint a detailed picture of their desired state of life. With an emphasis on action and change this approach was originally developed to stimulate short-term relief efforts to help people in crisis situations (Watson, 2006).

It was this focus on technique that relegated the therapeutic relationship to the category of "non-specifics" (Goldfried & Davila, 2005). However, in more recent times, although the debate continues over whether various different forms of

psychotherapy differ and what the active ingredients of therapy are, the distinction between "specific" or "unique" and "non-specific" or "common" factors has gained increasing attention in psychotherapy research.

The primary reason for this increasing interest is no doubt stimulated by a number of studies and several major reviews and meta-analyses of the literature that found all forms of therapy were equally effective for most client problems (Ahn & Wampold, 2001; Robinson, Berman, & Neimeyer, 1990; Wampold, 2001; Wampold, et al., 1997; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). Some researchers have attempted to quantify and explain the distribution of variance in treatment effectiveness suggesting that upward of 45% was due to nontechnical relationship factors with 15% attributable to technical factors (Lambert, Shapiro, & Bergin, 1986). Later Lambert (1992) suggested that 40% of the variance in treatment was attributable to client/extratherapeutic factors, such as social and family support systems, and 30% to the therapeutic relationship, whilst Placebo/hope/expectancy and structure/model/technique were thought to contribute only 15% each.

A later meta-analytic study confirmed and extended these findings suggesting that as much as 50% of the variance in treatment effects were due to relationship factors and at most 8% attributable to the unique contributions of models (Wampold, 2001). Similar results have been reported in cross cultural studies, for instance a study that explored factors associated with effectiveness among Latinos in America and Latin America found that the alliance explained 45% of the variance in effectiveness (Bernal, Bonilla, Padilla-Cotto, & Perez-Prado, 1998).

Rogers's core conditions, of accurate empathy, congruence and unconditional positive regard, are among the "common" factors most frequently studied. Extensive reviews of studies (Traux & Mitchell, 1971, as cited in Kirschenbaum & Jourdan, 2005; Orlinsky & Howard, 1986) reported that a substantial number of findings indicated that these dimensions were consistently related to outcome and, furthermore, that these findings seemed to hold with a wide variety of clients, therapists, theoretical orientations and contexts (Kirschenbaum & Jourdan, 2005). Client's level of therapeutic process or depth was also found to

be dependent on the level of conditions offered by the therapist with lower empathy and positive regard resulting in a drop in client's depth of intrapersonal exploration and higher levels resulting in a rise (Truax & Carkhuff, 1965). Further exploration, however, found that self exploration of low-functioning clients was a significant function of the level of conditions offered by the therapist while high-functioning clients intrapersonal exploration continued independently of the level of conditions offered by the therapist (Holder, Carkhuff, & Berenson, 1967).

The therapeutic alliance

Despite the empirical support for Rogers's core conditions they were not seen as defining the relationship. Researchers believed that they provided only a partial representation of complex relationship factors and that an adequate representation would take into account that both the therapist and the client make important contributions to the formation of an effective therapeutic relationship (Horvath & Symonds, 1991). To this end other models have been proposed as providing a more satisfactory explanation of the common factors that account for therapeutic progress.

Among them is the therapeutic alliance model, which is believed to provide a more complete conceptualisation of the relationship factors in therapy. Originating in the psychoanalytic literature and expressly intended to apply to all kinds of helping relationships this concept was developed by Edward Bordin in 1979. Originally described as including three independent components including the bond between the client and therapist, the goals to be pursued and the tasks to be practiced (Bordin, 1979), the pantheoretical feature of Bordin's therapeutic alliance theory captured the interest of both theorists and researchers (Hatcher & Barends, 2006; Safran & Wallner, 1991). Whereas Rogers's core conditions were more specifically related to attitudes offered by the therapist, Bordin's conceptualisation emphasised the client's positive collaboration with the therapist.

Over time, different formulations of the positive relationship factor have emerged. Included among the many descriptions of the therapeutic alliance has

been therapist's engagement, such as active intervention and interest, therapist's *collaboration*, such as a mutual, negotiating stance, and *agreement on goals* and *emotional bond* (Kirschenbaum & Jourdan, 2005). These variations were particularly well illustrated in a meta-analytic review that described the number of different alliance measures that had been utilised in the different studies that were reviewed (Martin, Garske, & Davis, 2000). These divergent views led Lambert and colleagues (1994) to comment that "There is more disagreement about the therapeutic alliance construct than there was with the client-centered conditions" (p. 165).

These discrepancies may be further compounded by the inconsistent use of the different terms, for instance, alliance and bond or therapeutic alliance and working alliance are sometimes used interchangeably while others refer to them as separate constructs. For example, while both were seen as part of the collaboration, the therapeutic alliance has been described as encompassing the more affective aspects, which are oriented towards the therapist, and the working alliance as the more skilful aspects, which are directed towards the tasks of treatment (Gaston, 1990). A slightly different perspective saw the alliance as a compact between the therapist and client and the bond as extending beyond their roles and including certain personal qualities of the relationship that forms between them (Orlinsky, et al., 2004). From this position the bond comprises three closely related dimensions, namely the working alliance, mutual affirmation, and empathic resonance.

Emerging during the therapist and client interaction, the quality of the bond is seen as a reflection of these dimensions rather than of the participants themselves. These dimensions have been further defined, for instance, the *working alliance*, has been described in relation to the investment of both the therapist and client in their appropriate roles, such as the client's motivation, their willingness to assume the role of the one who is seeking help and the one who will bring concerns into the session as well as the therapist's genuineness and credibility (Saunders, Howard, & Orlinsky, 1989). An alternative definition of the bond is the trust, attachment and mutual liking between the client and the therapist (Raue, Castonguay, & Goldfield, 1993).

Despite the differences among the many conceptualisations of the alliance and the fact that theorists and practitioners have used various terms as synonyms to describe different aspects of the therapeutic alliance, such as *therapeutic alliance*, *working alliance*, *therapeutic bond*, and *helping alliance* (Horvath & Luborsky, 1993; Martin, et al., 2000), there seems to be general consensus on the central features. These are broadly defined in terms of three aspects that generally correspond to cognitive, behavioural and affective attitudes. These comprise the collaborative element of the therapeutic relationship and agreement on treatment goals and tasks, reflecting the cognitive and behavioural aspects of the relationship, and the therapeutic or emotional bond between therapist and client, encompassing the affective aspect of the relationship (Bordin, 1979; Gaston, 1990; Horvath & Greenberg, 1989; Horvath & Symonds, 1991; Martin, et al., 2000; Saunders, 2000; Saunders, et al., 1989).

In order to attain a good bond the therapeutic interaction must be characterised by reciprocal respect, therapist understanding and client comfort. Therapeutic tasks consist of those activities engaged in during the session, such as cognitive restructuring, interpretation and role playing. It is important that both client and therapist perceive the tasks as important in order to engender a high degree of agreement. Goals are the objectives or areas specifically targeted for change, such as reduced symptomology or improved interpersonal relationships. Clear goals that are perceived as important and attainable by the client and therapist result in a high degree of agreement (Raue, et al., 1993). These three aspects are interdependent to the extent that therapist and client agreement about therapeutic tasks and goals is mediated by the quality of the bond between them, which, in turn, is mediated by the degree of agreement about tasks and goals. Depending on the particular form of therapy the relevant goals and tasks may vary, nevertheless, the quality of the alliance is believed to be a critical mediator of outcome in all forms of therapy (Safran & Wallner, 1991).

Alliance research has covered an assortment of therapeutic treatments, a broad range of clients with a variety of presenting problems and characteristics and has employed a large number of instruments, that measure related, but not identical, dimensions. The range of treatment modalities considered includes psychodynamic and humanistic psychotherapy (Constantino, Castonguay, &

Schut, 2002) Gestalt therapy (Horvath & Greenberg, 1989), interpersonal therapy (Krupnick, Sotsky, Simmens, & Moyer, 1996), psychodynamic-interpersonal (Raue, Goldfried, & Barkham, 1997; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998), as well as more structured approaches, such as cognitive (Krupnick, et al., 1996; Raue, et al., 1993; Rector, Zuroff, & Segal, 1999; Salvio, Beutler, Wood, & Engle, 1992; Stiles, et al., 1998) and cognitive-behavioural psychotherapies (Castonguay, et al., 1996; Feeley, DeRubeis, & Gelfand, 1999; Klein, et al., 2003; Krupnick, et al., 1996; Raue, et al., 1997; Rector, et al., 1999). Studies employ a variety of therapeutic alliance instruments. These generally fall into three categories that assess the therapeutic relationship from the perspective of the therapist, the client or through clinical raters who use videotapes, audiotapes or therapy transcripts. Scales based on clients' or observers' assessments have been found to be better predictors of therapy outcome than therapist alliance measures (Chatoor & Krupnick, 2001) .

A study that explored nonstandard therapies in natural settings found significantly different levels of alliance in cognitive behavioural and psychodynamic sessions (Raue, et al., 1993). Although alliance scores were high for both orientations the cognitive behavioural group had higher scores than the psychodynamic interpersonal group. The authors suggested that this might be due to the differences in focus and structure between the two approaches with cognitive behavioural therapist being more symptom oriented and therefore providing more structure, making the therapeutic tasks and goals more explicit and clearer to the clients (Raue, et al., 1993)

This finding was contrary to that of an earlier study that reported comparable levels of therapeutic alliance in different types of therapy, including placebo and minimally supportive conditions (Salvio, et al., 1992). These findings were later supported by one of the largest empirical investigation conducted in the United States. This study compared levels of therapeutic alliance and their relationship to outcome of depression across two different therapeutic approaches, cognitive behavioural therapy and interpersonal therapy, as well as active and placebo pharmacotherapy conditions. Many therapists and patients were involved in the study and patients were randomly assigned to treatment groups. The results

showed a significant relationship between total alliance ratings and treatment outcomes across the theoretically and technically different psychotherapies and also across active and placebo pharmacotherapy conditions with more of the variance in outcome attributed to alliance than to treatment method (Blatt, Zuroff, Quinlan, & Pilkonis, 1996)

A more recent study involving the treatment of chronic depression with psychotherapy considered the possible effects of client characteristics. This study controlled for client variables, such as prior change, gender, social functioning, history of abuse, chronicity and co-morbid conditions and found that few were associated with change in depressive symptomatology over time and that alliance remained significantly associated with change in depressive symptoms (Klein, et al., 2003).

These findings are most consistent with the view that the therapeutic relationship is a common factor across modalities of treatment distinguishable from specific techniques. Research reviews and meta-analyses have consistently found a positive association between the therapeutic alliance and treatment outcome (e.g., Binder & Strupp, 1997; Constantino, et al., 2002; Gaston, 1990; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Krupnick, et al., 1996; Luborsky, 1995; Luborsky, et al., 2002; Martin, et al., 2000) and Orlinsky, Graw, and Parks (1994), in their comprehensive review of outcome research in psychotherapy, reported that "the strongest evidence linking process to outcome concerns the therapeutic bond or alliance, reflecting more than 1,000 process-outcome findings" (p. 360). All of this evidence has served to increase confidence and establish the alliance as a popular new explanation for effective therapeutic relationships (Kirschenbaum & Jourdan, 2005) and it has led some to assert that, regardless of psychological interventions, the client will experience the relationship as therapeutic in and of itself if a proper alliance is established (Martin, et al., 2000).

As a result, virtually all schools of therapy now accept the notion that the therapeutic relationship is important for significant progress to be achieved in the therapeutic endeavour. Contemporary psychoanalytic approaches have broadened to include more relational perspectives and both behaviour therapy

and gestalt therapy have acknowledged the importance of a good therapeutic relationship and incorporated it into their approach (Goldfried & Davila, 2005).

The importance of the therapeutic relationship is now becoming more widely acknowledged. In response to the growing movement towards empirically supported treatments, and in the face of thirty years of research that demonstrated that treatment approaches made little difference in comparison to the therapeutic relationship, the APA division of psychotherapy set up a panel that was charged with the task of summarising the scientific research on the therapeutic relationship (Norcross, 2001). First among the six main conclusions was that, independent of specific treatment type, the therapeutic relationship makes substantial and consistent contribution to therapeutic outcome. The therapeutic alliance, empathy, and goal consensus and collaboration were identified as the three aspects of the therapeutic relationship shown to be *demonstrably effective*. Whilst positive regard, congruence, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretations were aspects of the therapy relationship judged to be promising and probably effective across therapies (Kirschenbaum & Jourdan, 2005; Norcross, 2001).

Other bodies also support this view. For example, The National Institute for Mental Health in England (NIMHE) produced a report for the Department of Health, acknowledging that particular therapy models and techniques are not the crucial ingredients for effective therapy. "In general," it said, "brand names rarely predict outcomes and in direct comparisons most studies show a broad equivalence between therapies" (National Institute for Mental Health in England, 2004).

Empathy, unconditional positive regard and congruence

Carl Rogers (1957) hypothesised that 'significant positive personality change does not occur except in a relationship' (p. 96). Rogers and his associates' conceptualisation of the effective therapeutic relationship was based on the premise that it is the therapist's ability to be empathic and congruent and to

assume a stance of unconditional positive regard toward the client was all that was necessary and sufficient for the client's improvement.

Whether considered among the common factors of effective therapy or facilitative of the therapeutic alliance the value of empathy, unconditional positive regard, and congruence continue to be supported by the latest generation of psychotherapy process–outcome research. Virtually all schools of therapy now recognise that these variables are important for progress in psychotherapy and fundamental in the formation of the working alliance, for instance, Wampold (2001) argued that, “empathy and the formation of the working alliance are intricately and inextricably connected” (p.211).

Empathy

Ever since Carl Rogers identified empathy as one of the three therapeutic variables believed to be ‘necessary and sufficient’ for constructive personality change, there has been considerable interest in empathy as a curative factor in psychotherapy. Psychotherapists have attempted to operationally define empathy in order to recognise it in the counselling interaction and to teach counsellors how to empathise with clients. In the past, theorists usually conceptualised empathy as the therapist’s attitude or state of mind. Focusing primarily on the therapist’s process and ability to receive a cue from the client and generate an empathic message and communicate this to the client, who, in turn, would accept a properly empathic response (I. J. Miller, 1989). Rogers’s early work described empathy as a skill that could be taught (C. R. Rogers, 1951). Others, however, saw empathy not so much as a behaviour but as a far more complex process and employed descriptors such as “crossing over” (Buber, 1955, as cited in Davis, 1990), “happening” or a “shared moment of meaning” (Stein, 1970, as cited in Davis, 1990) in an attempt to capture the phenomenon. From this perspective, while skills can be developed to facilitate the occurrence of empathy, empathy is viewed as a process that eludes teaching.

Although in his later work Rogers conceded that empathy was not so much a skill as a way of being, he emphasised that empathy was a cognitive process that

occurred wilfully through careful listening and mirroring of words and feelings (Davis, 1990). Other schools of thought vary in their view of the nature of empathy, some seeing it as primarily an affective phenomenon, experiencing another persons emotions, others as primarily a cognitive construct, intellectually understanding another person's experience, a third holding that empathy contains both affective and cognitive components either or both of which might come into play depending on the situation (Duan & Hill, 1996; Duan, Rose, & Kraatz, 2002). As a result definitions of empathy are many and varied in depth and breadth. Traux and Carkhuff (1967) defined empathy as the therapist's ability to "be with the client, be understanding, or grasp the client's meaning" (p.25), whilst, Kohut's (1984) definition conforms to the way in which empathy is generally used and, though brief, manages to communicate the complexity of the empathiser's task in having "the capacity to think and feel oneself into the inner life of another person" (p.82).

While Rogers's hypothesis was that all of the conditions together needed to be present for positive changes to occur, studies have considered empathy separately for its effect on outcome. In a study that considered the role of empathy in the treatment of depression using Cognitive Behavioural Therapy, Burns and Nolen-Hoeksema (1992) found that clients of therapists who were most empathic improved significantly more than clients of therapists with a lower empathy rating. This was one of the first studies that controlled for other factors, including initial depression severity, indicating that the quality of therapeutic relationship has a substantial impact on clinical recovery even in the case of a highly technical form of therapy (Burns & Nolen-Hoeksema, 1992).

Reviews of empathy studies have supported the positive association between treatment outcome and empathy (Bohart, Elliott, Greenberg, Watson, & Norcross, 2002; Orlinsky, et al., 1994; Sexton & Whiston, 1994). The largest of these, which included 47 studies conducted between 1961 and 2000 involving 3,026 clients, found a weighted, unbiased effect size of .32. This is considered to be a meaningful correlation between empathy and positive therapeutic outcome in the context of psychotherapy outcome research (Bohart, et al., 2002).

The confusion of definitions and mechanisms of empathy has resulted in a variety of empathy measures. Perhaps this, together with the inherent difficulties associated with attempting to measure a dynamic relationship construct that involves understanding, experiencing and communicating, has resulted in inconsistent research results. Nevertheless, overall, research verifies that empathy plays an important role in positive client change (Duan, et al., 2002) and over time empathy has developed into a key concept that is seen as an essential feature in knowing and understanding another person and in understanding the workings of therapy (Duan & Hill, 1996). Other theorists, including psychoanalytic and cognitive therapists, now believe that the communication of empathy to the client is helpful (Duan & Hill, 1996; Goldfried & Davila, 2005; I. J. Miller, 1989).

Although rarely mentioned, the important feature of empathetic understanding, when considered as an essential curative factor in psychotherapy, is that it must be utilised in a way that validates, confirms and communicates acceptance of the client's experience (I. J. Miller, 1989). Roger's (1957) referred to this acceptance as "unconditional positive regard" and listed it as one of the necessary and sufficient conditions for positive change. Reviews that have considered treatment outcomes and positive regard have found similarly positive relationships (Farber & Lane, 2001; Orlinsky, et al., 1994).

Unconditional positive regard

Unconditional positive regard refers to the unconditional acceptance of the client, the ability to respect and value the client as a separate person with dignity, including a positive, non-judgemental caring and a willingness to accept each aspect of the client's experience as being a part of that client (C. R. Rogers, 1957). A variety of overlapping terms have been used to refer to this aspect of the therapist's attitude including, unconditional positive regard, positive regard, acceptance, warmth and non-possessive warmth (Farber & Lane, 2001).

One review grouped acceptance, positive regard and non-possessive warmth together under the category of therapist affirmations. In summarising the results

of 154 findings taken from 76 studies the authors found that 56% of the findings showed a statistically significant positive relationship between therapist affirmations and positive therapeutic outcomes. This figure rose to 65% if the findings were based on the client's perspective or sense of the therapist's positive regard (Orlinsky, et al., 1994). In most instances, a positive association between the therapist's positive regard and treatment outcome was more likely when rated by the client (Farber & Lane, 2001). An important aspect of Rogers's hypothesis was that clients must perceive the therapist's empathy, unconditional positive regard and congruence so that a true test of his hypothesis is only achieved when these core conditions are rated by clients (Kirschenbaum & Jourdan, 2005).

While the majority of studies that have considered therapists' 'affirmation' of clients show a positive correlation between affirmation and outcomes (Kirschenbaum & Jourdan, 2005) the variation in effect size has led to the suggestion that specific conditions influence the contribution of this factor to outcome (Orlinsky, et al., 1994). Teasing out the specific contribution of therapists regard is problematic in as much as more recent studies tend to substitute measures of the therapeutic alliance for measures of therapist positive regard. Furthermore, therapists vary in their ability to convey positive regard and therapists' level of positive regard is influenced by client characteristics. Clients needs and the extent to which they benefit from positive regard also varies (Farber & Lane, 2001). However, even those studies that have focused on the working alliance model found positive associations between therapist positive regard and outcome (Kirschenbaum & Jourdan, 2005). Overall positive regard is significantly associated with successful outcomes particularly when the client's perspective is considered and, like empathy, this factor is seen as an integral part of the therapeutic process in that it facilitates the therapeutic alliance.

Congruence

Genuineness, or congruence, is the therapist's ability to relate honestly and transparently with the client (Truax & Carkhuff, 1967). This requires that the therapist provide consistent messages, for instance between verbal and non-

verbal cues, so that what the therapist says, feels and implies, through expression and tone of voice, is congruent (Grafanaki & McLeod, 1995). This is critical for the establishment of trust and communication of empathy, which, in turn, encourages the client to be more open about their thoughts and feelings and enables the therapist to be more helpful (Hill, Thompson, Cogar, & Denman, 1993). Congruence also enhances the credibility and intensity of verbal messages (Graves & Robinson, 1976).

Whilst this core condition is the least clearly explained and research on congruence has been ambiguous (Kirschenbaum & Jourdan, 2005) studies have generally found that congruence is significantly related to outcome (Grafanaki & McLeod, 1995). Congruence has also been identified as an important component of helpful events in therapy (Grafanaki & McLeod, 1995). Clients' impressions and feelings towards the therapist are influenced by the consistency or inconsistency of the therapist cues. Research indicates that therapist inconsistent messages are associated with lower ratings of therapist genuineness (Graves & Robinson, 1976). This impacts the therapeutic interaction and relationship so that clients, who might interpret inconsistent messages as deceiving and dishonest, feel psychologically more distant from the therapist and less inclined to disclose (Graves & Robinson, 1976).

Attending to feelings and emotions

Emotions and feelings of clients are thought to be significant clinical phenomena and the discharge of emotion, or "catharsis", is believed to be an important part of the change process in psychotherapy. Therapeutic approaches differ somewhat in their focus on the client's feelings. While some, such as psychodynamic therapy, draw attention to and emphasise the client's feelings, others, for instance cognitive behavioural therapy, attempt to reduce or manage affect in order to reduce stress (Blagys & Hilsenroth, 2000).

Theorists believe that emotions are basic processes that contribute to our survival and that emotional experiencing occurs independently and prior to any higher level cognitive processing. Facilitating affective processes in

psychotherapy enables the client to access material that might otherwise remain implicit (Paulson & Worth, 2002). Research indicates that reduction in clinical symptoms is further improved if, in addition to emotional arousal, clients' emotional material is processed, or reprocessed, in a more reflective, controlled and differentiated manner (Missirlian, Toukmanian, Warwar, & Greenberg, 2005).

Emotions have also been linked to behaviour change through their influence on mental functioning, action and learning (Carter, 2003; Paulson & Worth, 2002). Through brain imaging studies, neuroscience has discovered that much of our learning and problem solving occurs using "implicit, non-conscious, emotion-driven brain systems" and that "therapy causes physical changes in the brain areas implicated in emotion" (Carter, 2003, p. 238).

A growing body of research suggests that our physical and psychological health is dependant upon the unencumbered experiencing of our emotions. Inhibiting emotions impairs immune function and increases stress, doubling the risk of disease (Coughlin Della Selva, 2006). As a result there is increasing awareness about the importance of attending to emotions and emotional processes during psychotherapy (Ehrenreich, Fairholme, Buzzella, Ellard, & Barlow, 2007) and current trends suggest that previously divergent views held by different therapeutic approaches about the role of emotions in psychological functioning and therapeutic process are beginning to converge (Mennin & Farach, 2007). The potential harm associated with the avoidance of internal processes and the importance of cultivating mindfulness and acceptance of internal experiences has more recently become a topic of interest to therapists. Emotion regulation and distress tolerance are among the essential components of mindfulness and acceptance based approaches, which include acceptance and commitment therapy and dialectical behaviour therapy.

Relational control and managing the interaction

There appears to be general agreement, within the field of counselling psychology that the therapeutic relationship plays a central role in the process of

fostering change (Castonguay, Constantino, & Holtforth, 2006; Horvath, 2005; Horvath & Symonds, 1991; Martin, et al., 2000; Meissner, 2006). Specifically what role it plays is neither clear nor uniformly agreed upon, although its effects on outcome are said to moderate the effects of interventions as well as directly mediate improvement. Historically, therapists have held a common view that therapeutic change occurs once a stable relationship with the client has been established.

Early research pointed to the effect of the facilitative conditions offered by the therapist, influencing the client's therapeutic process and depth of intrapersonal exploration, particularly in the case of low-functioning clients (Holder, et al., 1967; Truax & Carkhuff, 1965). The depth at which low-level functioning clients explore themselves is a function of the level of facilitative conditions, empathy, respect and genuineness, offered by high-level functioning counsellors. In contrast, the level of self-exploration was independent of facilitative conditions offered by high-level functioning counsellors for high-level functioning clients. Both low- and high-level functioning clients deteriorated in the degree to which they explored themselves with a low-level functioning counsellor (Holder, et al., 1967; Truax & Carkhuff, 1965)

The client's level of self-exploration has also been found to influence the level of conditions offered by the therapist. When clients lowered their depth of self-exploration high-level functioning counsellors increased their level of functioning, responding to the client as if this were a crisis. Low-level functioning counsellors, however, did not acknowledge the crisis and responded by decreasing their level of functioning (Alexik & Carkhuff, 1967; Carkhuff & Alexik, 1967). Low-level functioning counsellors were manipulated by the client's lowering of self-exploration and often failed to re-establish the levels of facilitative conditions, in some instances consistently lowering the level of conditions they offered even after the client resumed self exploration (Carkhuff & Alexik, 1967).

Further exploration of the effects of client level of self exploration on counsellor level of facilitative conditions supported these earlier findings indicating that a sudden decline in client self exploration had a significant effect on the level of facilitative conditions offered by the counsellor. The majority of counsellors

involved in this study were successfully manipulated by the clients lowering of self exploration, suggesting that the level of conditions offered are often determined by the client (Friel, Kratochvil, & Carkhuff, 1968).

Placebo, hope and expectancy

The term placebo refers to the benefits of any substance or intervention that is produced solely through the power of the mind, that is, through hope or expectation (Wampold, Imel, & Minami, 2007). A client's expectation of improvement has been identified as one of the most influential factors associated with counselling outcome (M J Lambert, 1992).

This class of therapeutic factors, then, refers to the clients own curative factors, the portion of improvement deriving from the client's knowledge of being treated, the credibility of the therapist's rationale and the hopeful expectations that accompany entering treatment (Sparks, et al., 2008). Howard et al (1986) found that between 10% and 18% of patients improved prior to the first session of therapy, possibly as a result of mobilisation of resources that entering therapy requires. The decision to seek treatment has been associated with significant symptom relief, implying concomitant expectations of improvement.

Expectancies and their influence on therapeutic process and outcome cut across various treatment approaches and, as such, have been considered by some to be one of the common factors associated with therapeutic outcome. After positive relationship and client factors, Lambert (1992) identified expectancy as the third most influential factor associated with outcome. His review of four decades of psychotherapy outcome research indicated that expectancy, together with placebo and placebo effects, accounted for approximately 15% of variance in therapy outcome. Others have suggested that it is more than this, arguing that therapy gains are contingent on client expectancies of improvement (Frank, 1968; Goldstein, 1962; Shapiro, 1981).

Research results have since pointed towards client expectations as a powerful predictor of therapy outcome across samples and treatments (Meyer, et al.,

2002). Clients' expectations of improvement have been found to predict the reduction of depressive symptoms and the probability of full recovery (Sotsky, et al., 1991), as well as predicting socially phobic clients' response to cognitive behaviour treatment (Safren, et al., 1997). According to goal theorists (e.g., Austin & Vancouver, 1996) positive expectancies predict persistent effort and negative expectancies result in abandonment of goals. Therefore, clients will engage in treatment constructively if they expect that the treatment will lead to the desired outcome. Studies have supported this theory, reporting that clients' pre-treatment expectations of therapeutic effectiveness predicted active engagement in therapy, which in turn resulted in greater relative improvement (Joyce & Piper, 1998; Meyer, et al., 2002).

Expectancy has been found to predict the quality of the therapeutic alliance as well as treatment response among clients with mixed diagnoses (Connolly Gibbons, et al., 2003 ; Joyce & Piper, 1998). Joyce and Piper (1998) reported that "expectancy accounted for 18% to 40% of the variation in alliance ratings" and "7% to 10% of the variation in outcome scores" (p.242). Other studies that have considered client expectancies, alliance and outcome have replicated these findings, suggesting that the effect of clients' treatment expectancies on outcome is mediated by alliance ratings so that expectancies predict alliances and alliances predict outcome (Meyer, et al., 2002).

Client variables

Recognising client variables highlights that every client is unique in terms of a myriad of conditions that they bring with them to psychotherapy. Many of these characteristics have the potential to influence the therapeutic venture as well as the responses and behaviours of the individual therapist (Clarkin & Levy, 2004). In as much as psychotherapy involves an interpersonal process between the therapist and the client, and as the link between the alliance and outcome has become more recognised, it would seem that the client's ability to engage with the therapist and contribute to the therapeutic alliance is essential to the success of therapy. Literature on client characteristics that contribute to the alliance, however, is fairly small, with few replicated findings (Constantino, et al., 2002).

In addition, the much larger literature on client variables predicting psychotherapy outcome has been notoriously inconsistent (Clarkin & Levy, 2004; Garfield, 1994).

Client variables are limitless and all of them inform the process and outcome of psychotherapy (Clarkin & Levy, 2004). Whilst some characteristics are innate, such as intelligence, and relatively stable, such as personality traits, others are more external, such as environmental conditions (Clarkin & Levy, 2004). Clients present with an array of disorders, for instance, depression, anxiety and drug dependency, with degrees of severity, such as co-morbidity, chronicity and history of abuse, and a variety of historical backgrounds, social supports and current stressors. In addition, motivation, capacity to engage and relate and ability to identify the problem are among other client variables that are seen as moderators or mediators of change (M J Lambert & Cattani-Thompson, 1996).

While isolating and understanding client variables and their effects has proven difficult it would seem that the client may be the single most potent contributor to therapy outcome (Sparks, et al., 2008). It has been estimated that between 40% (M J Lambert, 1992) and 87% of the variance in treatment is attributable to client/extratherapeutic factors (Wampold, 2001) and empirical research points towards the benefits of clients' active engagement in treatment showing that, regardless of treatment modality, clients who actively engaged in therapy were more likely to improve (Clarkin & Levy, 2004). Overall, it would seem that the client more often determines outcomes than the therapist. Nevertheless, therapists, too, bring their share of traits, such as sex, age, personality and race, and characteristics, such as values, attitudes and beliefs, as well as theoretical orientation, training, experience, skill and style (Beutler, et al., 2004).

Therapist contributions

In practice there is an assumption that some therapists facilitate larger positive effects than others as few practitioners refer clients indiscriminantly. A therapist's specific contribution to client outcomes has been an avenue of interest in therapy research for some time and indications are that therapist

effects vary considerably (M J Lambert & Ogles, 2004). Even in a comprehensive, well controlled study that used manuals and included a rigorous selection process, that only included those therapists approved by expert evaluators, relatively large variations among therapists were identified (Blatt, Sanislow, Zuroff, & Pilkonis, 1996). Characteristics of effective therapists were not related to the type of treatment provided or to the therapist's level of experience but rather to the therapist's psychological, rather than biological, orientation to the clinical process and their expectation that effective change would require more treatment sessions. Less effective therapists tended to more often combine therapy with medication (Blatt, Sanislow, et al., 1996). Other studies, however, have reported that the therapist contribution appeared not to be significant, although, as the authors noted, the low reliability and truncated scores of the therapist factor made it difficult to detect an effect (Krupnick, et al., 1996).

These inconsistencies seem to support those reported in an earlier meta-analysis. Of 15 studies that were included in the meta-analysis one study showed therapist effects accounting for 49% of the outcome variance while others showed no independent therapist effects (Crits-Christoph & Mintz, 1991). This led the authors of the study to suggest that 'studies in the literature with modest to large therapist effects may have drawn misleading conclusions on the basis of overly liberal tests of statistical significance. That is, the presence of therapist effects may have led to conclusions that treatments differ when in fact they do not' (Crits-Christoph & Mintz, 1991, p. 24).

A subset of therapist effects literature involves the comparative effectiveness of professionals and paraprofessionals. The aim of many of these studies was to ascertain the value of therapy beyond the contribution of a warm and caring human encounter. Studies have analysed the relationship between experience and outcome and training and outcome. While findings tend to be inconsistent the literature and correlational data provided by meta-analytic reviews find little evidence of a relationship between experience and outcome (Horvath, 2001; M J Lambert & Ogles, 2004). Similarly inconsistent are the results of studies that have considered training and outcome, although once again the general consensus has been that professional training makes little difference (Horvath, 2001; M J Lambert & Ogles, 2004). Few studies, however, have been specifically

designed to investigate the effects of experience and training on client outcome. In addition, questions have been raised regarding the internal, external and construct validity of these study designs therefore limiting the interpretations and generalisability of the reported findings (M J Lambert & Ogles, 2004). Nevertheless, overall results indicate that the important dimensions that appear to influence therapeutic outcomes are the qualities of the therapist (Blatt, Zuroff, et al., 1996; Burns & Nolen-Hoeksema, 1992; Horvath & Symonds, 1991; Krupnick, et al., 1996). Examples of this are apparent when considering that clients who had difficulty forming relationships developed stronger alliances with experienced therapists (Kivlighan, Patton, & Foote, 1998) and that one therapist could be very effective, despite providing only support and encouragement as a minimal therapeutic condition for patients receiving placebo (Blatt, Sanislow, et al., 1996). It would seem then that while questions remain about the effects of paraprofessionals, overall, research results appear to complement conclusions drawn about common factors.

Dose-response

Overall, the psychotherapy outcome literature points to a correlation between the number of therapy sessions received and the amount of client improvement (Orlinsky, et al., 1994; Orlinsky, et al., 2004) with greater gains associated with longer treatment (Callahan, 2004; *Consumer Reports*, 1995).

The dose-effect model of psychotherapy emerged from a meta-analytic study that included findings spanning 30 years and including 2,431 clients in individual therapy. This study utilised a probit analysis, determining the observed rates and resulting probability of a response for a particular dose. The studies included represented a diverse sample of clients, presenting problems, therapists, therapeutic orientations, treatment settings and outcome criteria. Indications were that 25% of clients were measurably improved after one session, 50% by the eighth session and 75% by the 26th session (Howard, et al., 1986). Further analysis suggested that depressed clients responded to lower doses of therapy, followed by those suffering anxiety, with borderline-psychotic clients requiring the highest dosage for response to treatment (Howard, et al., 1986).

In further investigating individual psychological symptoms and their response rates to increasing dosages of therapy, a later study reported that on average 58 sessions were required before 75% of clients showed clinically significant improvement (Kopta, Howard, Lowry, & Beutler, 1994). In addition, symptoms associated with particular dimensions were found to respond to treatment at different rates with 'acute' symptoms requiring 5 sessions, 'chronic' symptoms requiring 14 sessions and 'characterological' symptoms requiring 104 sessions for a 50% response rate. A possible explanation for these discrepant findings lies in the differences between measures of general improvement, employed in the former study, versus a return to normal functioning, employed in the latter study (Kopta, et al., 1994).

Differences in samples, instruments and measured outcomes perhaps explain the significantly different estimates reported in a further study that found that only 22% of clients were improved after eight sessions and that double this number of sessions was required before a 50% rate of recovery could be expected. This study utilised a standardised outcome instrument and strict criteria for judging clinically significant change as well as only including those clients who were initially categorised as dysfunctional (Kadera, Lambert, & Andrews, 1996). In addition, treatment outcome was measured on a session-by-session basis rather than on pre-post assessment. A later review of psychotherapy in its naturalistic setting more closely supported these findings reporting that between 15 and 19 sessions were typically required to observe a 50% rate of recovery (N. B. Hansen & Lambert, 2003).

Early improvement in psychotherapy has been highly associated with final outcome (Crits-Christoph, et al., 2001; Klein, et al., 2003). Early response was associated with remission of symptoms at termination and also with maintenance of treatment gains at two years (E. Haas, Hill, Lambert, & Morrell, 2002). The absence of any relapse suggests that these gains are not consistent with any form of placebo, however, what the active ingredients were, whether specific techniques or common factors, was unknown.

Perhaps not surprisingly though, given the associated research and literature support, the dose–response curve has also been found to exist in studies involving the therapeutic relationship. These studies report an association between early improvement in therapy and the therapeutic alliance (J. P. Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein, et al., 2003). In a study of outpatients receiving supportive-expressive therapy measures of the therapeutic alliance in the early phases of therapy, at sessions 2, 5, or 10, significantly predicted subsequent change in depressive symptoms, even after controlling for change in depressive symptoms prior to assessment of the alliance (J. P. Barber, et al., 2000). Klein et al.'s (2003) later study replicated and extended these findings utilising a larger sample, a different treatment approach and controlling for the effects of a number of client characteristics that could potentially confound the alliance–outcome relationship among other modifications.

While inconsistencies are apparent, indications are that, depending on client characteristics, presenting problem and symptom duration, anywhere between five and 104 psychotherapy sessions are required in order to achieve a 50% client improvement rate. In addition, it would seem that providing more treatment results in greater client improvement. Unfortunately, in routine practice the median number of sessions received by clients falls between four and ten (N. B. Hansen, Lambert, & Forman, 2002).

Duration and frequency

While there are many studies that consider the association between outcome and number of sessions, session duration and session frequency have received scant attention. In their review of studies conducted between 1993 and 2001 Orlinsky, Ronnestad and Willutzki (2004) identified only one study on session duration and five studies on session frequency. In an earlier review no studies were found on session duration while more, 14, were found on session frequency (Orlinsky, et al., 2004).

Over time, features of the psychotherapy treatment framework have moved through some significant changes. During his initial period of practice Freud had the time for extended sessions but as he became busier he standardised the therapeutic session to 50 minutes, allowing a 10 minute break for note taking, thus the 50 minute hour became the convention in the early days of psychoanalysis (Marmor, as cited in, Goleman, 1984) and has been traditionally used in psychoanalysis and psychotherapy ever since (Turner, Valtierra, Talken, Miller, & DeAnda, 1996). In some instances, and particularly where psychoanalysts are concerned, the duration of a session has been further reduced to 45 minutes (Goleman, 1984; Psychoanalytic treatment, 2006, June 10). It is perhaps not implausible to think that therapy sessions will become even less standardised, particularly with the provision for 20 to 50 minute sessions in the Australian Medicare funded mental health items.

When considering duration, weekly 30 minute sessions were found to be as effective as weekly 50 minute sessions using a brief therapy model (Turner, et al., 1996). Several factors limit the findings of this study, however, including the university student sample, consisting primarily of young white males and females, and the exclusion of more seriously disturbed students, so that only those seeking assistance for common, age-appropriate problems were included. In addition, it would be safe to assume that only those who felt that their problems could be addressed within a short session would have chosen to take part (Turner, et al., 1996).

The frequency of therapy sessions, originally six, hour-long sessions per week, also changed as demand grew. In general therapists now might offer between one and three sessions a week, depending on their orientation. The few studies that have explored session frequency have shed little light on the impact of frequency on outcome. Some have found only small and inconsistent differences between groups receiving less than one session per week, one session a week and more than one session per week (Kordy, von Rad, & Senf, 1988), whilst others have found a low but significant correlation between session frequency and specific symptomatic gain and session frequency and satisfaction with the treatment received (Freedman, Hoffenberg, Vorus, & Frosch, 1999).

Overall, it would seem that the 50 minute therapeutic hour and weekly sessions evolved more as a convenience for the therapist than as a response to scientific inquiry. While this is likely a fruitful area of therapeutic effectiveness inquiry, it seems likely that the growing demands and constraints of managed mental health care may exert a considerable influence on therapeutic practice.

Challenges to the therapeutic endeavour

Therapists must be fully engaged and able to maintain high levels of self, client, process and relational awareness and analysis. It is not surprising, given the multiple levels of context and the number and complexity of variables involved, that on occasion therapists get it wrong. Indications are that negative process is unavoidable in the course of treatment, regardless of theoretical approach, and that the preservation of a positive therapeutic relationship and positive treatment outcomes essentially relies on the therapist's ability to recognise and effectively manage negative process (Binder & Strupp, 1997).

Therapists, like others, often struggle with constructively dealing with interpersonal conflicts (Binder & Strupp, 1997). They also have varying capacities and abilities to recognise, respond to and successfully repair negative process. In fact, research indicates that even experienced therapists have difficulty recognising these cues (Safran, Muran, Samstag, & Stevens, 2001). Ruptures in the therapeutic relationship have the potential to impede the continued growth of the therapeutic relationship and may also lead to premature treatment termination (Binder & Strupp, 1997). Therapists' negative reactions to their clients, for instance, appearing disinterested, tense, bored, or judgemental, as well as therapist's misapplication of treatment techniques, including a lack of treatment frame and session structure, inflexibility, inappropriate use of silences, unsupportive confrontation and unyielding use of interpretation, tend to be precipitants of negative process and relationship ruptures (Ackerman & Hilsenroth, 2001). In this regard, ruptures in the therapeutic alliance may be the result of technical errors as well as the therapist's occasional inability to demonstrate minimally facilitative conditions, such as positive regard (Farber & Lane, 2001).

Clients' perceptions and the meanings they attach to other people's behaviours are likely to be organised around core cognitive structures, or generalised expectations, that are based on past experiences. Dysfunctional structures activate maladaptive cognitive-interpersonal cycles within which clients' expectations pilot particular behaviours that elicit predictable interpersonal consequences that, in turn, confirm their dysfunctional expectations. If therapists act in a fashion consistent with the clients dysfunctional interpersonal expectations they effectively perpetuate, and reinforce, an existing dysfunctional cognitive-interpersonal cycle (Safran, Crocker, McMain, & Murray, 1990). Overall, disconnecting experiences with counsellors and therapists reinforces clients' perceptions of isolation and despair (Paulson & Worth, 2002).

More overt signs of relationship ruptures might surface as disagreement about therapy tasks or goals or as a client's anger and hostility towards the therapist, while compliance and non-responsiveness to interventions might be more covert signs of rupture (Safran, et al., 1990). The therapist's ability to address the alliance rupture provides a unique opportunity to explore the feelings, beliefs and expectations that play a central role in the client's dysfunctional schema. A central mechanism of change in therapy is the therapist's intervention that acts to disconfirm the client's beliefs and the successful resolution of an alliance rupture can be one of the more potent means of inducing change (Safran, et al., 1990).

Commentary

The presence of a supportive therapeutic relationship as well as the ability to talk, tell our story openly and connect with our feelings and emotions seem to be the core ingredients of the therapeutic recipe. While these aspects might be the foundation, however, they bring with them a multitude of other ingredients, each of which interacts with and influences the other, adding their own special flavour and combining to create a unique blend. The client and the therapist each bring with them their own distinctive utensils, mixers and blenders that they endeavour to use together to effectively combine the ingredients in an attempt

to create a dish that is to the client's liking. The qualities of the final product, its wholeness and fit, are compared against clients' own personal measures of success. Clients' reports of improvement are coloured by their expectations and the extent to which therapeutic process and progress has met, or failed to meet, them (Goldstein, 1962). In this way, the final product cannot be described without the client and the therapist and the incomparable blend they create together.

This broad review of some of the factors involved in psychotherapy begins to paint the picture of the complexity of the process of change and the difficulties involved in discovering the key ingredients and measuring their effectiveness. A variety of elements play important roles that are in constant interaction and cannot be easily differentiated. Recognising and accepting this necessarily requires an embracing of a contextual framework. This includes a consideration of the physical and cultural context within which counselling practice is shaped (McLeod & Machin, 1998). For these reasons, Sparks et al (2008) admonish the continued use of the medical model as a map of the psychotherapy domain, arguing that it sends both research and practice in the wrong direction.

The continuing struggle to create this separation and establish the field of psychotherapy as an independent discipline is apparent in the continuing and growing disparity between our knowledge and practice within the field of psychotherapy and the external demands and political pressures bearing down on it. The knowledge of what makes therapy effective is in the hands of mental health professionals (Sparks, et al., 2008). Nearly 50 years of research clearly points to the defining role of therapeutic factors that are common to all therapies. A common factors framework informs the therapeutic endeavour one client at a time and is not a specific set of techniques or model but more closely resembles a metatheoretical framework (Sparks, et al., 2008). Practising therapists are coming to realise that no single approach holds all of the answers and, where in the past, practitioners tended to adhere to a single, pure theoretical approach, practitioners are increasingly becoming more eclectic, drawing on ideas and utilising techniques from different theoretical approaches (Lazarus, 2008). Shifting towards a more client-driven therapy, however, is in opposition to the current evidence based practice climate that assumes the

effectiveness of the specific ingredients of a given approach. When diagnosis and theory driven assessment and treatment continue to permeate policies and procedures:

"We may say then that psychotherapy is a good communication within and between men (sic). We may also turn that statement around and it will still be true. Good communication, within or between men (sic), is always therapeutic" (C. R. Rogers, 1961, p. 330).

Chapter 4

Telephone Counselling

The previous chapter considered some of the central elements relevant to face-to-face psychotherapy. In particular it highlighted the core ingredients of the therapeutic recipe, the defining role of common factors, the complex interactions of a variety of elements and the need to embrace a contextual framework. This chapter contextualises the growth and evolution of telephone counselling, provides a review of relevant research and literature and considers the challenges involved in measuring the effectiveness of generalist telephone crisis counselling services.

Telephone counselling

The use of the telephone as a means of providing mental health services is becoming increasingly popular (Beckner, Vella, Howard, & Mohr, 2007; L. J. Haas, Benedict, & Kobos, 1996; Reese, Conoley, & Brossart, 2002). Indeed, as far back as 1993, an attempt to quantify the use of a range of helplines operating in the UK produced an astonishing result, finding that a call was made to a helpline every seven seconds (Rosenfield, 1997). However, despite the growing utilisation of telephone counselling the factors that contribute to its effectiveness remain relatively unknown (Beckner, et al., 2007; Reese, et al., 2002).

Historically, telephone counselling services have been closely identified with suicide prevention, the roots of which can be traced back to the beginning of the twentieth century and the establishment of religious based and voluntary organisations (B. L. Mishara, et al., 2007a). The growth of telephone based counselling services, however, occurred in the late 50s and was first widely used

in the 1960s (Lester, 2002c), for instance the establishment of the Samaritans in England in 1953, of the Los Angeles Suicide Prevention Centre in 1958, and of Lifeline in Australia in 1963. This provided the main impetus for the crisis intervention movement which has rapidly grown and now plays an increasingly important role in servicing community mental health needs (Urbis Keys Young, 2002).

Many agencies, however, are no longer specifically orientated around suicide prevention having developed additional policies in an effort to cater for recurrent callers. Some focus on providing counselling for a range of problems, others on information giving whilst others focus on referral. Often they are established in response to a specific need and thus target a particular problem, for instance smoking cessation (e.g. Quit Line), or a particular client group, for instance young people (e.g. Kids Line). Other telephone counselling services, such as Lifeline's, offer a broader more generalist service available to everyone, which endeavours to handle a comprehensive range of issues. The majority of these services utilise non-professional volunteers as their primary staffing resource and have training programs that differ in approach and length. As a result, each develops a unique character that is a blend of the emergency response concept and the perceived needs of the community within which, or for whom, they are established (Brockopp, 2002a).

The growth of telephone counselling services was not based on empirical evidence but was often as a result of a perceived need and a widespread belief in their therapeutic and preventative value. In addition, the design and implementation of interventions that were adopted were frequently not theory informed but were usually based on a set of explicit or implicit assumptions about what was thought might work (Chen, 2005; A R. Hornblow, 1986; B. L. Mishara, et al., 2007a). The effectiveness of an intervention relies on assumptions about the causal processes through which the intervention is supposed to work (Chen, 2005). If the assumptions are invalid then the programs effectiveness will, at least, be reduced or, at worst, be harmful.

Telephone counselling services

There is no central database of telephone counselling services so there is no way to know the exact number, and nature, of programs in existence in Australia. There have been calls, however, for a comprehensive survey of telephone counselling services worldwide (Lester, 2002a). Attempts to create registers or directories of counselling lines indicate that there are a vast number of telephone counselling services, both public and private. The UK Directory of Helplines, originally established in 1996 by the Telephone Helplines Association (THA), currently lists some 1100 national, regional, local and international services. Over 500 helplines are members, including the Samaritans, and together these members handle over 22 million calls each year.

Helplines Australia, incorporated in 2002, provides a similar service to that of the THA and is the main source of information and consultancy in relation to the setting up and running of non-profit helplines in Australia. Membership provides a national listing of over 500 local, regional and national telephone and internet based services in Australia. While some of the services listed relate to mental health and social wellbeing there are a number of other categories that are oriented towards other health related aspects, such as chronic disease, and other concerns, for instance legal and accommodation. In 2002, a scoping of free or token cost telephone counselling services in Australia identified 155 services (Urbis Keys Young, 2002). A minority of these provide an Australia wide service while those operating across a single State or Territory make up the majority. Most of the telephone counselling services target a specific issue, 76.5%, or a particular audience, 75% (Urbis Keys Young, 2002).

The growing body of literature on telephone counselling, both descriptive and evaluative, reflects the increasing diversity of this discipline. For example, there are accounts of help lines for the suicidal (J. G. Barber, Blackman, Talbot, & Saebel, 2004), for children (Clark & Reid, 1998; King, Bambling, Reid, & Thomas, 2006), for marital problems (Hunt, 1993), for family therapy (Hines, 1994) and for parenting (Pierce, et al., 2008). There are also accounts of more specialised telephone counselling services that cater for problems such as alcohol

and drug dependence (McKay, et al., 2004), self harm (Evans, Morgan, & Hayward, 2000), eating disorders (Hugo, Sedgwick, Black, & Lacey, 1999), depression in multiple sclerosis patients (Mohr & Likosky, 2000), panic disorder with agoraphobia (Swinson, Fergus, Cox, & Wickwire, 1995), fear of driving (Wiederhold, Wiederhold, Jang, & Kim, 2000), depression (L. Miller & Weissman, 2002; Mohr, et al., 2005; Simon, et al., 2004) or medical conditions such as cancer (Sandgren & McCaul, 2003), coronary heart disease (Van Wormer, Boucher, Pronk, & Thoennes, 2004) and AIDS (World Health Organization, 2003a).

In addition, there is a large body of literature concerned with the practice of telephone counselling in general. For instance, research has been conducted to evaluate its effectiveness (Davies, 1982; A R Hornblow & Sloane, 1980; Reese, et al., 2002), analyse the skills required (Bobevski & Holgate, 1997; Bryant & Harvey, 2000; B. L. Mishara, et al., 2007b) and the phases of helping (Echterling & Hartsough, 1989; Young, 1989), explore the experience of callers and therapists (McLaren, 1992), survey clients perceptions (Reese, Conoley, & Brossart, 2006), as well as examine the role of the counselling alliance (Beckner, et al., 2007) and even considering the effects of the lunar phases (Wilson & Tobacyk, 1990). However, most of the telephone counselling services that are discussed in the literature have involved either problem or population focused treatments (Reese, et al., 2006). A recent study that considered the effectiveness of crisis telephone counselling for non suicidal callers (Kalafat, Gould, Munfakh, & Kleinman, 2007) is among the few that have taken a more inclusive approach.

Models of telephone counselling can be described as falling into one of two types of service, according to the longevity of the counselling intervention, namely crisis intervention or ongoing counselling. Examination of the service delivery focus suggests that these can be further delineated according to those that target a particular sub-population or a specific problem. Problem focus can be further defined as either health or mental health related. Help by telephone is also not limited to charitable organisations and the voluntary sector, there are now many commercial employee assistance programmes, staffed by private

health professionals, that generate revenue for the companies that run them (Rosenfield, 1997).

The next section will present an overview of crisis intervention, as a key model influencing telephone counselling practice.

Crisis intervention theory and practice

Crisis intervention does not fall under the rubric of traditional psychotherapy (Auerbach & Kilmann, 1977). Initially viewed more as an orientation than as a systematic body of theory and practice, crisis intervention procedures evolved from the 1944 studies of grieving, conducted by Erich Lindemann in the aftermath of a major night club fire, and from the 1947 military writings of Kardiner and Spiegel. Kardiner and Spiegel posited three basic principles of crisis work, immediacy, proximity and expectancy (Flannery & Everly, 2000). More integrated multifaceted approaches to crisis intervention have been proposed in recent times (Everly, Flannery, Eyer, & Mitchell, 2001). While there is no single model of crisis intervention, there is general agreement on the basic principles, goals and agents of change.

Unlike the usual practices of psychotherapy that anticipate a period of ongoing therapeutic intervention, crisis intervention is a short term action oriented model of intervention that utilises a problem solving approach (Roberts, 2002). Often prescribed as only a single intervention, crisis intervention can be defined as emergency psychological care. The presence of a specific, discernible stressful event seems to be the single most important variable in differentiating crisis from other maladaptive response states. However, since this is based on a subjective reaction to the experience, the individual's perception of the event as causing considerable distress and their inability to resolve the disruption through the use of usual coping mechanisms is also necessary (Roberts & Ottens, 2005). The clear implication of most models is that crisis intervention emphasises dealing with adequately functioning individuals who are responding with disabling levels of distress to discrete environmental stressors, as opposed to chronically

maladjusted individuals whose behaviour seems to stem from a chronic psychological or psychiatric disorder.

New theories are beginning to emerge that challenge traditional understandings of crisis phenomena. For example, indications are that the crisis phenomenon for individuals suffering severe long term psychiatric disorders is associated with exacerbating illness symptoms (Ball, Links, Strike, & Boydell, 2005). A recent study conducted by Ball (2005) reported that exacerbating illness symptoms, such as depression, anxiety and sleep disturbance, which brought about the onset of crises, usually occurred without a precipitant. This suggests that, even in the absence of a clear external precipitant, these individuals are prone to recurring crises. The key features of these crisis episodes were reported as participants feeling overwhelmed and lacking control (Ball, et al., 2005). This study highlighted two important aspects of the current limitations of our understandings of crisis. The first being that in traditional crisis theory illness symptoms are not implicit and the other being that participants in the study described numerous methods of resolving and preventing crises that diverge from traditional crisis theory.

Where crisis intervention is concerned the immediacy of the intervention is seen as a crucial component and the focus is on mitigating the acute signs and symptoms of distress. The aim is to stabilise the individual and mobilise their resources with a view to either restoring adaptive independent functioning or facilitating access to higher level care (Flannery & Everly, 2000). In addition to more traditional agents of change, such as catharsis, three factors have been proposed as important agents of change in crisis procedures (Flannery & Everly, 2000). These include ventilation, social support and adaptive coping. The ability to share the experience and its negative emotional impact is seen as an important step in recovery, for instance allowing the person to share their fears as well as understand the impact of the event. In addition, social support networks provide companionship, support and instrumental assistance. Adaptive coping, with an emphasis on information gathering, cognitive appraisal, reasonable expectations of performance and skill acquisition, is considered to be the third agent of change (Flannery & Everly, 2000).

In terms of goals, crisis intervention focuses on resolution of immediate problems and emotional conflicts, as opposed to restructuring of basic personality and can be defined as a short-term active therapy. Models of crisis intervention provide frameworks which guide practitioners' response as they strive to resolve clients' presenting problems in a minimum number of contacts (Roberts, 2002). These models are thought to be particularly important in aiding crisis workers, who may have limited clinical experience, to walk the fine line between being active and directive yet not take ownership of the problem away from the client (Roberts & Ottens, 2005).

Crisis is generally believed to be a temporary state brought on by the inability to cope with a particular situation utilising customary methods of coping. In general, the experience of crisis is marked by increased anxiety and confusion, which interferes with problem solving (Kalafat, 2002; Simington, Cargill, & Hill, 1996). People in crisis are thought to be upset by both the event as well as their inability to respond effectively (Kalafat, 2002). The understanding is that the person is generally more open to change and willing to accept help because they are in a highly vulnerable state. This provides an opportunity for growth as well as regression and a successful resolution of crisis reflects additional coping mechanisms and strategies as well as improved self-esteem or confidence associated with success (Kalafat, 2002).

Crisis line telephone counselling

Since the crisis state is not static and the person in crisis will either get better or get worse (Kalafat, 2002), the ability to reach out at any stage during the crisis process would seem to be particularly important. Telephone counselling offers both accessibility and immediacy. Crisis counselling is a term used to describe a wide range of telephone counselling services that usually operate 24 hours a day seven days a week. Trained personnel or volunteers, who assist anonymous callers, often staff these services. Callers may access the service only once or any number of times, however, treatment is not ongoing and callers generally speak to a different counsellor each time.

While it is not possible to list all of the crisis intervention telephone counselling services examples of some of these services and where they might fit within the categories mentioned above are provided in the following figure.

Figure 4.1. Categories of telephone crisis intervention services.

		Problem	
		Specific	Non-specific
Population	Specific	SuicideLine, Women Hurt by Abortion, Women’s Domestic Violence Crisis Service, Parent Line, Aidsline, The Green Card program	KHL, WIRE, Veterans Line, Men’s Referral Service, Bush Crisis Line & Support Service Gay and Lesbian Switchboard
	Non-specific	RelateLine, Grief Line Drug Information Service, Direct Line Cancer Helpline G-Line	Lifeline, CareRing The Samaritans

Some crisis counselling services target a specific group of people struggling with a particular problem. Both SuicideLine and Women’s Domestic Violence Crisis Service can be seen as fitting within this category. SuicideLine is available throughout Victoria and provides suicide prevention and crisis intervention counselling and support 24 hours a day, seven days a week. Staffed by professionals from an array of different health focused backgrounds, including psychologists, social workers and nurses, the service answers approximately 14,000 calls every year, about 5% of which are suicides in progress (SuicideLine, n.d.).

Problem and population specific crisis telephone counselling programs that are not suicide focused include The Green Card, offered to in-patients admitted to three general hospitals in Bristol, UK, that provides a 24 hour crisis telephone consultation program for managing deliberate self harm (Evans, et al., 2000). While the Women’s Domestic Violence Crisis service of Victoria fits within these parameters, providing 24 hour crisis support to women experiencing abuse in

their relationship, other services provide assistance for a broader range of issues. The Women's Information and Referral Exchange (WIRE) is an example of a service that targets a particular group and assists with information, support and referral for a range of problems, such as accommodation, women's health issues and domestic violence.

Services, such as Kids Help Line (KHL) and Veterans Line, are examples of other services that target particular sub-populations and assist with a range of presenting problems. First established in Brisbane in 1991 KHL has existed as a free national telephone counselling service in Australia since 1993. The service provides a 24 hour telephone and online counselling service specifically for young people aged between 5 and 25 years and responds to a wide range of issues. They field thousands of calls each year from children and young people. The service is staffed by professional, paid telephone counsellors and callers can choose to speak with either a male or female counsellor as well as arrange to call back and access the same counsellor if they wish (Kids Help Line, 2006). Like KHL, Veteran's Line is a crisis service operating 24 hours a day seven days a week throughout Australia. The service provides crisis counselling to veterans and their families.

In some instances, agencies focus more on a particular problem and provide assistance to the general population. Examples of services that fit into this category are G-Line, which provides counselling and referrals to individuals struggling with difficulties associated with problem gambling behaviour, DirectLine, which provides a counselling and information service to anyone concerned about alcohol and drugs, and RelateLine in the UK, that assists with problems associated with relationship difficulties. Helplines that focus more on health related problems could also be seen as fitting within this category, for instance the Cancer Helpline. First established in 1990, the Cancer Helpline is operated by the Cancer Council Victoria, in the state of Victoria, Australia. The major aim of the Helpline is to support people affected by cancer including those who have been diagnosed, their families and friends.

Finally, there are more generalist services that provide assistance for a range of problems to the general population, such as Lifeline and the Samaritans. These

services operate 24 hours a day, seven days a week, 365 days of the year. They have been in existence for many years and now have affiliated centres that operate in many countries around the world. Both services are staffed by counselling volunteers and provide a vast number of counselling hours every year.

Research and literature

Many services do not formally evaluate their service, however, descriptions of their service and informal analyses are often reported on websites or other written materials. For instance, they might report profiles of callers or other pertinent information. An example of this can be found in relation to the Bush Crisis Line, a 24-hour telephone counselling and debriefing service established in 1997 for rural and remote health professionals and their families. They report a profile of their database that illustrates the imbalance between the population and the level of service provided to 135 'discrete indigenous communities'. Practitioners working in these communities are reported as calling the Bush Crisis Line and expressing a level of distress summed up by a quote that equates the experience as worse than working in a 'war zone' (Ellis & Kelly, 2005).

Research and literature that has examined the array of different crisis line services have used various approaches and considered a number of dimensions. Among them are profiles of calls and callers, analyses of counsellor skills and abilities as well as attempts to measure effects. These components have been assessed with a number of different measures and from a number of different perspectives. In some instances, studies have considered a combination of these different aspects, for instance mapping trends in callers and exploring outcomes. The following section provides an outline of some of the research and literature relevant to crisis line counselling.

Measuring outcomes

Despite the broadening and diversification of services, crisis lines remain at the forefront of continuing efforts to prevent suicide. Early attempts to measure the impact of telephone counselling services on suicide rates were inconsistent with some finding measurable effects (Bagley, 1968) and others failing to find any difference in suicide rates between regions that had services and those that did not (Bridge, Potkin, Zung, & Soldo, 1977; Jennings, Barraclough, & Moss, 1978). A meta-analytic review reinforced the inconsistency of results and the overall lack of suicide centre effects on suicide rates (Dew, Bromet, Brent, & Greenhouse, 1987). Results of later studies proved to be equally inconsistent with one study (Leenaars & Lester, 1995) failing to replicate reported preventative effects found in an earlier study (Lester, 1993).

A more recent study conducted by Leenaars and Lester (2004) found a similarly weak preventive impact of suicide prevention centres on suicide rates when they replicated their earlier 1995 study. Overall, it would seem that finding significant associations between suicide prevention services and lower suicide rates continues to be a challenge. Arguably there are a number of reasons for this, including the nigh on impossible task of isolating the effects of suicide prevention activities from all other significant influences during the period in question (B. L. Mishara & Daigle, 1997).

Another way in which proximal outcomes have been assessed is through the silent monitoring of calls (B. L. Mishara & Daigle, 1997). A study that monitored 617 calls to two Canadian suicide centres reported proximal effects on depression and suicidal urgency in callers. In particular they found that having a more Rogerian nondirective approach, which included some directive components, was related to a significantly greater decrease in depression from the beginning to the end of a call and a greater likelihood of making a contract with the caller (B. L. Mishara & Daigle, 1997).

A more recent, and much larger study, that silently monitored and observed the nature of the help provided and caller reactions in 1,431 calls to 14 helplines,

reported similar findings. This study included help provided to all callers in crisis, including suicide related crises, and found that positive call outcomes, as observed by the end of calls, were more likely when the helper expressed empathy and respect for the caller (B. L. Mishara, et al., 2007b). Obvious limitations of these findings, as the authors identified, include the uncertainty that short-term effects are related to long term benefits (B. L. Mishara, et al., 2007b).

This question was answered to some extent by a study that employed the callers own ratings of mental state and suicidality (Gould, Kalafat, Munfakh, & Kleinman, 2007). This study assessed the immediate proximal effects of the crisis intervention, from the beginning of the call to the end of the call, as well as the duration of an effect and the impact of the telephone intervention on future suicidal behaviour and risk at 2 and 4 weeks. Significant decreases in intent to die, hopelessness and psychological pain were found during the course of the telephone session, however, while callers' hopelessness and psychological pain continued to lessen in the weeks following, the intensity of their intent to die did not diminish and a substantial proportion continued to express suicidal ideation (Gould, et al., 2007).

This finding seems to support an earlier study that surveyed outcomes of suicide callers to Lifeline aged between 15 and 25. At one week follow up, 51 of the 72 callers who took part indicated that they had taken additional action, mostly involving accessing professional help, and 43% reported that the problem they had called about had improved. Of the 39 participants who completed the full three months of the survey, self reports indicated that, 15 males had a clear trend towards improvement, two males had deteriorated and that females were more likely to report modest improvements or no change, with more reporting a resurgence of their distress. Overall, indications were that while the first week saw an initial drop in suicidal thoughts there was no subsequent movement and, of the 39 who remained involved for the full three months, thoughts of self-harm and suicide persisted for more than half of them (Turley, 2000). A similar finding was reported by Gould (2007) suggesting that, for many, crisis is not a discrete time limited event but more often reflects ongoing struggles with complex factors that precipitate and perpetuate the crisis cycle and experience.

Like recent crisis intervention studies, these findings may be identifying the need for telephone crisis intervention models to encompass multiple sessions. A meta-analysis of 11 studies, representing 2124 participants, that investigated the impact of individual crisis intervention with medical patients reported that, consistent with previous research, the results of the study provided clinical and statistical evidence that single session interventions are less effective than multiple sessions (Stapleton, Lating, Kirkhart, & Everly, 2006).

Few studies have considered the effectiveness of generalist telephone crisis services for non-suicidal callers (Kalafat, et al., 2007; Urbis Keys Young, 2002). However, some studies have considered proximal outcomes, as measured by changes in callers' state from the beginning to the end of a call, in relation to depression and anxiety. One study reported considerable improvements in self-reported anxiety and depression from the start to the end of a call (Urbis Keys Young, 2002). A later study evaluated both immediate outcomes, as measured by a self-report instrument administered by the telephone counsellor, and intermediate outcomes, as measured within three weeks of the call. Of the 1,617 crisis callers who were assessed during their call, 801 participated in the follow up assessment. Results indicated that callers' crisis states and hopelessness significantly decreased during the call and continued to do so in the weeks following (Kalafat, et al., 2007). However, nearly a quarter of the callers involved had re-contact with the centre for one or more calls. These callers were overall more distressed than those callers who did not re-contact the centre (Kalafat, et al., 2007).

A particular concern that emerged from this study, however, was that at follow up many callers, 12%, whom crisis service staff had coded as non-suicidal reported having suicidal thoughts either during or since their call to the centre (Kalafat, et al., 2007). This calls into question telephone counsellors' ability to accurately gauge callers' level of distress. A number of factors may be responsible for this, including telephone counsellor skills; however, conditions associated with crisis intervention telephone counselling is also likely to play a part, for instance, the lack of visual cues and ongoing relationship.

Efforts to evaluate services are often limited by these same factors, for instance the anonymity of callers, and studies attempt to ascertain effects via other means. One example of this is an evaluation of a telephone counselling service for marital problems, Relate Helpline. This study reported that the overall impression the researchers gained, through the sustained and concentrated reading of log-book entries, was that the telephone contact with a counsellor played an important part in helping many people who were in trouble (Hunt, 1993). Telephone counsellors, however, tended to feel limited in the help they were able to offer and reportedly found counselling via the telephone challenging, in particular because of the lack of visual cues (Hunt, 1993).

Another example is a study of the Green Card support system. This study reported that only a limited number of Green Card self harm management program participants chose to access the crisis telephone counselling service, and that males appeared more willing to utilise the service than females. While the study was mainly a description of how the service worked in practice there were reportedly some positive effects, measured by the number of services accessed, with the intervention group accessing fewer psychiatric and non-psychiatric services than the control group (Evans, et al., 2000).

Profiling calls

Perhaps because of the inherent difficulties associated with conducting research and evaluation studies, many studies focus on profiling the calls received by crisis line services. A study that mapped trends in suicide calls to Lifeline reported that females tended to seek help more than males, that relationship difficulties were the most significant precipitating factor, that many callers were assessed as being at either moderate or high risk of suicide or self-harm and that many were accessing other forms of professional help. In addition, over half of the callers had previously been in contact with Lifeline (Turley, 2000). A study that profiled calls to KHL revealed similar caller concerns. A retrospective analysis of suicide calls made to KHL identified that the single largest call category was related to relationship difficulties, particularly parent and family relationships (Clark & Reid, 1998).

Rather than focusing on suicide calls, other studies have broadened their scope and considered all calls received. A study that profiled all calls to Lifeline discovered a number of interesting aspects regarding caller characteristics and concerns. Amongst them was that caller concerns generally fall into four main areas including relationship issues, mental health, loneliness and suicide. Many callers were struggling with feeling isolated and alone and indications were that, for both genders, the critical time fell between 35 and 44 years of age, when a higher number call about loneliness, and that men experience loneliness far more intensely than women. Interestingly, a proportionately higher number of metropolitan callers call about loneliness while a proportionately higher number of rural callers call about other problems (Cartwright & Hughson, 2005). This is possibly as a result of 'suburban isolation' where opportunities for social relationships are reduced as a result of social and occupational mobility and looser family ties. Loneliness was also found to be closely related to mental health callers who showed weaker links in relationships and most often presented with concerns about loneliness (Lifeline, 2004a).

Mental health was found to feature in two ways, where mental health was the presenting issue and where mental health was background to the presenting issue. Depression, schizophrenia and anxiety were the most frequent presentations with more specific mental health issues related to behaviours such as problem drinking, drug misuse, trauma reactions and gambling. About 27% of counselling calls were known to be about mental health. This is generally believed to be a conservative estimate. Only 38.2% of callers with general mental health concerns reported that they were receiving treatment or counselling for their condition (Lifeline, 2002).

These facts point to the possibility that Lifeline may be the sole point of reference for mental health consultation for many individuals (Andrews, Slade, Naylor, & Kercher, 2003). This proposition is further supported by a pilot study that measured the level of non-specific psychological distress among callers who were not suicidal or critically distressed. The findings revealed that callers to Lifeline demonstrated levels of non-specific psychological distress, indicative of

likely anxiety or affective disorders, at 12 times the national rate (Andrews, et al., 2003).

Profiles of calls to other services, even those that target a specific subpopulation, appear to identify some idiosyncratic caller concerns yet also identify relationship difficulties as the most common problem. For instance, a nine-week survey of the pattern of calls to Veteran's Line revealed that major problems were related to domestic conflict, substance abuse, traumatic memories, depression and anger at government. Crisis intervention was required for 18% of calls due to suicide threats or threats to others and, while 32% of callers were identified as being in formal therapy at the time they called, the majority had no affiliation with other counselling services (Bryant, 1998).

Utilising a variety of simulated scripted calls, a later evaluation of Veteran's line counsellor skills found that most of the telephone counsellors displayed good ability to establish rapport, empathy and unconditional acceptance. However, on performance dimensions related to specific knowledge about veterans, including common psychopathology and ability to assess the level of risk that the caller represented to themselves or another, a significant number displayed inadequacy. This was despite receiving training in a range of veteran specific skills including typical crisis problems reported by veterans, veteran terminology and common veteran psychopathology (Bryant & Harvey, 2000). While assumptions are that relevant knowledge and understanding about callers and their presenting problems is essential, this study did not consider the relationship between these components and caller outcomes.

Where services specialise, for instance targeting a particular subpopulation or issue, relevant knowledge may be essential. A recent analysis of calls to the Cancer Helpline described the information and support needs of callers and the response of the service to these needs (Jefford, et al., 2005). An analysis of caller information spanning a six year period, identified that along with obtaining psychological and emotional support, callers wanted information about cancer including symptoms, diagnosis, treatment and management. The majority of callers were women, who were younger than the general cancer population and

most commonly enquiring about breast cancer. Information and emotional support were most frequently provided to callers (Jefford, et al., 2005).

Ongoing telephone counselling

Ongoing telephone counselling services operate in a similar way to face-to-face counselling except that the counsellor and client are unlikely to ever meet. Callers are provided with counselling on a continuing basis, are known to the counsellor and connect with the same counsellor on each occasion they call. Telephone counselling sessions are also usually arranged in advance.

There are a number of ongoing telephone counselling services available in Australia (Coman, Burrows, & Evans, 2001 119). Like crisis intervention services they tend to be either population or problem specific. A few examples of ongoing telephone counselling services and where they might fit in the provision of services have been provided in the following figure.

Figure 4.2. Categories of ongoing telephone counselling services.

		Problem	
		Specific	Inclusive
Population	Specific	Quitline Interpersonal therapy for women with breast cancer Cancer Care Lifeline	Bayside Openline Telelink Dutch Care Ltd Kids Help Line
	Inclusive	Eating Disorders Foundation Phone Counselling MS Connect Domestic Violence Helpline	Employee Assistance services

Examples of ongoing telephone counselling services that target a specific group of people struggling with a particular problem includes Lifeline’s Suicide Crisis

Support Program developed in order to offer short term telephone crisis support to people who are at risk of suicide. The aim of the program is to help callers stay safe, improve their coping skills and resilience and encourage them to establish links with other supports including professional, personal and community. Callers regularly engage with a specially selected and trained telephone counsellor volunteer who calls them over an agreed upon period of up to 8 weeks.

Quitlines, such as the Victorian Quitline service in Australia and the smoker's helpline, operated by the University of California, San Diego, are other examples of the application of ongoing telephone counselling aimed at a particular subpopulation with a specific problem. Ongoing telephone counselling services that assist with health related problems, such as cancer, might also be categorised in this way.

Examples of services that target specific populations but are not problem specific include the Bayside Oonline Telelink, based in Melbourne, which provides a group telephone link for an hour once a week to housebound elderly people, and the Bush Crisis Line & Support Service, which offers support to health professionals working in rural areas. The ability for callers to develop a long-term arrangement with a particular counsellor means that Kids Help Line may also be seen as fitting within this category.

There are also a number of other ongoing telephone counselling services that provide help to anyone struggling with a specific problem. Amongst these are the Domestic Violence Helpline, the Eating Disorders helpline and MS Connect. Ongoing telephone counselling services are not always available 24 hours a day, for instance both MS Connect and the Eating Disorders Helpline offer services during working hours only. Others, such as the Domestic Violence Helpline which is available 24 hours a day to both men and women who are troubled by violence, might be regional services that represent similar resources established in other areas.

Finally, there are those more generalist services that provide ongoing telephone counselling for a range of problems to the general population. Few of these

services exist, however, although they service particular organisations, employee assistance programs can be seen as fitting within this category.

Research and literature

Ongoing telephone counselling has been found to be helpful for a number of different concerns as well as a number of different client groups. Examples include those interventions that are orientated towards helping people deal with the effects of physical ailments, such as cancer, those that assist with the effects of psychological ailments, such as depression, as well as those that assist with the effects of social ailments, such as addiction.

Measuring outcomes

When compared with telephone crisis counselling services, evaluations of ongoing telephone counselling services appear to provide far more consistent results, perhaps because there are fewer barriers involved, for instance, callers are not anonymous, and measures of ongoing effects are easier to collect. An alternative explanation may be that the short-term benefits of crisis intervention are consolidated with ongoing telephone counselling. For instance, unlike the inconsistent outcomes associated with suicide crisis line intervention an evaluation of Lifeline's 8 week Suicide Crisis Support Program showed strong effects in the reduction of suicidal ideation, improved coping and increased resources over the course of the program. Callers also appeared to be better connected with professional and informal supports (Rickwood, 2008).

However, beneficial outcomes are most notably reported for those ongoing telephone counselling services that target specific problems and subpopulations. Studies into smoking cessation services provide a particularly good example of this. For instance, a comparative study conducted at the Smokers Helpline in San Diego, explored three treatment groups. One group received a self-help quit smoking kit sent in the mail, another received the self-help kit and a 50-minute pre-quit telephone counselling session and a third group received the self-help kit, the pre-quit counselling session and five post-quit counselling sessions with

the same counsellor. Results indicated that, while the single pre-quit session with the self-help kit significantly increased both the incidence and duration of quit attempts, the group that received all six telephone counselling sessions had the highest percentage of participants that remained free from smoking at 1 week, 1 month, 3 months, 6 months and 12 months (Zhu, et al., 1996).

The model incorporated three distinctive features including proactive counselling, a structured counselling protocol and relapse-sensitive scheduling, so that after the smoker made the first call counsellors initiated all subsequent calls, the counselling interaction was brief and focused and, in contrast to the traditional weekly sessions, sessions were scheduled according to the probability of relapse with calls decreasing in frequency following successful cessation (Zhu, et al., 1996). In contrast, other programmes whose call-back schedules were more fixed and arbitrary have not been as effective (Borland, Segan, Livingston, & Owen, 2001)

A recent randomised controlled trial of callers to the Victorian Quitline service in Australia compared untailed self-help materials; computer-generated tailored advice only, and computer-generated tailored advice plus call back telephone counselling, involving a series of calls the number and times of which were negotiated with the caller. Although the computer generated tailored advice did not enhance telephone counselling the telephone counselling condition had the greatest initial impact on cessation rates compared to the other conditions (Borland, Balmfors, Segan, Livingston, & Owen, 2003). These results supported the findings of an earlier study (Borland, et al., 2001) as well as the conclusions of a meta-analytical review of studies that investigated the effectiveness of smoking cessation telephone counselling reporting that proactive telephone counselling helped smokers quit (Stead, Perera, & Lancaster, 2006).

Ongoing telephone counselling has also been utilised in the treatment of cancer patients as a means of helping patients and their partners to better manage the psychological impact of diagnosis and treatment. First reports of telephone interpersonal psychotherapy with cancer patients and their partners reported direct positive effects on the psychosocial and physical well being of patients and indirect positive effects on their partners (Donnelly, et al., 2000). A later case

study of a telephone counselling intervention provided by an appropriately trained oncology nurse to a women with breast cancer and her partner, supported these findings reporting that the couple experienced substantial positive changes in emotional distress and in the nature of their relationship with each other and with their children (Badger, Segrin, Meek, Lopez, & Bonham, 2004).

Ongoing telephone counselling has also been found to be effective for specific mental health concerns. For instance studies have found evidence that ongoing telephone counselling is effective in the reduction of depression (Ludman, et al., 2007; L. Miller & Weissman, 2002; Mohr, et al., 2005; Mohr & Likosky, 2000; Simon, et al., 2004), and anxiety disorders (Swinson, et al., 1995) and as a treatment for eating disorders (Hugo, et al., 1999; Myers, Swan-Kremeier, Wonderlich, Lancaster, & Mitchell, 2004).

A recent randomised controlled study explored the effects of three treatment options for depression. These included usual care, usual care plus low-intensity medication monitoring and a telephone care management program, and usual care plus the medication monitoring and care management program integrated with a structured cognitive-behavioural therapy (CBT) program delivered by telephone. The CBT intervention included eight sessions followed by two to four booster sessions that were provided over the course of the following year. Initial sessions occurred weekly with intervals between sessions increasing. Depending on need booster sessions occurred every 8 weeks or more often (Simon, 2004). Initial findings indicated that the addition of the CBT program significantly improved satisfaction and short-term clinical outcomes (Simon, et al., 2004). A later report that compared the usual-care group to the telephone CBT group found that the benefits of the telephone psychotherapy program were sustained during the 12-month booster session phase of treatment and that clinical benefits endured in the 6 months after treatment was discontinued (Ludman, et al., 2007).

A study that considered a telephone counselling programme for clients with bulimia nervosa found similarly beneficial effects. The program consisted of 10 weekly telephone counselling sessions followed by a session at one month then

three monthly intervals for up to two years after the initial 10 weeks. The results of the study found a significant reduction in binge-eating, vomiting and laxative abuse (Hugo, et al., 1999). Another example of an ongoing telephone counselling service is a programme developed in Canada for clients diagnosed as suffering panic disorder with agoraphobia (Swinson, et al., 1995). This program comprised of eight scheduled, one hour, telephone counselling sessions conducted over a 10 week period. The intervention consisted of a behavioural treatment package based on self-directed *in vivo* exposure exercises. Counselling via telephone was found to be effective in reducing participants' phobic avoidance, fear and anxiety with gains maintained at the 3 month follow up and continuing improvement evident at the six month follow up (Swinson, et al., 1995).

A recent study of a 12 week continuing care program for substance dependent patients compared telephone-based monitoring and brief intervention with face-to-face interventions, including group therapy and individualised relapse prevention (McKay, et al., 2004). This study found that, over a 12 month period, abstinence-related outcomes did not differ between the treatment groups for the complete sample or on cocaine use outcomes in participants with cocaine dependence. However, where participants with alcohol dependence only were concerned the telephone intervention produced better alcohol use outcomes on all measures than group therapy and better outcomes than relapse prevention on some of the measures (McKay, et al., 2004).

Recent developments in telephone counselling include the increasing use of Employee Assistance Programmes (EAP's) that offer both helpline support and formal counselling via the telephone (Sanders & Rosenfield, 1998). For instance a leading managed behavioural health care company in the United States of America offered private companies, universities and state agencies a telephone counselling service as an adjunct to existing EAP's or as a stand alone mental health service (Manisses Communication Group Inc., 1994). Four organisations immediately took up the latter option including a university with a 20,000 strong student base. Other outsourcing companies offering telephone based EAP's followed suit and many large companies, including Bridgestone with an employee base of 22,000, took up the option (Rafter, 2004). No doubt much of the appeal is related to cost cutting with significant reductions in cost despite increased

uptake, however, according to Bridgestone, after switching to 'teletherapy' the percentage of people who got better increased markedly (Rafter, 2004).

An earlier study considered the effectiveness of telephone counselling in the context of an agency that provided free telephone counselling for the employees of three large Fortune 500 companies as well as other smaller, regional companies (Reese, et al., 2002). Over 2 million people across the United States, Canada, and parts of Mexico had access to the service. There was no limit to the number of sessions and clients prearranged telephone counselling sessions with the same counsellor. Telephone counsellors who were trained in the use of solution-focused therapy, had masters' degrees and were licensed to work in the field (Reese, et al., 2002).

In order to aid comparisons with face-to-face counselling this study utilised the same measures as those used in the Consumer Reports (1995) study. Results indicated that respondents were satisfied with their telephone counselling experience and believed that telephone counselling helped them improve their lives. Over 80% reported that the specific problem that led them to counselling had improved, however, both global improvement and specific improvement mean scores were slightly lower than the face-to-face counselling scores. Overall, when compared to face-to-face studies, the telephone counsellor was viewed as emotionally invested and there was no difference in the amount of therapeutic bonding or social influence. Nevertheless, a particular concern that surfaced was related to the effectiveness of telephone counselling for clients who reported functioning very poorly at the beginning of counselling. These clients reported significantly less improvement when compared to face-to-face counselling (Reese, et al., 2002).

The dose response curve, found by both Howard et al. (1986) and the Consumer report study (1995) in face-to-face counselling, was also evident in the case of ongoing telephone counselling with rate of improvement found to be a function of treatment (Reese, et al., 2002). Clients who used telephone counselling for a year or longer reported more improvement than those clients who spent less time in treatment (Reese, et al., 2002). Similar dose response effects have been

found for smoking cessation with more counselling calls increasing the chances of quitting (Stead, et al., 2006).

The therapeutic alliance

Early process evaluations of telephone crisis counselling focused on the conditions of empathy, warmth and genuineness offered by telephone counsellors. Moderate levels of these conditions, as rated by role plays and simulated calls, were found, as were increased levels associated with experience and training (Bleach & Claiborn, 1974; France, 1975). These studies, however, did not explore the relationship between these components and caller outcomes. Studies that did consider this relationship reported mixed findings. One study that interviewed callers five days after calling a crisis centre found that callers most frequently cited 'providing clear and accurate information' as the most helpful behaviour (Slaikeu & Willis, 1978), while another, that monitored calls, found that effective telephone crisis intervention was associated with warmth, empathic reflection and exploration (Delfin, 1978). Later studies, that interviewed callers immediately after their call, reported that callers more often cited empathic behaviour as most helpful (Young, 1987, 1989). However, another study, that considered the presence and timing of establishing a helping relationship, assessment of the crisis, affect integration and problem solving and their relationship to caller outcomes, reported that establishing a helping relationship was negatively related to successful crisis intervention outcome (Echterling & Hartsough, 1989).

In the latter study observers monitored helper responses throughout the call and findings indicated that higher levels of climate behaviours, which included sustaining telephone contact, establishing helper and caller roles and developing a helpful relationship, were related to less likelihood the helper could facilitate a resolution along affective and behavioural dimensions (Echterling & Hartsough, 1989). Few studies have supported this finding, however, with more recent studies suggesting that, like face-to-face counselling, the strength of the therapeutic alliance may play an important role in crisis telephone counselling (Kalafat, et al., 2007; B. L. Mishara, et al., 2007b; B. L. Mishara & Daigle, 1997;

Reese, et al., 2002). These studies report that the counselling relationship is associated with more successful telephone counselling outcomes and is a powerful predictor of positive outcomes.

A study that investigated two ongoing telephone administered therapies, a cognitive behavioural and supportive emotion focused therapy, and the relationship between the therapeutic alliance and both depression and multiple sclerosis supported this supposition. At the conclusion of the study, during which participants received weekly 50 minute sessions for 16 weeks, the therapeutic alliance was found to be related to outcome and, contrary to expectations, alliance scores were found to be significantly greater for those participants who received cognitive behavioural therapy (Beckner, et al., 2007).

These findings reflect both models of telephone counselling, crisis intervention and ongoing counselling, and suggest that the counselling relationship is an important component of the interaction even in the event of a single transaction. This is perhaps not surprising when the characteristics that define the telephone counselling interaction are considered. For instance, the absence of visual cues requires a more interactive approach and intensive listening and responding than would normally be the case in many types of therapies when the client and therapist are in the same room (Rosenfield, 1997).

Where the telephone interaction is concerned attention and concentration are narrowly focused on the person on the other end of the line, the caller and the counsellor become immersed in the interaction and there is a feeling of proximity in that there is a sense of the voice being inside the head and the two parties are literally mouth to mouth (Rosenfield, 1997). This has the potential to raise the intensity, and level of intimacy, so that the two people are drawn together very quickly (Rosenfield, 1997). Anecdotal evidence suggests that in many cases callers display much deeper emotions than might be the case when sitting in the same room with the counsellor, and that the release of emotions occurs at a much earlier stage in the telephone counselling relationship (Rosenfield, 1997). Another possible consequence of the available information being restricted solely to the auditory channel is that words and voice must compensate for the absence of nonverbal information and uncertainty of meaning is heightened (Fish,

Gumpert, & Fish, 1990). There is no opportunity for either the caller or the counsellor to evaluate or respond to the other's body language cues (Hines, 1994).

This lack of visual cues is an obvious difference between telephone counselling and face-to-face counselling and it seems that there are some concerns about this aspect of telephone counselling. Some suggest that it may significantly limit the therapist's ability to make sense of the client's experience as well as impacting the ability to maintain attentiveness (L. J. Haas, et al., 1996). Another disadvantage is that it reduces the ability of the counsellor to implement physical exercises, such as utilising a whiteboard or referring to an illustration or piece of text (Coman, et al., 2001).

Telephone counsellor skills, characteristics and conditions

Initial evaluations considered the effectiveness of hotlines as a mental health delivery system in terms of the adequacy of counselling and information provided to role players who presented typical problems to hotline workers. Counselling was defined as empathy, warmth and genuineness as measured by independent raters. Major differences were found between hotlines with one hotline performing better than all the others. Suggestions were that selection criteria and amount and type of training accounted for the difference while work experience was not related to effectiveness (Bleach & Claiborn, 1974).

The majority of telephone counselling crisis intervention services utilise nonprofessional volunteers as counsellors (Lester, 2002b; Urbis Keys Young, 2002). A national survey of three of the major crisis lines in Australia, Men's Line Australia, Care Ring and Lifeline, reported that three quarters of telephone counsellors surveyed were volunteers and that many were motivated to work in the field by a desire to develop counselling skills to support their career development and study (Urbis Keys Young, 2002). The telephone counsellor's ability to relate to the caller through their 'humanness' is thought to be particularly important and some have proposed that academic and professional training are a hindrance where this is concerned (Brockopp, 2002b).

Suggestions are that the problem solving type of relationship associated with a crisis intervention model is at odds with the more traditional therapeutic model that trains professionals to work with "sick" people. It is posited that this interferes with their ability to see the caller in terms of their strengths and reduces their ability to relate to the caller in a "real" way (Brockopp, 2002b).

Characteristics of telephone counsellors are generally perceived to be an integral part of positive outcomes (Urbis Keys Young, 2002). Most callers identify understanding and empathy, as well as a genuine, friendly, caring and non-judgemental attitude as important (Urbis Keys Young, 2002). While some of the studies already mentioned (e.g., (B. L. Mishara & Daigle, 1997) identify these as essential and necessary components, other studies have identified additional components of effective intervention (Bobevski & Holgate, 1997).

A study that explored the characteristic of relatively more versus less helpful telephone crisis counselling sessions, as perceived by a role playing actor caller, reported that counsellors who structured the session, were more verbally active, explored all of the aspects of the problem and addressed both practical and emotional concerns were perceived as more helpful (Bobevski & Holgate, 1997). More verbally active counsellors spoke briefly and often, making more use of complete statements and less use of minimal encourager responses, they also tended to respond quickly to statements so that there were no silences. In addition, they actively structured the interaction so that all of the components of the callers problem were addressed, attended to practical concerns as well as making more use of interpretations and providing more information and direct guidance (Bobevski & Holgate, 1997).

An earlier study, that employed a similar methodology utilising role playing actors, assessed telephone counsellors skills as well as their conceptualisation accuracy. Indications were that the telephone counsellor's ability to conceptualise callers' problems and needs played an important role in mediating counsellor behaviour and determining outcome (McLennan & Culkin, 1994). In other words telephone counsellors' ability to accurately conceptualise callers' problems and needs during the course of the interaction was related to their level of counselling performance. Telephone counsellors who demonstrated relatively

lower levels of counselling skills tended to seize upon the first piece of problem-related information, make early judgements of callers needs and did not incorporate into their understanding any emerging new information (McLennan & Culkin, 1994).

A later exploratory study conceptualised the telephone counselling interaction as fitting within a complex, dynamic, decision process framework and investigated its ability to predict the effectiveness of crisis line counsellors. The joint effects of a counsellor's level of motivated effort, anxiety, emotional involvement and expertise were found to predict the level of caller-rated counsellor effectiveness. Anxiety was found to have a negative impact, as were high levels of emotional involvement, possibly because they distract from the task and interfere with other counsellor resources such as memory. Counsellor levels of self reported motivated cognitive effort and the amount of actual experience counsellors had accrued determined caller rated counsellor effectiveness. The authors concluded that caller rated telephone crisis counsellor effectiveness was significantly related to specific motivational, emotional and cognitive counsellor state variables suggesting that a telephone counselling interview can be conceptualised as a complex, dynamic, decision process (Bobevski & McLennan, 1998).

Caller characteristics

Telephone crisis counselling caller profiles tend to be similar across the literature with the majority of callers being female and the most prominent presenting problems being loneliness, depression or conflict with others (J. G. Barber, et al., 2004; Cartwright & Hughson, 2005; Ingram, et al., 2008; Lifeline, 2004a). A large study that described over 300,000 crisis calls made to a large US national hotline over a 5-year period found that 21% of all crisis calls were mental health related, for instance depression, anxiety and loneliness (Ingram, et al., 2008).

The research literature identifies certain types of callers as causing telephone counsellors the most difficulty (Lester, 2002b). Among these are a particular group of callers who repeatedly call telephone crisis counselling services. The high percentage of repeat callers is another commonality amongst crisis lines.

'Chronic callers' are often thought not to be in crisis or a suicide risk and therefore run the risk of being identified as a nuisance (Brockopp, Lester, & Blum, 2002; Greer, 1976; Rosenfield, 1997). Brockopp, Lester and Blum (2002), however, found that chronic callers did not differ in any way from the one time caller either demographically, sociologically or in terms of presenting problem and suicide history or risk. What this means in relation to telephone counselling service policies, procedures and practices is uncertain and perhaps highlights the need to gain a better understanding of this population. Potential implications for services may include changes to policies and procedures, for example in the management of recurrent callers, and in the type of services provided.

References to the 'chronic caller' can be found in early literature on telephone counselling, identifying that the 'chronic caller' represented almost half of the callers to these services and pointing to the conflict that they engender in crisis intervention services (Greer, 1976). Service responses most often focused on agency management of these callers rather than on therapeutic treatment (Greer, 1976). This is perhaps because they were seen as not fitting within the 'primary prevention' auspices of the service. While many services have incorporated additional strategies in response to the 'chronic caller', it is unclear whether these are aimed at improving treatment or at improving management of these callers.

Recent surveys suggest that repeat callers continue to represent at least half of all calls to crisis lines (Ingram, et al., 2008; Urbis Keys Young, 2002). In addition, an increasing number of callers are identified as struggling with a range of mental health problems with repeat callers more often presenting with mental health concerns (Ingram, et al., 2008; Urbis Keys Young, 2002). Suggestions are that this is as a result of the growing number of health practitioners who use telephone counselling services as an adjunct support service (Urbis Keys Young, 2002).

Features of telephone counselling

Counselling via the telephone has both advantages and disadvantages. A distinct feature of telephone counselling is its ability to provide immediate support and assistance as and when required. This feature has been expanded further with the utilisation of mobile phones for *in vivo* exposure treatments, such as in the case of driving phobias. For driving phobics having difficulty making the transition from driving accompanied to driving alone knowing that the therapist was available via the mobile telephone, if required, was a useful resource (Wiederhold, et al., 2000). Often this knowledge alone was sufficient support to enable the client to make unaccompanied or longer trips (Flynn, Taylor, & Pollard, 1992).

Another feature of telephone counselling is its affordability and ease of access; enabling callers to call at any time from any place they have access to a telephone (Coman, et al., 2001; Lester, 2002b). Many people, including the elderly, people of low socioeconomic status, the physically disabled, those struggling with psychological disabilities and the geographically isolated who would otherwise be deprived of counselling services, are able to access counselling with the minimal of disruption to their lives (Coman, et al., 2001; Lester, 2002b).

Research points to convenience as a primary attraction for clients with 87% rating the ability to receive counselling at home and on the same day as important or very important (Reese, et al., 2006). Others have suggested that the ability to make contact without the need to visit a particular location may be a disadvantage of telephone counselling. Suggestions are that the need to travel to the therapist's office and have a defined, protected environment may help to substantiate the reality of the therapeutic relationship as well as enabling the client to identify the therapist's credentials (L. J. Haas, et al., 1996).

Anonymity is another feature and is thought to facilitate access to those who, for whatever reason, are reluctant to seek face-to-face counselling, for instance clients who live in small rural communities and are well known might prefer not

to access local services (Coman, et al., 2001). Anonymity is also believed to encourage greater self disclosure, minimising censure and the threat of possible hurt or ridicule associated with the counsellors reactions (Lester, 2002b). This may be particularly relevant in the case of those individuals who might struggle with feeling vulnerable or embarrassed (Fish, et al., 1990). Some have argued that anonymity also enables the caller's ability to fantasise about the counsellor and make of them what they need (Lester, 2002b). Whether anonymity can be maintained in the case of recurrent callers to the service has been questioned, however. In practice, anonymity might only be preserved in the instance that neither client nor therapist would be able to recognise each other in the street. The clinical wisdom of maintaining this aspect of anonymity has also been questioned (L. J. Haas, et al., 1996).

Research also points to the caller's sense of being in control and wanting to control the process of the session (Reese, et al., 2006). Not being seen by the therapist increased the client's perception of control as does being able to initiate and terminate the call (Fish, et al., 1990; Reese, et al., 2006). The ability to terminate the call at any time is believed to be an advantage of telephone counselling that provides the caller with the 'ultimate power' over the telephone counsellor (Lester, 2002b; Rosenfield, 1997).

Telephone counselling is also useful in providing support as an adjunct to face-to-face counselling, either prior to or between face-to-face counselling sessions (Flynn, et al., 1992; Swinson, et al., 1995). Clients who are resistant to attending face-to-face counselling may feel more comfortable accessing support by telephone, until such time as they feel ready (Swinson, et al., 1995), while those who experience difficulties or relapses between scheduled face-to-face counselling sessions may utilise telephone counselling as a support (Flynn, et al., 1992). When surveyed, crisis line telephone counsellors in Australia estimated that 18% of their calls were referred by health care professionals or health services (Urbis Keys Young, 2002).

Commentary

Telephone counselling services are becoming increasingly popular and diverse, incorporating both crisis intervention and ongoing telephone counselling services that respond to a variety of sub-populations and perceived community needs. Regardless of service type, the literature identifies telephone counselling as having four major strengths, including convenience, affordability, accessibility and control (Coman, et al., 2001; Reese, et al., 2002; Urbis Keys Young, 2002). In addition, apart from services that target a specific physical illness, caller profiles and the themes presented by the majority of callers are similar across the literature. For instance, females are more likely to call than their male counterparts and, regardless of whether they were in crisis or suicidal, callers' issues generally revolve around loneliness, depression and relationships (Brockopp, et al., 2002). Furthermore, despite the tendency for recurrent callers to be perceived as a nuisance or service managed, it appears that there is little difference between them and the one time caller. Instead, recurrent callers may simply be a reflection of the ongoing and complex nature of the crisis cycle and experience.

Despite the growing utilisation of telephone counselling services and their developing community health role providing some face validity to the value of these services, the factors that make telephone crisis counselling effective are still relatively unknown (Beckner, et al., 2007; Reese, et al., 2002). Much of the research that has considered crisis intervention services has focused on profiling calls. While these studies are essential and provide important information, more is needed if we are to gain a better understanding of telephone crisis counselling. This is particularly evident in the case of telephone crisis counselling services that endeavour to provide support to the general community for a wide range of issues. Even in the event that callers' crisis state appears to improve during the course of a telephone counselling session, research indicates that this may be short term and an important consideration is whether these short term effects are related to long term benefits (B. L. Mishara, et al., 2007b). Indications are that, even in the case of crisis intervention, programs should encompass multiple sessions (Stapleton, et al., 2006).

Like face-to-face counselling, the therapeutic relationship is considered to be an important component of the telephone counselling interaction, even in the event of a single session crisis intervention such as suicide. The therapeutic effects of the relationship, however, might be graded by the degree of connection. For instance, a recent study that compared outcomes between a single session of telephone counselling and a single session of online counselling provided by KHL suggested that telephone counselling was associated with better outcomes, higher session impact and stronger alliance (King, et al., 2006). Nevertheless, while the single session appears to reflect some of the benefits of the therapeutic relationship, the discrete effects of the interaction suggest that these benefits may only be short term. Ongoing telephone counselling, or a continued telephone counselling relationship, however, appears to yield more consistent and longer-term benefits.

Clearly, there are a number of complexities in trying to demonstrate the effectiveness of crisis line telephone counselling. There is a lack of understanding about the role that these services play within the health care system and the general community as well as what encompasses effectiveness and from which perspective, service, counsellor or caller. Relevant comparisons against which to measure the impact of telephone counselling are also inadequate. In addition, there is a general assumption that the crisis line interaction equates to what is generally understood to be face-to-face counselling, however, knowledge about how theoretical underpinnings of face-to-face counselling and its practices apply to telephone counselling is limited.

One of the central difficulties associated with evaluating outcomes for telephone counselling is in the operational definition of effectiveness. For certain circumscribed problems, such as smoking cessation, telephone counselling has been found to be effective (Zhu, et al., 1996). In this instance operationalising effectiveness is a relatively straightforward exercise since the outcome is easily recognised and measured. However, defining effectiveness for generalist telephone crisis counselling services is not so easily accomplished. Part of the difficulty is in defining the aims of the service, which are most often broad so as not to disqualify anyone, and in tracking the effects of the service when callers

expect anonymity (Leach & Christensen, 2006). Given the complexities involved, as well as the methodological and practical difficulties associated with conducting research in this field, it is perhaps not surprising that we have made little progress over the past few decades.

A further concern, and one that face-to-face counselling research has begun to consider, is the importance of exploring more than one perspective. Studies have pointed towards differences between the client's and counsellor's overall level of satisfaction in relation to the number of sessions, suggesting that they operate different criteria for success, different objectives for counselling, and different agendas (D. Rogers & McLeod, 1995). Later studies seem to add weight to this finding indicating some major discrepancies between lay and professional beliefs about the helpfulness of interventions for mental disorders (Caldwell & Jorm, 1998; Jorm, Korten, Jacomb, Rodgers, & Pollitt, 1997; Jorm, Korten, Jacomb, Rodgers, Pollitt, et al., 1997). This is an important consideration and further exploration of this issue in relation to crisis line counselling may lend itself to a broader understanding in this area.

As this review of the telephone counselling field illustrates, the proliferation of telephone counselling services has seen a growing diversity in specialisation and an array of studies that have focused on exploring different dimensions utilising a mixture of approaches, tools and measures. Overall, the vast majority of these studies have been narrowly focused and limited to specific populations or types of problems. Few studies have described therapeutic approaches that are utilised at generic telephone crisis counselling services (Ingram, et al., 2008).

As a result, little is understood about how various models of face-to-face counselling fit with the unique characteristic and qualities of a single session telephone counselling interaction or, indeed, whether these approaches are even appropriate for use. Furthermore, few studies have considered which components are perceived to be of most importance to the consumer. Consequently, there is no evidence base upon which to evaluate these services or to understand the processes, therapeutic or otherwise, that are critical to achieving effective outcomes. These gaps in the evidence base exist against a background of increasing demands for evidence based practice and limit the

capacity of telephone counselling services to fully understand and enhance their service. Gaining broader and deeper understandings of crisis line counselling is essential if we are to begin to understand the role that these types of services play within the broader context of a public health framework.

Chapter 5 Lifeline In Context

The previous chapter provided a review of the research and literature, contextualised the growth and evolution, and considered the challenges associated with measuring the effectiveness of generalist telephone crisis counselling services. This chapter presents general information about Lifeline and more specific detail pertaining to Lifeline Melbourne's daily operations. This enables a further contextualising of the environment within which this study was conducted. The data reported in this section, and not otherwise referenced, was drawn from the Lifeline Melbourne database and reflects calls, not callers, providing a guide to patterns of service utilisations and collective profiles rather than number of individuals accessing the service. This information begins to illustrate Lifeline's increasingly important role in the provision of community mental health.

Lifeline's History

Lifeline was first established in Sydney by The Reverend Dr Sir Alan Walker in response to what he perceived to be a community need for a free telephone service where the lonely and troubled could call in times of need (Lifeline, 2004a). Sir Alan Walker believed that a telephone service staffed by trained volunteers could offer a 'listening ear' and provide the caller with a place 'to be heard'. The idea of establishing a telephone counselling service came to him after an encounter he had with a distressed man who called him late one Saturday night to tell him that he had written him a letter outlining his intentions to suicide. Sir Alan arranged to meet with the man the following Tuesday, however, five minutes before the meeting he was advised by the police that the man had been found dead (Lifeline Australia, 2003).

Two years later, in March of 1963, Lifeline Sydney opened its phone lines with the first call received within a minute of opening. The centre operated out of the Methodist Central Mission and received over one hundred calls on its first day of operation (Lifeline, 2004a), suggesting that the Reverend's perception of this community need was accurate. Lifeline Adelaide was established only months after Lifeline Sydney opened its doors. Lifeline has continued to grow with 42 centres (Lifeline Australia, 2007) responding to in excess of 1200 calls a day now functioning across Australia (Lifeline Australia, 2008).

A feature article on the Lifeline service, in the international edition of the American based magazine 'Time' in January 1964, sparked much interest across the world and centres began to emerge in other cities. The first International Convention was held in Sydney in 1966 and Lifeline International was established shortly after in an effort to aid the establishment of other centres and to provide practice standards (Lifeline International, 2006). Lifeline centres continue to be established throughout the world with reports indicating that more than 300 centres are in operation in 19 countries (Lifeline Australia, 2008). While all Lifeline centres around the world adhere to the same standards, they often choose different names, for instance in the United States of America the service is called 'CONTACT' and in Canada 'Telecare' (Lifeline International, 2006).

The Australian organisation is self-funded and managed by a National Board based in Canberra. Lifeline Australia is the peak body responsible for the accreditation of individual centres and for the provision of the policies and guidelines that are reflected in the management of each centre. Individual centres are embedded within their local community where the primary function is to provide free telephone counselling and information via a national telephone number (Lifeline, 2004b).

Lifeline articulates its mission as a strategy 'to alleviate distress and optimise coping through its telephone counselling service'. Two key premises underpinning Lifeline practices are that its counselling service should be *generalist* and *accessible*. Their mission and determination to 'place services that support living and wellbeing within the reach of everyone' in Australia (Lifeline Australia, 2004, p. 11) is one reason why Lifeline has remained a counselling

service provided by telephone. This means that as long as a person has access to a telephone they are able to call for help at any time. This is particularly important for those who would not otherwise be able to access support, such as those who are housebound or living in communities that are underserved. The Lifeline telephone counselling service is also not restricted to people struggling with a particular problem or to a specific sub-population, so that anyone struggling with any problem is able to call.

While telephone counselling is 'the front line', many Lifeline centres offer additional services, such as face-to-face counselling for a variety of issues including family and financial problems, trauma and suicide, and bereavement as well as offering aged care support and education and support groups (Lifeline Australia, 2005). Many of the clients of these services are people referred from the main Lifeline telephone counselling service. Up until June of 2005 Lifeline Melbourne also serviced the suicide helpline, although this was staffed separately from the crisis line. This service is now operated by another organisation. Nevertheless, Lifeline Melbourne continues to receive and respond to calls from suicidal individuals.

Lifeline continues to view suicide prevention as a strategic priority and an integral component of their service and, as an extension of their normal telephone counselling service, they incorporate a variety of initiatives aimed at enhancing the suicide prevention capabilities of Lifeline Centres (Lifeline Australia, 2008). For instance, a number of centres throughout Australia offer a suicide prevention 'buddy' program. This is a call back service that offers short-term support to people over the age of 18 who have attempted suicide. Callers are referred through the normal telephone counselling service and, if assessed as suitable, assigned a volunteer counsellor for up to eight weeks. This volunteer makes regular phone contact with the individual with the aim of keeping them safe and encouraging the person to seek long-term support elsewhere. These supplementary services are funded in a variety of ways, for instance, the suicide prevention 'buddy' program is funded by the Commonwealth Department of Health and Ageing (Lifeline Australia, 2005). Other programs, such as the Seniors Enquiry Line and the Elder Abuse Prevention Unit in Brisbane, are

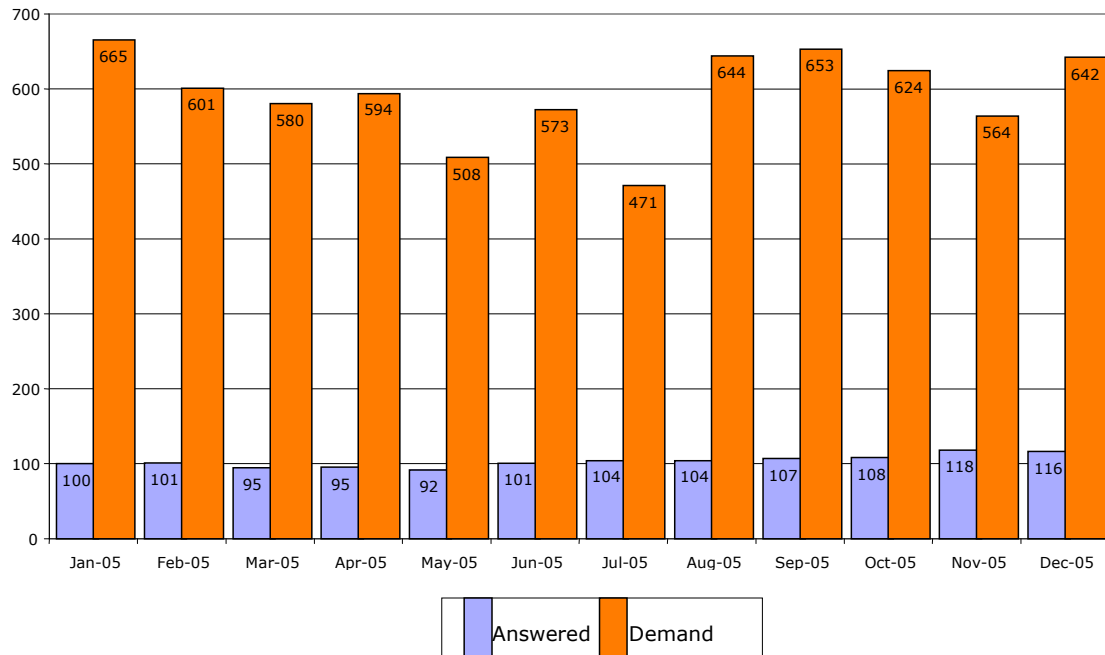
competitively tendered for and fully funded by government (Urbis Keys Young, 2002).

Lifeline Melbourne

Despite the demand for the Lifeline service in Sydney, and pressure from Sir Alan Walker, Melbourne was reluctant to follow in Sydney's footsteps because a similar service already existed. The Personal Emergency Service had been partly instigated by another Methodist minister, Rev C Irving Benson, and was supported by the Mental Health Authority. Like Lifeline, volunteer telephone counsellors staffed this service and leading Methodist church members were amongst its most prominent supporters. However, Benson's successor, Rev Arthur Preston, believed that many people would never use The Personal Emergency Service because of its mental health auspice. With the help of another Baptist minister, Brian Allen, who had been trained in counselling, he approached Melbourne Rotary for funding. Rotary funded a preliminary feasibility study and provided a further twelve months of funding to establish the service. Finally, in April of 1971, after intense lobbying of the Managing Committee of the Victorian Methodist Mission, Lifeline Melbourne opened for business (R. Howe & Swain, 1993).

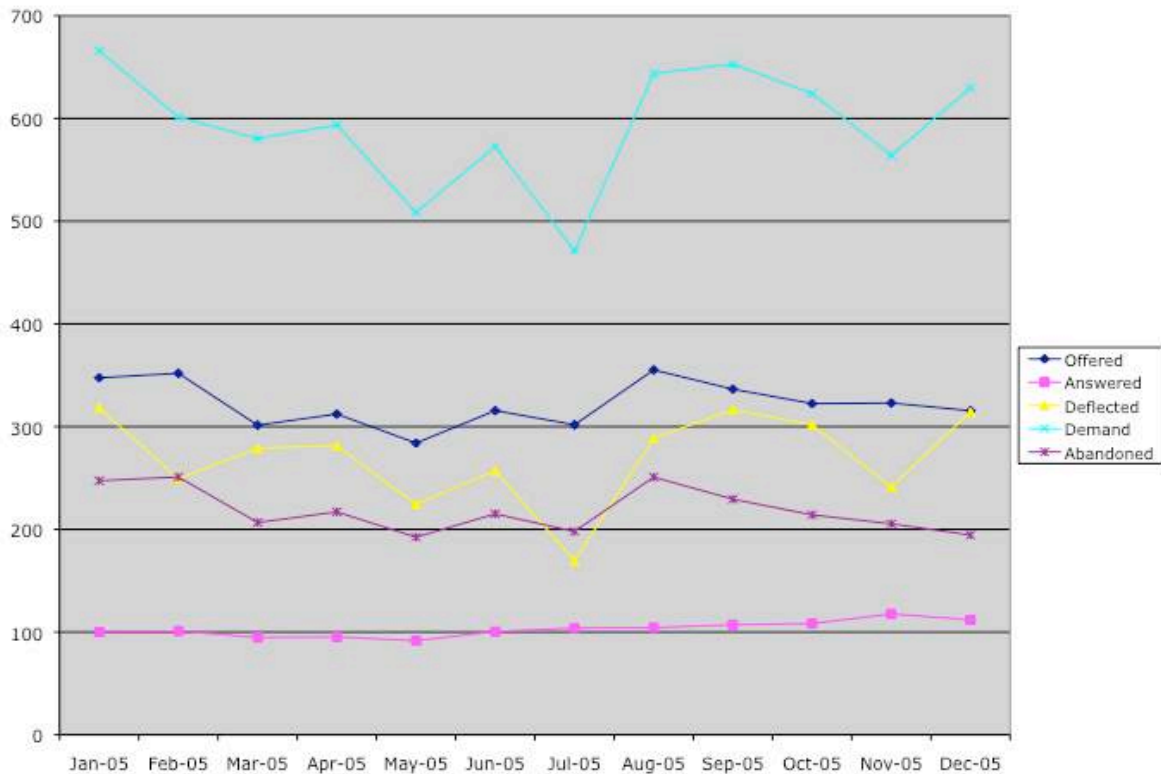
In the first twelve months of operation, Lifeline Melbourne received 14,000 telephone calls. This rate continued to rise and after 10 years appeared to reach a ceiling of around 35,000 calls a year. Statistical records indicate that in the year ending December 2005, Lifeline Melbourne successfully responded to over 37,000 calls. However, this response does not accurately represent the demand for the service with many more callers being unsuccessful in their attempts to get through. Figures provided by Lifeline Melbourne indicated that, on average, only 18% of calls made to Lifeline Melbourne in 2005 were answered, leaving 82% of calls unanswered. This represents a figure of over 216,000 calls. The graph below clearly illustrates the degree to which community demand outstrips Lifeline's resources. This perhaps reflects community need and the widening treatment gap.

Figure 5.1. Daily call averages by month: Demand vs. Answered: Lifeline Melbourne, 2005.



An alternative explanation may reside with callers repeated attempts to get through. While the following chart provides some breakdown of how the system manages the overflow of calls it is difficult to know exactly how many of these are generated by frustrated callers who continue to redial until such time as they are successfully connected to a counsellor. Anecdotal evidence indicates that a small increase in queue spots is reflected by a much greater reduction in the number of calls 'deflected', suggesting that many of the unanswered calls are callers repeated attempts to get through. Prior to the queue system coming into place only ten to 12 percent of calls were answered, however, with the advent of only one or two spots on the queue the percentage of calls answered increased to around 20 percent (Althorpe, 2007). Analysis of Lifeline Melbourne's database records reveals the daily call average by month and how these are managed by the system.

Figure 5.2. System managed daily call average by month: Lifeline, Melbourne, 2005.



The above chart reflects that, on average, in 2005 Lifeline Melbourne answered around 100 calls per day. The calls 'offered' and calls 'deflected' are combined to reflect the total 'demand'. Calls 'offered' are those that go into a queue and are either 'answered' by a counsellor or 'abandoned' by the caller. Calls that register as 'deflected' are those that do not get through to either a counsellor or the queue so that the caller hears an engaged signal.

Lifeline Melbourne's telephone counselling service operates 24 hours a day, seven days a week with the majority of the calls, at least two-thirds according to statistical data, received outside of normal business hours (i.e. 9am – 5pm, weekdays) and during the weekends. Staffing levels are substantially reduced overnight so that these figures are most likely an illustration of frustrated callers' continued efforts to get through combined with other factors, such as, other services and social supports being less accessible, and callers' inability to call during work hours.

Lifeline's crisis counselling line is mostly staffed by volunteers and at any one time they have almost 4000 volunteers working as telephone counsellors Australia-wide, with approximately 2,500 volunteers trained to be telephone counsellors each year. For Lifeline Melbourne, this translates to almost 500 volunteers with 170 new volunteers trained each year.

Volunteer telephone counsellors are provided with training to ensure they have basic counselling skills such as reflective listening, assertiveness, crisis management and referral. In Melbourne, the training program is undertaken over the course of several months and consists of 75 hours of basic counselling skills classroom training followed by 15 hours of workshops. Telephone counsellors then undertake a further accreditation period, of approximately 40 hours, of practical telephone counselling and group supervision. They are also required to engage in ongoing skill development and supervision on a regular basis.

Caller profiles

Recurrent callers

Despite the lack of an ongoing therapeutic relationship, Lifeline Melbourne statistics indicated that in 2005 the majority of callers to Lifeline Melbourne were recurrent callers with just over 8% representing first time callers. In addition, an earlier report indicated that 65% of callers to Lifeline had utilised the service for more than a year (Lifeline, 2002). Recurrent callers are characterised as those people who call the service several times a month, daily or more often. They are also more likely to fit within the 'chronic presentation' category and present with issues relating to mental health and loneliness (Lifeline, 2005).

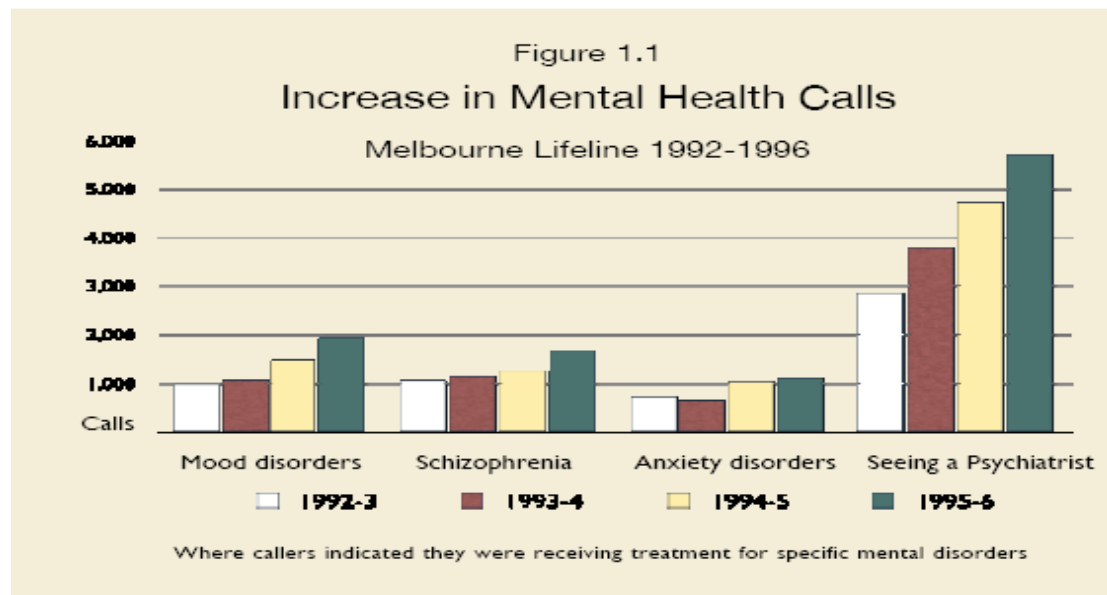
While a similar split in clientele might be seen in face-to-face counselling practices, where utilisation is concerned the two practices differ in a major way. In the case of face-to-face counselling practice, client appointments are usually spaced out and, except perhaps in the case of long term psychoanalysis, clients rarely attend more than once weekly, however, many of the callers to Lifeline

reported that they called Lifeline regularly with about 10% saying that they called practically daily or more than daily. In addition, unlike face-to-face counselling practice where session duration is usually pre-arranged, telephone counselling session duration is unspecified.

Mental health profiles

As a generalist telephone counselling service Lifeline is available to callers with a wide range of needs and presenting problems. According to Lifeline Australia (2002), since they were first established there has been a significant shift in their caller profile with an increasing number of callers struggling with serious mental health issues. This trend was particularly well illustrated by research conducted by Lifeline Melbourne over a four year period during the 1990s that showed that, within the context of an 8% increase in all calls, there was a corresponding 102% increase in calls from people seeing a psychiatrist. This indicates a dramatic increase in the proportion of calls known to be about mental health issues (Lifeline, 2002). A copy of this chart can be seen below.

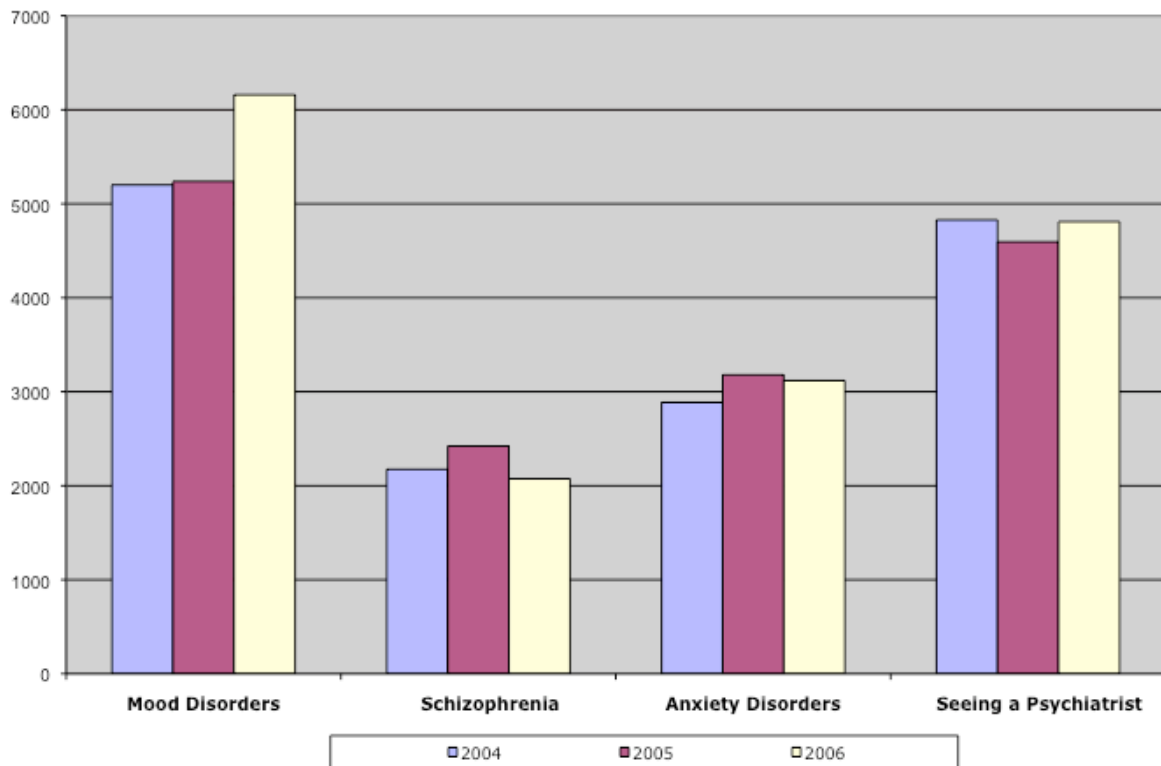
Figure 5.3. Increase in mental health calls: Lifeline, Melbourne 1992-1996.



(Lifeline, 2002)

In order to assess any shifts in this trend this study undertook an analysis of more recent data. The chart below reflects the continued growth in the number of callers identifying as receiving treatment for specific mental disorders.

Figure 5.4. Increase in mental health calls: Lifeline, Melbourne 2004-2006.



Where callers indicated they were receiving treatment for specific mental disorders

These figures do not take into account those who are not receiving treatment or those who have not yet been formally diagnosed. It is interesting to note that, while increases can be seen across the board and particularly where mood disorders are concerned, the number of callers identifying as seeing a psychiatrist has remained relatively stable.

Although telephone counsellors do not conduct clinical assessments they are trained to listen for presenting mental health themes and will record these as subjective assessments, if they determine they are present. In order to assist counsellors in their assessment they are asked to consider whether the

presenting mental health theme has been stable and affecting the caller for at least two weeks. The information collected by Lifeline Melbourne in this manner demonstrated that in 2005 approximately one third of callers were assessed as having a mental health issue.

There are inherent difficulties associated with the telephone counsellors gathering reliable data in the context where anonymity is seen to play a significant part, where there is an absence of visual and behavioural cues and when the duration of a call is often limited. Callers may also be reluctant to share information about their mental health status or may only discuss the problems that are precipitated or complicated by their mental health condition, for instance callers with a personality disorder might discuss issues relating to relationship crises or work difficulties (Lifeline, 2002). Furthermore, observations and inquiries suggested that while telephone counsellors try to gather information the caller voluntarily offers about their mental health status, they generally do not actively seek this information. As a result counsellors often choose not to record any information at all or might make a considered assessment.

Preliminary data familiarisation and checking of data reliability

During the early stages of the study, information and data held within the Lifeline Melbourne database was explored and analysed. As a preliminary familiarisation exercise, and in order to check the reliability of the information collected by the telephone counsellors at Lifeline Melbourne, additional information was collected about current counselling practice.

Lifeline Melbourne, like the majority of Lifeline centres, uses a custom designed software package that allows the counsellors to enter the details of their calls directly into a computer database. Where this technology is not available centres still use the old system that requires counsellors completing written forms that are then manually entered into the national system by administrative staff. As part of this study, during a one-week period in March 2006, an additional section, the completion of which was a mandatory requirement for all counsellors, was written into the computer 'Call Record' and counsellors were

instructed to actively collect the information from callers. In cases where they were unable to reliably do this, counsellors were asked to record 'unknown' or 'not asked' rather than make a subjective assessment. The following is an example of this section on the 'Call Record' as a telephone counsellor completed it during this period (see appendix A for an example of a full version of this section and the complete dataset).

Called previously

Yes (Regularly)

Frequency of calls

More than once a week

Time of calls

Unknown

Demographic Details

Gender

Male

Age

45-49

Education

Not asked

Employment

Pension

Relationship

Single

Mental Health Issues

Professionally Diagnosed with a Mental Illness

Yes

Diagnosis made by whom

Psychiatrist

Diagnosis made when

Over 5 years

Mental Health Diagnosis

Depression

Receiving Treatment from

Lifeline Melbourne

Psychiatrist**Currently Receiving Treatment for**

Depression

Previously Received Treatment for

Depression

Social Supports

Friends

Of the 49% of callers who were asked, 29% identified as having been professionally diagnosed with a mental illness with most reporting the diagnosis as being made either by a Psychiatrist or GP. The most common diagnosis reported was depression, followed by anxiety disorders and schizophrenia with the majority having received the diagnosis more than twelve months prior. This information supports earlier reports of national data that documented 27% of counselling calls as featuring mental health issues and identified the most frequent presentations as depression, schizophrenia and anxiety with psychiatrists and GP's the most common source of formal support (Lifeline, 2002). Information gathered about demographics also reflected earlier reports with approximately two thirds of callers identified as female and most callers falling between the ages of 25-54. Many callers disclosed that they were receiving some form of psychological treatment with GP's and psychiatrists predominating, and counsellors and psychologists the next most common source, with some callers reporting that they were receiving treatment from more than one source.

The data collected reinforced the reliability and validity of the information already held by Lifeline and provided additional support to Lifeline's perception of the changing profile of their callers with more and more presenting with complex psychological issues. Furthermore, since the information collected reflected only those callers who had received an official diagnosis it would be fair to suggest that this might be a conservative estimate of the number of callers struggling with significant mental health issues since many others suffering similar difficulties may not have been formally diagnosed or sought help for their symptoms. General findings reported in the Australian National Survey of Mental

Health and Wellbeing (Australian Bureau of Statistics, 1998) indicate that this is often the case with only 38% of people with mental disorders accessing formal care.

In 2005 almost all, nearly 98%, of Lifeline's Melbourne's callers were calling to discuss issues directly related to themselves with the other 2% focusing on a family member or friend with an occasional contact from someone wishing to discuss something in relation to a professional helping role. In addition to mental health issues, Lifeline's nationally accumulated data reflected relationship breakdowns and loneliness as the most prominent issues for callers (Cartwright & Hughson, 2005). These same issues were noticeably the most frequently presented difficulties recorded for Lifeline Melbourne in 2005 as well. Overall, 90% were 'counselling-non-suicide' with a little over six percent recorded as 'counselling-suicide-own risk' and the remainder representing calls related to the risk of another's suicide, grief after a suicide or non-counselling calls.

Lifeline Melbourne records indicated that in 2005 the average length of a counselling calls was a little under 20 minutes. This is equivalent to the 21 minute average duration of calls reflected in nationally accumulated data (Lifeline, 2005). Together with the number of calls responded to this translated into an overall figure of approximately 34 hours of counselling per day, seven days a week, 365 days a year.

Lifeline Melbourne's model of counselling

The historical origins of Lifeline's counselling model are located in humanistic person centred approaches that emphasise relationship development. The adoption of this approach was influenced by the contemporary psychotherapy climate of that era, which saw the rise of the Person-centered approach, and Rev Alan Walker's belief that a Person-centered approach would answer the needs of the community.

Established by Carl Rogers in the early 50s, the Person-centered approach posits that the relationship between counsellor and client is the key ingredient of

psychotherapy. Rogers' saw the development of the relationship as dependant on the conditions offered by the therapist, in particular, the therapist's ability to be empathic, congruent and to assume a stance of unconditional positive regard towards the client. Lifeline Melbourne's counselling model also draws upon crisis intervention models to inform counselling practice.

As noted earlier, crisis intervention can be defined as emergency psychological care and is a short term action oriented model of intervention that focuses more on a problem solving approach (Roberts, 2002). Assumptions are that discrete environmental stressors, perceived by adequately functioning individual as causing considerable distress, impact usual coping mechanisms (Roberts & Ottens, 2005). Immediate intervention is seen as crucial and the aim is to mitigate acute signs and symptoms of distress, stabilise the individual and mobilise their usual coping resources (Flannery & Everly, 2000).

The role of the telephone counsellor

In accordance with Alan Walker's original Lifeline model the primary task of the counsellors is to maintain a constant presence whilst holding to a Person-centered approach that reflects a non-judgemental, caring and accepting attitude (Lifeline International, 2006). Brian Allen, however, saw Lifeline as meeting the needs of those whose normal coping mechanism had broken down and so he incorporated into Melbourne's model a crisis intervention approach (R. Howe & Swain, 1993). Although Lifeline Melbourne's approach remains consistent with a person centred framework that draws on crisis intervention strategies, changes to this model have occurred over time and aspects of both Solution Focused and Cognitive Behaviour Therapy techniques have also been incorporated (Dawson, 2006). These changes have been integrated in an effort to better respond to different caller presentations.

The Lifeline Melbourne model consists of five stages that first rely on the telephone counsellor's qualities, such as empathy and understanding and the ability to develop rapport, and then utilises strategies, such as containment, focusing and goal setting, to address the caller's problem. However, while the

model remains basically the same, there are some differences in the ways in which callers, who are assessed as either having an acute presentation or a chronic presentation, are managed. This difference is particularly evident where 'containment' is concerned. For instance, where the 'acute presentation' caller is encouraged to tell their story and the counsellor instructed to actively explore this, the focus for the 'chronic presentation' caller is on maintaining firm boundaries with story content and detail being actively limited.

The following table outlines the telephone counsellor's role at each stage of the model for both 'acute presentation' and 'chronic presentation' callers.

Table 5.1

Telephone counsellor response guidelines: Lifeline Melbourne 2007

Acute presentation caller	STAGE	Chronic presentation caller
Achieve a working relationship- support, engage, make connection	1 An invitation to talk. I am here and I am listening	Achieve a working relationship- support, engage, make connection
Encourage the caller to tell the story, explore, open questions, precursors, etc	2 Tell me more, I want to understand your situation	Validate distress. Contain content and limit detail. Try to understand what the situation means for the caller rather than talking about the situation.
Assessment – what most needs attention now? Establish a focus for helping. What can you do within the limits of your role?	3 I want to determine how I can help this situation now.	Determine your role with this caller including risk assessment and consultation if applicable. Identify and validate feelings and underlying themes.
Consider options for action/change. Look at obstacles to action. Consider what is helpful for caller within the terms of the crisis counselling model.	4 Let’s look at options. What would you like to get from this call?	Short term plan including linking to supports and coping strategies.
Completion and closure. Focus and identify support and resources. Plan manageable steps towards larger goals. Refer, support and affirm.	5 We have worked out the next moves together. I have a belief that you can get there.	Completion and closure. Focus and identify support and resources. Plan manageable steps towards larger goals. Refer, support and affirm. Keep firm boundaries. Do not open up anything further.

(Lifeline Melbourne, 2007)

For the 'acute presentation' caller the focus is on listening to their story, discovering their needs and considering options for action or change. For the 'chronic presentation' caller the focus is on identifying and validating feelings and meanings, containing the story and assessing risk.

Differences between telephone and face-to-face counselling practice

In face-to-face counselling interactions the therapeutic environment and the context within which therapy is occurring is more clearly defined. In addition, the therapist has the ability to gather additional information through observing the client's presentation and body language. In the case of telephone counselling, environment and context are ambiguous and the lack of physical presence reduces the amount of information exchanged. In addition, some service conditions adopted by telephone counselling practice are often not associated with face-to-face counselling, for instance the anonymity of both client and counsellor.

Lifeline's philosophy and approach to telephone counselling incorporates counselling models and general practices associated with face-to-face counselling. However, unlike face-to-face counselling, anonymity is perceived as playing an important part and is a well established component of the Lifeline service. Further, in telephone counselling, anonymity goes both ways so that it is not only the caller who is anonymous but the counsellor also. Inevitably this has an impact on the counselling interaction as well as on the way the service is utilised by callers and managed by the organisation. For instance, where a face-to-face counselling client will usually connect with the same counsellor on repeat visits, Lifeline counsellors do not case-manage clients and therefore do not develop an ongoing relationship with particular callers; instead recurrent callers to Lifeline engage with any counsellor who might answer their call.

In addition, unlike face-to-face counselling practice, where appointments are usually prearranged with frequency and duration of sessions reflecting consistent practice with regards to attendance and session timing, few boundaries define

the telephone crisis counselling interaction. Frequency and session duration are not predetermined and callers are able to access the service as and when they need to.

Commentary

Lifeline telephone counselling service was established in response to a perceived community need for a crisis intervention service, with a particular focus on suicide prevention that was easily accessible and available to everyone. The Lifeline Melbourne telephone counselling model specifically integrated crisis intervention strategies and techniques and continues to focus on crisis intervention in the context of an anonymous, one off, telephone counselling interaction. However, the majority of callers to Lifeline are recurrent callers presenting with chronic conditions that often reflect complex mental health issues. Indications are that recurrent callers and those struggling with psychological disorders characterise a growing proportion of Lifeline's calls. This appears to point to an increasing disparity between Lifeline's telephone counselling model and the population they service.

Many of the recurrent callers access the service regularly and some call daily or more often. It may be that recurrent callers require more ongoing support rather than crisis intervention or it may be an indication of callers' adaptation of the service to meet their own needs. Conditions surrounding crisis intervention telephone counselling practice makes it difficult to ascertain how callers are utilising the service and what needs Lifeline is fulfilling. Notable differences between the telephone counselling model and face-to-face counselling models include the anonymity of both telephone counsellor and caller, the lack of any predetermined session duration, the lack of any preset counselling schedule and the lack of an ongoing counselling relationship.

The demand and utilisation of Lifeline's service suggests that Lifeline plays a significant public health role in responding to the mental health needs of callers and the community. Their profile within the community and the 94% public recognition of the Lifeline brand reinforces this position (Lifeline Australia, 2008).

An important question that emerges, however, is how the integration of crisis intervention and person-centred approaches, adopted by Lifeline, work within the telephone counselling context.

Chapter 6

Research Design & Methodology

The preceding chapters have established the context of the research in a number of ways. First, by highlighting the growing need for mental health services and the role that telephone counselling plays, second, by presenting an overview of the core theoretical frameworks underpinning different schools of therapy, third, by reviewing research and literature dedicated to the focal area of counselling and telephone counselling and, finally, by contextualising telephone counselling practice as it occurs in the Lifeline setting and distinguishing this form of counselling from more generic models of face-to-face counselling practice. This information helps to illustrate the complexities of counselling and the multitude of possible influences and variables. It also situates the significance of this study in the field of counselling and provides a perspective from which I am positioning myself as a researcher and a theoretical base for a research design that fits with qualitative principles.

This chapter describes the methods used for exploring telephone counselling interactions and participant interviews. The first part of the chapter discusses the epistemological position that underpins the current study and the implications of this positioning for the methodology, methods and data collection and analysis adopted. The second part outlines what occurred during the research process and provides profiles of the study participants. Finally, issues relating to validity and trustworthiness are discussed and the researcher's biography and entry into the setting presented.

Research Aim

The aim of the current study was to explore the dynamics of telephone counselling within the context of the provision of services offered by Lifeline Melbourne.

The key research questions orienting this study were:

- How are traditional counselling theories applied in the telephone counselling context?
- How do telephone counsellors and callers experience telephone counselling?
- What are the factors that influence telephone counselling service provision and how do these affect caller satisfaction and outcomes?

These questions endeavoured to address identified gaps in the research. The research was designed to generate a knowledge base about how face-to-face counselling models are applied and fit within the telephone counselling context and to identify which components are perceived as important and what processes influence effective outcomes from the callers' perspective.

The focus of the research was on the holistic experience and processes of telephone counselling rather than on the level of overall outcome. This study was interested in highlighting the intricacies and the many levels at which they interact rather than narrowly assessing the therapeutic outcomes of telephone counselling. This breadth provides the opportunity to discover aspects of telephone counselling that might otherwise be overlooked. Conceptualising these within the system that they are occurring also offers the promise of discovering responses to, or understandings of, environmental and contextual impacts.

Research Design

The nature of the research questions was well suited to a qualitative research design. Qualitative research utilises methods such as interviews, observation and document analysis, to generate information about individuals' experience and the meanings they attribute to those experiences (Patton, 1990). In this study the major methods of data collection were interviews with telephone counsellors and callers, observation of calls, analysis of Lifeline documentation including the organisation's history and objectives, training offered to telephone counsellors, and analysis of existing de-identified caller records.

The design adopted in this study was based on a constructivist epistemology and drew on some of the principles and techniques of the methodological processes of Grounded Theory (Charmaz, 2000, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). The constructivist perspective acknowledges the inherent challenges of developing overarching explanatory frameworks and acknowledges the researcher and participant mutual creation of knowledge (Guba, 1994; Schwandt, 1994). Grounded Theory methodology provided strategies and analytic processes by which to structure and explore the diverse experiences of telephone counselling. In this study, however, the intention was not to develop theory, but to identify core processes relevant to a telephone counselling context.

The following section outlines traditional approaches adopted in the study of counselling practice and makes an argument for the approach employed in the current study.

Review of traditional approaches in psychotherapy research

Psychology encompasses a broad field of behavioural sciences that spans the natural and social sciences. While historically psychology was widely regarded to be a branch of philosophy, in the middle of the 19th century a scientific and eventually experimental form of the discipline emerged. Psychology as an

experimental field of study was formally established in Germany in 1879, when Wilhelm Wundt founded the first laboratory dedicated exclusively to psychological research (Farr, 1991; Hatfield, 2002).

Objective, scientific observation was considered the most appropriate method to learn the 'truth' about phenomena, the premise being that phenomena have particular essential properties that can be discovered through the rigorous application of quantitative methods and that researchers are able to be detached from what is observed (J. T. Hansen, 2006). Methodologically, many of the traditional approaches to therapy adopted an empiricist approach with the corresponding belief that behaviour can be explained by the use of experiment, measurement and the scientific method. This hypothetico-deductive approach focuses its efforts on verifying a-priori hypotheses through the execution of tightly controlled experimental or quasi-experimental studies. Data is collected and statistically analysed with the primary goal being an explanation that ideally leads to prediction.

The empiricist approach has been criticised by some for employing an overly reductionist view of the person that ignores context and, therefore, the meaning and significance of experience and behaviour (Lincoln and Guba, 1985, 1989). Some psychologists see a need for studies that capture the complex dynamics and the experiences of the individuals at the centre of the counselling interaction. These psychologists emphasise the importance of exploring the lived experience of a person and the value of understanding the subjective meaning of a person's experience.

Emergence of constructivist approach in psychotherapy research

In the last two decades the constructivist epistemology has begun to influence the counselling profession. While counselling psychology continues to be dominated by an empiricist research paradigm and the associated preferences for quantitative methods, there is evidence of a gradual paradigm shift to a more balanced reliance on both quantitative and qualitative methods (Ponterotto, 2005).

When considered from a constructivist perspective, psychotherapy can be understood as the transformation of the client's construction of narrative meaning through collaborative dialogue (Botella & Herrero, 2000). Qualitative research, like psychotherapy, often calls for a constructivist approach that reflects the psychosocial experiences of people and places emphasis on interaction, and construction of meaning and interpretation. The constructivist approach that underpins much qualitative research acknowledges the role of the researcher, the social context, multiple perspectives, complexity, individual differences, holism and the circular nature of interactions (J. T. Hansen, 2006).

These types of studies rely on face-to-face interviews and a fairly intense researcher-participant interaction that allows for the examination and interpretive understanding of the participant's experience. Researchers who adopt a constructivist perspective acknowledge that knowledge is socially constructed and, therefore, does not exist in isolation from context and social processes (Dahlberg, Moss, & Pence, 1999).

The constructivist researcher does not attempt to unearth a single 'truth' recognising that there are multiple meanings in the minds of the people who experience a phenomenon, as there are multiple interpretations of the data (Ponterotto, 2005). In practice they do not seek other researchers verification of identified themes, but seek to develop strong claims through thick description, prolonged engagement, and researcher reflexivity (Patton, 1990).

From this perspective the researcher and the participants, through their interactive dialogue and interpretation, jointly construct findings. This interactional stance is often reflected in the rhetoric of research reports that present procedures and findings in the first person (Ponterotto, 2005). In addition, researchers generally acknowledge and explicate their assumptions and expectations, maintaining that these cannot be divorced from the research process (Ponterotto, 2005).

The theoretical underpinnings of constructivism together with the aims of the current study and the nature of the gaps in the existing research on single

session telephone counselling pointed to the need for a qualitative research design. The principles of Grounded theory as a specific design framework within qualitative research provided a flexible, heuristic approach that was consistent with the philosophical underpinnings of constructivism.

Grounded Theory

Grounded Theory is credited as being at the forefront of the qualitative revolution and is recognised as one of the most established qualitative research approaches (Charmaz, 2000). Although there is some debate regarding the anchoring paradigm of Grounded Theory, its processes and procedures can be used flexibly and many researchers have adapted their own version (Ponterotto, 2005). The adoption of certain components or adaptation of this approach can be viewed as the natural evolution of the methodology and is perhaps a parallel process to that which is occurring in the psychotherapy field.

The following section provides a description of the grounded theory approach and its evolution and details of how different strategies of the methodology were drawn upon and utilised in this study.

The evolution of Grounded Theory

Developed by sociologists Anselm Strauss and Barney Glaser in the 1960s, grounded theory has its roots in the symbolic interactions school of sociology, which focuses on the meanings that people assign to events that, in turn, determine their responses. The main aim of grounded theory, as it was originally conceived, was to avoid preconceived ideas and instead generate theory from the data (Dey, 1999).

Originating from studies of the “awareness of dying” (Glaser & Strauss, 1965), grounded theory approaches utilise an inductive and deductive process as a way to explore, primarily subjective experiences. Central to grounded theory research is the constant comparative method that allows the researcher to identify

patterns and develop new understandings of the phenomena without the constraint of a priori hypotheses. Glaser and Strauss (1967) stated that "dependent on the skills and sensitivities of the analyst, the constant comparative method is not designed (as methods of quantitative analysis are) to guarantee that two analysts working independently with the same data will achieve the same results" (p. 103).

Although Glaser and Strauss were the original proponents of Grounded Theory, there are now several forms of Grounded Theory. While many grounded theory studies reflect more of an objectivist approach, other researchers that hold a constructivist perspective have utilised grounded theory strategies for their empirical studies (Charmaz, 2000). Shifts in the theory and practice of research are common and reflect the adaptations of the approach across disciplines and content areas.

Charmaz (2000) argues for a constructivist approach to grounded theory. She believes that grounded theory need not be a rigid, formulaic process as presented by Strauss and Corbin. In her view Grounded Theory is best conceptualised as a set of flexible, heuristic strategies adopted to address key research questions.

Relevance of a constructivist grounded theory approach for this study

The constructivist approach to grounded theory reaffirms studying people in their natural setting, recognises the dynamic interaction between the researcher and participant and acknowledges the multiple meanings of a phenomenon in the minds of the people as well as the multiple interpretations of the data (Charmaz, 2006; Ponterotto, 2005). In addition, while early texts of Grounded Theory assumed an unbiased gathering of data from which the researcher discovered inherent categories and concepts, the constructivist Grounded Theory approach recognises that the categories and concepts emerge from the researcher's interaction within the field and questions about the data (Charmaz, 2000). Thus, the interactive nature of both data collection and analysis is recognised. The data then does not provide a window on reality rather the "discovered" reality arises

from the interactive process, the contextual conditions that encompass it and the meaning the researcher and participants confer upon it (Charmaz, 2000).

The conceptualisation of Grounded Theory endorsed by Charmaz (2000) sits well with the theoretical underpinnings and practical endeavour of psychotherapy. In addition, it reflected the researcher's epistemological positioning and allowed the researcher to remain consistent with these beliefs during the process of inquiry. In light of this, this study drew on some of the tenets of the constructivist grounded theory approach. Some were adapted, for example, existing theories of counselling influenced the selection of a set of preselected themes, in the form of certain possibilities and processes, which provided some focus on initial ideas and areas of interest. This assisted in the preparation of an interview guide that outlined topics within which the researcher was free to explore, probe and ask questions.

In keeping with current practices in reporting qualitative research, sections of the research procedure and findings are written using the first person pronoun. This practice is consistent with recommendations in the 5th edition of the American Psychological Association (APA) Publication Manual (2001), which acknowledges the appropriate use of the first person and active voice in research manuscripts. The use of the first person makes explicit my position as researcher and interpreter.

Key research domains and method

The previous section has outlined the orienting assumptions underpinning this research. As the current study aimed to explore the dynamics of telephone counselling, a qualitative approach was considered appropriate.

The key domains of focus for the research were:

- The application of traditional counselling theories in the telephone counselling context

- The experience of telephone counselling from the perspective of callers and telephone counsellors, and
- The factors that influence telephone counselling and their perceived impact on effectiveness.

Data were gathered in a number of different forms. These included observations, Lifeline documentation, records (statistical and written), audio taped telephone counselling sessions and telephone interviews with telephone counsellors and callers to Lifeline. While the interviews played the central role other forms of information afforded a deeper and broader understanding of contextual factors.

Data were collected in two discrete, phases. The first phase involved familiarisation with the context of telephone counselling. This phase incorporated extensive observation at Lifeline. This observation phase also assisted in building rapport with the staff working at Lifeline. The second phase formed the core empirical base of the study. This phase involved interviews with telephone counsellors and callers, and recording and analysis of counselling sessions.

The table below provides an overview of the research domains, methods and sources of data. Different methods of data collection were utilised and a number of data sources were drawn upon in order to address the key questions. The initial phase addressed questions relating to Lifeline's Melbourne's model and practice and drew upon Lifeline's documentation as well as informal discussions with Lifeline staff. The latter phase considered a number of questions and drew upon an assortment of methods and a variety of sources.

Table 6.1

Domains of focus and data collection methods

Domains of focus	Methods	Source
1. The application of traditional counselling theories in the telephone counselling context	Document analysis	Lifeline documentation
	Informal interviews	Supervisors of telephone counsellors, trainers and managers
2 The experience of telephone counselling from the perspective of callers and telephone counsellors	Interviews	5 telephone counsellors
	Observation and recording of counselling sessions	6 telephone counselling sessions
	Triad interviews	2 telephone counselling session + caller interview + telephone counsellor interview
3 The factors that influence telephone counselling and their impact on effectiveness.	Reviews of the literature	14 callers

Phase I: Counselling triads

The initial design was to record up to 8 telephone counselling sessions and conduct interviews with both the telephone counsellor and caller involved in the interaction. These triads were intended to provide evidence from three sources with a common reference point of the counselling session. I hoped that matching these three data points would afford an additional level of analysis and provide another source of data triangulation.

Procedure

Ethics approval was sought through Victoria University Human Research Ethics Committee and Lifeline and once granted information was posted on the telephone counsellors' staff notice board together with a supply of plain language

statements (see appendix B). Potential participants were able to call me directly or register their details to participate in the research on the form.

Given the nature of the research it was anticipated that recruiting participants, in particular callers, might pose some difficulties, mostly because of the context in which the study was being conducted, the sensitive nature of the inquiry, and the ethical considerations and sensitivity that would be required in recruiting participants. It was agreed that some calls were not appropriate for recording. Suicide related calls and callers who were extremely distressed or considered to be unable to provide informed consent were excluded.

Participant telephone counsellors

At any given time, Lifeline Melbourne has almost 500 volunteer telephone counsellors registered on their database. Some of these counsellors may be inactive in the service and many relatively inexperienced as telephone counsellors. While it is not possible to know the exact number, potentially 100 telephone counsellors were aware of the study and had the opportunity to record their interest in taking part.

In all, 18 telephone counsellors registered their interest in taking part in the study, 12 females and six males. For the first phase of data collection, the focus of the recruitment strategy was to identify experienced counsellors who had completed a minimum of 30 shifts at Lifeline. This sampling criterion reduced the potential number of candidates to 11. Eight were female and three were male, all were aged between 24 and 56 years.

These telephone counsellors were contacted individually, invited to take part in the study and arrangements made for my attendance at their next shift. The purpose of this visit was to address any questions or concerns regarding the study, to familiarise them with the study and its requirements regarding caller recruitment, and to prepare them for this process. Following this preparatory visit, four subsequently withdrew. One cited time constraints as the reason and another, as a result of a promotion, was no longer in a position to take part. The

limited availability of the other two telephone counsellors meant that it was not feasible to include them in the research. The final pool of seven participant telephone counsellors signed informed consent forms (see appendix C), and agreed that I shadow them on all their shifts.

At the beginning of each participant's shift I would meet them, and set up my recording equipment. At this stage no recording occurred. Telephone counsellors were provided with instruction sheets and asked to review the information prior to taking calls (see appendix D). At the start of each call and prior to asking the caller, the counsellor assessed the suitability of the caller to take part in the study. Since counsellors were asked only to recruit those callers that fitted the category of callers seeking counselling, those who were only seeking information were not included. In addition, it was deemed inappropriate to ask any caller who appeared to be too young, overly distressed, suicidal or intellectually disabled to take part.

A decision tree form enabled a consistent and structured procedure that assisted telephone counsellors in the caller recruitment process (see appendix E). Telephone counsellors invited callers they considered to be suitable to take part and provided the caller with information about the study by reading them the plain language statement (see appendix E). Caller consent for the recording of the session and to being interviewed was sought verbally. At this stage the recording equipment was turned on. Callers were advised that the recording device had been turned on and were asked to repeat their consent to take part and for the session to be recorded for the official consent record. Callers were asked to provide telephone contact details so that they might be contacted for an interview in the days following the call.

Telephone counsellors who successfully recorded a telephone counselling session provided their contact details on the record sheet (see appendix E) and were contacted and an interview conducted with them in the days following the counselling call. Regardless of the number of calls recorded telephone counsellors took part in only one interview. Two telephone counsellors were unsuccessful in their attempts to recruit caller participants and therefore did not take part in an interview.

Calls recorded

During the initial data collection period the seven telephone counsellors involved responded to 121 calls. Ten telephone counselling sessions were recorded. A variety of reasons were reported in relation to the non-participation of the other callers, most of which reflected the telephone counsellor's judgement regarding the appropriateness of extending the invitation to take part in the study, while some callers declined to take part (see Appendix F).

Participant callers

The participants who volunteered to take part in this phase of the study were eight females and two males aged between 25 and 74. Six were married or partnered and four were single or widowed. The majority were recurrent callers and two were first time callers. Most callers presented with multiple issues although all identified problems relating either to relationship difficulties, anxiety or depression. All of the calls were recorded between 0830am and 9pm with three recorded between 0830am and 12 noon, two recorded between 12 noon and 5pm and the remaining five recorded between 5pm and 9pm.

Of the ten telephone counselling sessions recorded only two resulted in post session interviews with callers. Two callers withdrew from the study, two represented short calls that did not fit within the usual counselling call duration and so were not contacted for an interview and three callers were non contactable. The following table provides additional call and caller information. Participants' names have been replaced with pseudonyms to protect their identity. The names in bold are those two who were interviewed post session.

Table 6.2

Phase 1. Telephone Callers Participant details in brief (N=10)

Name	Age group	Duration of call	Call history	Focus	Issue	Outcome of call	Inter-view	Reason no interview
Matthew	45-54	09 mins	First time	Self	R'ship referral		No	Short call
Helen	25-34	41 mins	Recurrent	Self	multi counselling		No	UTC
Robert	35-44	10 mins	Recurrent	Self	multi counselling		No	Short call
Diana	45-54	34 mins	Recurrent	Self	multi counselling		Yes	
Gina	35-44	28 mins	Recurrent	Self	R'ship counselling		No	Withdrew
Vivian	65-74	51 mins	Recurrent	Self	multi counselling		No	Withdrew
Annette	??-??	37 mins	Recurrent	Self	multi counselling		No	UTC
Karen	45-54	17 mins	Recurrent	Self	R'ship counselling		No	No number
Pam	25-34	16 mins	Recurrent	Self	Multi counselling		No	UTC
Jackie	35-44	17mins	First time	Self & Family	multi Counsel/ref		Yes	

UTC = unable to contact Ref = referral

Phase I: Constraints on data collection

There appeared to be a number of other explanations why this phase of data collection was not more successful. These included the practicalities and technological considerations, the result of which was that only one telephone counsellor per shift had the means to record their counselling sessions. In addition, telephone counsellors often engaged in a 'gate keeping' role that usually consisted of either protecting the caller or protecting the researcher. One concern was a perceived threat to the caller's anonymity, which many telephone counsellors seemed to hold in high regard and saw as an essential component of the Lifeline service. Reassurances that protections were in place so that callers would remain anonymous and reminders that callers were able to decline the invitation to take part, withdraw at any time and, if need be, provide a pseudonym if they preferred, did little to alleviate these concerns. Other examples include deciding that it would be too hard on the caller to take part and deciding that 'chronic' callers would not be suitable or that others would be too verbose to be interviewed.

Telephone counsellors also had to make an immediate assessment as to the suitability of the caller and the appropriateness of the invitation. Inclusion in the study required that the call be deemed a counselling call, that is, not a caller requiring information, such as telephone numbers, and that it would fit within the framework of what was seen as a 'typical' counselling call. The parameters of which were, that the caller be non-suicidal and that the issues discussed be self-focused. Other exclusion criteria included that the caller be over 18 and of a fit mental state to provide consent. Telephone counsellors also needed to be sensitive to the caller's emotional state so that highly emotional callers were treated with care. In addition, telephone counsellors often reported feeling uncomfortable inviting callers to take part prior to them establishing some rapport with the caller, by which time they were already engaged in the counselling interaction.

This phase of data collection represented an intensive and prolonged period of time. Given data from only two full triads was possible, I proposed to Lifeline management that the data collection process be simplified so that callers were only invited to take part in interviews. Since this was already part of the study design there were no ethical implications associated with this change. Lifeline management were supportive of the change in approach, and the new data collection phase was communicated to staff.

Phase II: Caller interviews

Recruitment for this phase of data collection was not as difficult as the initial phase. Counselling interactions were not being recorded which alleviated the technological difficulties associated with that and meant that any or all of the telephone counsellors on shift were able to invite callers to take part in an interview. This also meant that telephone counsellors could extend the invitation to take part in the study at the end of the call, eliminating the counsellors' need to make a quick decision regarding the suitability of the caller as a participant as well as the appropriateness of the invitation. Extending the invitation at the end of the call also allowed the telephone counsellors to establish rapport with the caller so that they felt more comfortable in extending the invitation to participate

in the research. Nevertheless, there still appeared to be some degree of reluctance on the part of some of the staff and telephone counsellors to engage with the research endeavour. Nearly a week later, only three, of the six hundred plus, callers had been invited to participate in interviews. Telephone counsellors may have been explicitly acting as gatekeepers to protect callers from a potential threat to their anonymity.

I initiated a meeting at this point with senior management, and they agreed to take a more active role in encouraging supervisors and telephone counsellors to request participation. The following three days yielded a dramatic increase in the number of callers invited to take part.

Participant callers

Of the 152 calls, fielded by 35 telephone counsellors who took part during this phase, 33 callers were invited to participate in the research and 21 callers consented to an interview. The 11 callers who declined the invitation cited protecting their anonymity, feeling anxious and other commitments as their reasons. Of the 21 callers who consented to an interview 14 were interviewed, three callers were non contactable, one caller had been asked by two separate telephone counsellors and had agreed to take part on both occasions, two callers were deemed to be inappropriate and another later withdrew from the study.

The participants who volunteered to take part in this phase of the study were 12 females and two males aged between 30 and 80. Three were married or partnered and 11 were single, divorced or widowed. The majority were recurrent callers and one was a first time caller. Most callers presented with multiple issues although all identified problems related either to relationship difficulties, anxiety or depression. The calls were recorded across a range of time periods.

The following table provides additional call and caller information relevant to the 14 callers who took part in this phase of the study. Participant names have been replaced with pseudonyms to protect their identity.

Table 6.3

Phase 2. Telephone Caller Participant details in brief (N = 14).

Name	Age group	Duration of call	Call history	Focus	Issue	Outcome of call	Inter-view
Alison	50-54	38 mins	Recurrent	Self	Multiple	Counsel/ref	Yes
Anita	60-64	59 mins	First time	Self	Relationship	Counsel/ref	Yes
Brett	35-39	29 mins	Recurrent	Self	Multiple	Counselling	Yes
Harry	45-49	15 mins	Recurrent	Self	Multiple	Counselling	Yes
Jane	40-44	25 mins	Recurrent	Self	Multiple	Counselling	Yes
Judith	80+	22+21 mins	Recurrent	Self	Loneliness	Counselling	Yes
Lauren	40-44	40 mins	Recurrent	Self	Multiple	Counselling	Yes
Lisa	40-44	39 mins	Recurrent	Self	Relationship	Counselling	Yes
Marion	50-54	33 mins	Recurrent	Self	Relationship	Counselling	Yes
Nina	65-69	23 mins	Recurrent	Self	Multiple	Counselling	Yes
Rita	35-39	31 mins	Recurrent	Self	Relationship	Counselling	Yes
Rosemary	30-34	35 mins	Recurrent	Self	Multiple	Counselling	Yes
Tracey	40-44	48 mins	Recurrent	Self	Relationship	Counselling	Yes
Wendy	40-44	19 mins	Recurrent	Self	Multiple	Counselling	Yes

Ref = referral

Interviews

Telephone interviews were conducted with the callers and telephone counsellors in the days following the telephone counselling session. I attempted to provide a non-threatening and safe environment for individuals who were willing to participate. Before the interview began, the purpose of the study, expectations of participation, and the possible consequences for the participants were discussed. Participants were informed that the interview was to be recorded. They were also reassured about confidentiality and that their identity would be protected through the use of a pseudonym. The participant's right to withdraw from the study or refusal to discuss particular areas was reiterated. Once I was confident that the participant understood this information and that any issues or questions they had were addressed, the recording device was activated and participants were asked to repeat their consent for the interview to be recorded. On the one

occasion that a caller participant declined to have the interview recorded written notes were taken throughout the interview.

Recorded telephone interviews, lasting between 45 and 90 minutes were conducted with each participant. The participants were asked to take a couple of minutes to consider their perceptions of Lifeline in general and to review their experiences of telephone counselling and in particular the telephone counselling session that had taken place in the days prior to the interview.

The interviews undertaken were an informal, interactive process utilising open-ended questions and guided by the responses given by the participant. However, a set of general concepts, in the form of certain possibilities and processes, provided some focus on initial ideas and areas of interest. This assisted in the preparation of a guide that outlined topics within which I was free to explore, probe and ask questions (see appendices G & H).

The interview was designed to elicit information about the participants' perceptions of Lifeline in general and their experience of the telephone counselling interaction, including observations about themselves, the other and their perceptions of content and process variables. The principal question asked was 'how would you describe your experience of the telephone counselling session?' other broad areas of interest included perceptions of needs, expectations, the relationship and outcomes.

As recommended by Patton (1990) demographic questions were interspersed throughout the interview in an attempt to create as near as possible a natural conversational interaction and to promote rapport and authentic communication patterns. Nevertheless, the demographic information collected was minimal and was gathered with great sensitivity so that caller participants in particular did not feel any threat to their anonymity. The participant determined the pace and depth of the interview.

At the completion of the telephone interview a return call from a Lifeline supervising counsellor was offered to callers. Four of the callers who were interviewed spontaneously offered to be contacted again in the future should the

need arise and many others expressed their pleasure at having the opportunity to 'give back' by taking part in the study. Caller interviews appeared to be less threatening as callers were consenting to an interview only and were not being asked to consent to the recording of their telephone counselling interaction.

Data Management

Except for one interview where the caller declined, all the telephone counselling sessions and interviews, with both callers and telephone counsellors, were digitally recorded. Recorded sessions and interviews were transcribed verbatim. Transcripts were then checked against the recordings for accuracy, missing data, identifying material and typographical or spelling errors. All identifying names and places were replaced with pseudonyms.

Each document was formatted in preparation for input into NVivo7 computer data analysis package. NVivo7, developed by QSR international, was used to assist in the management, manipulation and analysis of the data. NVivo7 is a computer software package specifically designed to manage the many functions required for qualitative analysis, for instance complex coding, indexing data and categories, retrieving relevant sections of data, asking complex interactional questions of the data, storing memos and annotations as well as having the capacity to graphically display the data through models (Bazeley, 2007).

The decision to use NVivo7 was based on the research aims, which called for a qualitative analysis to elicit meanings and processes from unstructured data, and the ability of the software package to facilitate complex questioning of the data, which fits with the principles of grounded theory. In addition, the use of NVivo7 allowed multiple coding of paragraphs, which was particularly useful because of the exploratory nature of the study.

Information about individual participants, such as demographic information and their use of the service, were recorded as *attributes* in the NVivo program. Attribute information can be used in a number of ways, for instance to make comparisons across the data, such as between first time and recurrent callers to

Lifeline. In addition, in order to preserve any connections between different units of analysis, I assigned the various components of the data sets to cases. For instance data that pertained to a particular counselling triad, that is the telephone counselling session, the telephone counsellor interview and the caller interviews, were coded as a single case node. In the NVivo software package, nodes are the containers that store the information about a particular concept, category or code (Bazeley, 2007).

Data Analysis

Telephone counselling sessions and interviews were analysed utilising the constant comparative method advocated within Grounded Theory (Charmaz, 2006; Glaser, 1992; Strauss & Corbin, 1998). The constant comparative method assisted with the conceptualising and categorising of the data, whereby the data, for instance sentences or paragraphs, were broken down and each event, idea or incident labelled. The constant comparative method was employed so that as incidents or issues were noted they were compared against other examples for similarities or differences. The analytic process was based on immersion in the data and repeated sorting, coding and comparisons that characterise the grounded theory approach. The constant comparison process allowed for the renaming and refining of categories to improve fit, yielding increasingly complex and inclusive categories. A total of 27 transcripts were analysed.

Coding procedure

While the coding procedure in Grounded Theory can be seen as incorporating three major stages, open coding, focused coding and axial coding, this was not a strictly linear process reflecting discrete phases. Instead the lines between them were often blurred and as analysis progressed, and I became more familiar with the data and its complex interactions, I often reviewed the contents of nodes, checking that I had picked up all the important aspects of a segment of text, perhaps coding some segments onto other nodes or refining code names.

Open coding was the beginning process of formally analysing the data and pertains specifically to the naming and categorising of data. The following sections describe the coding procedure undertaken in this study.

Open coding

Formal analysis began with open coding (Charmaz, 2006). Open coding required close reading of the data and examination and naming of sections of the text made up of individual words, phrases or sentences. I first read and reread each transcript in its entirety and recorded ideas and reflections as memos during this process. Case summaries for each telephone counselling session and interview were prepared to synthesise key ideas present in each session or interview. An example of caller interview case summary is provided in appendix I.

Summaries of cases also included pertinent information from the case notes recorded by the telephone counsellor at the conclusion of the call. An example of a counselling session case summary is provided in the box that follows, with comments from the telephone counsellor's notes appearing in italics and responses from interview questions in inverted commas.

Box 6.1. Case summary: Telephone counselling session

A female telephone counsellor (TC) answers a call at 0509pm. The caller is a female who has called into Lifeline several times in the past month. She identifies family, friends and her GP as supports and mentions that she has been experiencing depression for which her GP has prescribed medication. She also has a referral for face-to-face counselling, which she has not yet followed up on. The TC does not ask her age, however, she records that *the caller was struggling with a relationship issue* and that she *explored coping strategies with the caller*. The TC also discusses 'the limitations of Lifeline' with the caller and suggests that face-to-face counselling might provide a better avenue for the caller to help her 'resolve her feelings'. The TC notes reflect that *she struggled to understand the caller's 'presentation'* and that she *found it difficult to 'get in her shoes'*. The call lasts for 39 minutes. The TC noted that *the caller might have attempted to extend the call by reintroducing her major problem towards the end of the call*.

Researcher's memo

This was a really difficult session to transcribe. The TC spoke very quickly and often slurred her words together. I noticed that the TC asked the Caller a lot of questions, many of them 'feeling' questions, with no real sense of where they were leading. She also seemed to have difficulty in summarising the information for the caller and appeared to be as 'stuck' as she thought the caller was. This was a very frustrating call to listen to and although I was able to identify many of the key questions that seem to be part of the LL approach (i.e., what have you done before? What are you going to do now?), it seemed that the caller was left to come to her own understandings and was often the one doing the counselling 'work' (i.e., summarising, identifying the major problems and connecting the underlying issues). The referral to the caller's attempt to reopen the discussion was interesting. My sense was that this was one of the caller's major concerns that the TC had glossed over earlier; however, at this point the TC begins the process of perhaps getting to the important underlying issue (power and control) before ending the call. It was a struggle not to focus on the TC's skill level rather than listen for the broader themes, and I was left asking myself the question 'what was it in this call?' It's a shame that I didn't get the opportunity to interview this caller.

Initially all the data were coded as 'free nodes'. Free nodes were used to capture just a word or phrase without assuming any relationship or imposing any structure on the ideas. During this phase no preconceived codes or categories

were applied, instead the nodes were created and defined by the content of the interviews and telephone counselling sessions, that is in-vivo codes derived directly from the data and capturing the words or phrases that were actually said by a participant and recorded in the transcripts. An example to illustrate this initial coding process is included in the following figure.

Figure 6.1. Example of *in vivo* codes

Interview extract	<i>In-vivo codes</i>
<p>I just have a mash of feelings and sometimes I'm disconnected completely from any sense of a feeling. So what I tend to now do is ring lifeline and talk around something, to find out what it is I'm feeling, ...these days I can actually identify feelings, it's more when I'm very overloaded and so what that does is actually, (it's) like a depressurising of feeling overwhelmed and if I'm able to do that I don't actually get as depressed</p>	<p style="text-align: right;">Mash of feelings Disconnected completely from feeling Ring Lifeline Talk around something Identify feelings Very overloaded with feelings Depressurising feeling overwhelmed Feeling overwhelmed I don't get as depression</p>

As this process progressed and I began to observe similar themes emerging, I moved on to formal coding. From this point on any text that did not seem to fit with existing codes was coded at the same time as a new node was created. These initial codes were provisional and grounded in the data. Wherever possible, in an effort to stay close to the data, the language of the participant grounded the development of codes and category labels so that categories that captured and preserved actions and processes were utilised.

Focused coding

A second phase of data analysis followed. This focused on coding to synthesise and explain larger amounts of the data, by utilising the most significant or most frequent earlier codes to sift through large amounts of data. This required assessing the adequacy of the initial codes and deciding which made the most analytic sense to categorise the data incisively and completely (Charmaz, 2006). This is in keeping with the aim of grounded theory coding practices which is to 'account for as much variation in behaviour in the action scene with as few categories and properties as possible' (Glaser, 1992, p. 18). During this process some *in vivo* code names were changed to reflect more general constructs that better expressed what was being learnt from other participants. An example to illustrate this process is included in the following figure.

Figure 6.2. Example of focused coding process

Interview extract	In Vivo codes	Focused codes
I just have a mash of feelings and sometimes I'm disconnected completely from any sense of a feeling. So what I tend to now do is ring lifeline and talk around something, to find out what it is I'm feeling, ...these days I can actually identify feelings, it's more when I'm very overloaded and so what that does is actually, (it's) like a depressurising of feeling overwhelmed and if I'm able to do that I don't actually get as depressed	Mash of feelings	Reasons for calling
	Disconnected completely from feeling	Connecting with LL
	Ring Lifeline	Using talk
	Talk around something	Connecting with feelings
	Identify feelings	Identifying change
	Very overloaded with feelings	Attending to feelings
	Depressurising feeling overwhelmed	Helps
	Feeling overwhelmed	Change
	I don't get as depression	Outcomes

Initial codes ranged widely over a variety of topics and oftentimes segments of data were multiple coded to capture what was happening. The NVivo computer program enables the slicing of data into component parts by coding the same data into multiple codes (Bazeley, 2007). In this study for instance, if a caller reported finding several things helpful, such as the repeated telling of their story,

talking to different telephone counsellors and being able to express emotions, rather than creating nodes for each combination and repeating *helps* several times, just one node was created for *helps*. In this way, if callers talked about some of these aspects as also being unhelpful, the same section of data might also be coded as *hinders*. For instance, talking to different telephone counsellors was coded as both *helps* and *hinders*. The NVivo program then enables the reconstruction of links between the data when needed through the use of a coding query.

Codes continued to be refined as central categories emerged and became more apparent. For instance, it became clear that 'connecting with feelings' was only one aspect of a much bigger theme. 'Connecting with the problem, 'connecting with the telephone counsellor' and 'connecting with the organisation' were all aspects of 'connecting' that emerged as a central phenomenon.

Axial coding

As the analytic process advanced categories reflected both descriptive as well as broader more complex themes. These tended to be more abstract codes reflecting overarching ideas, such as 'managing the system'. At this stage I started to connect both existing and any emerging new nodes into a branching system of tree nodes that reflected the structure of the data. For instance, categories that were seen as relating to the counselling interaction, such as 'telling the story', 'talking about feelings' and 'containment', were classified as subcategories of 'counselling interaction'.

In this final stage of coding the aim was to relate categories to subcategories and specify their properties and dimensions (Charmaz, 2006). According to Strauss and Corbin (1998) axial coding builds a dense texture of relationships around the 'axis' of a category. In this way the data that has been fractured into separate pieces and distinct codes during initial coding is brought back together as a coherent whole so that the studied phenomenon can be more fully described.

This final phase helped to contextualise the telephone counselling phenomenon, so that conditions and processes were related and the complexity and dynamic

nature of events understood. For instance, a recurrent caller's sense of being 'disconnected from feelings' (open code) and her 'needs' to 'connect' (focused code) becomes frustrated because telephone counsellors work at 'containing the call/er' (focused code). The ensuing attempts at 'managing the interaction' and 'managing the system' are mediated by conflicting 'needs' and plays out against the tensions associated with 'anonymity' (loss of), 'discontinuity' (talking to different telephone counsellors on each occasion) and 'time' (frequency of calls and unknown duration of interaction). The latter, being axial codes that reflect both actions and conditions, can also be seen as relating to the central theme of 'connecting', insofar as they all revolve around and/or influence the type and quality of connections.

Validity and Trustworthiness of Qualitative Research

In any research study it is important to consider issues of validity of the claims derived from data. This section addresses the limitations of traditional conceptions of validity adopted in quantitative research, and presents relevant standards for qualitative research practice.

Traditional concepts of rigour

Historically, in the disciplines of science and psychology, validity and reliability were reliant on the development of logical and empirical methods for discovering objective reality or truth. Verifiable through replicated research, valid and generalisable laws were assumed to emerge and correspond to observable reality. This approach attempts to exclude all biases from the research inquiry by working with pre-designated hypotheses expressed in terms of independent and dependent variables. Such an approach is based on an empiricist assumption that we live in a knowable world in which there are universal truths, expressed in terms of cause and effect, which an objective observer can discover.

Clearly, the philosophical and theoretical underpinnings of this research project do not lend themselves to this type of approach. While acknowledging the

ongoing debates about the relevance of validity criteria in qualitative research, writers argue that, in the absence of universal validity procedures, trustworthiness, established through ensuring rigour in the process of data collection and analysis, is essential.

Trustworthiness criteria for qualitative research

Trustworthiness is often defined as the equivalent of validity (Jacelon & O'Dell, 2005). Lincoln and Guba (1985) proposed that trustworthiness is a more appropriate concept for the practice of qualitative research. They proposed a number of strategies to enhance the trustworthiness of claims, including prolonged engagement, member checking, triangulation, peer debriefing, negative case analysis, thick description, and reflexivity. Researchers are encouraged to select the strategies most relevant to the study. For example, in ethnographic work the notion of prolonged engagement is particularly important and this is a key strategy adopted by those who draw upon this design framework.

While I drew on a combination of strategies throughout the research process as tools to enhance trustworthiness, some practices were more difficult to incorporate, potentially posed additional challenges or were not relevant. For example, member checking, the practice of consulting with participants and allowing them to read and discuss the research findings, was limited by callers' anonymity. In addition, although this practice is seen by some as enhancing credibility, it relies on the assumption that there is a fixed truth that can be accounted for by the researcher and confirmed by the participant (Sandelowski, 1993), which is in opposition to the epistemological paradigm underpinning this study that depends on the intersubjective creation of meaning (Angen, 2000). Member checking may also present problems. Examples of these include, participants difficulties with understanding abstract synthesis, participants and researchers having conflicting agendas and different stories to tell and participants disagreement with the researchers interpretations (Angen, 2000). As a result, member check procedures were not implemented. Instead, in recognition that all research is subject to researcher bias and in order to manage

subjectivity (Morrow, 2005), external auditing of the analysis, which included the reviewing of sections of raw data and its interpretation by two research supervisors, as well as supervisor and peer debriefing, in the form of critical discussions about the researcher's experiences and reactions, was undertaken. Prolonged engagement, observation and audit trails are other strategies that are recognised as enhancing credibility, as is reflexivity (Freeman, deMarrais, Preissle, Roulston, & St. Pierre, 2007; Morrow, 2005; Ryan, Coughlan, & Cronin, 2007), which is seen by some as contributing 'significantly to the substantive validation of the work as the necessary precondition for all further understanding' (Angen, 2000, p. 14).

Therefore, the main practices I incorporated to strengthen the rigour of my interpretations were, triangulation of evidence methods and sources, prolonged engagement through periods of consistent observation, and the maintenance of a reflexive stance, principally achieved through a reflective journal and reflections on self as researcher. These processes are outlined in more detail below.

Triangulation of evidence and sources

The rigour of data collection and analyses in this study was achieved in several ways. Firstly, multiple data sources provided opportunity for comparison of data between different types of data sources as well as among and between participants and allowed a more comprehensive understanding. Secondly, telephone counselling sessions and interviews were audio taped as a way of ensuring complete and unbiased recording of the information, thirdly, full transcriptions of the audio tapes were prepared and the transcripts checked against the original recording. In addition, I repeatedly listened to the recordings as a way of immersing myself in the data.

Reflexivity

Reflexivity has been seen as a critical practice to ensure the trustworthiness of claims generated from qualitative research, because, in qualitative research, the researcher is the instrument of data collection and qualitative inquiry (Patton, 1990; Seale, 1999). Reflexivity can be defined as a practice whereby researchers explicitly and self consciously look back upon their research process and provide an account of the study's impact on them and their impact on research participants. This appeared to be a particularly important consideration throughout the study especially during data collection. The growth and development of the study was profoundly affected by my interactions in the field as were the participants affected by my presence, their interactions with me or simply because of the existence of the study.

Throughout the data collection process I kept a journal to document my research experience and reflections. Initially these were recorded on paper and reflected what I saw happening at the Lifeline office, or within telephone counselling or interview accounts. Included in the journal were observational notes, design and sampling decisions, comments made by participants, and personal reflections about the tensions that occasionally arose during the research process as well as recommendations about how things might have been done differently. Self-reflective memos documented my personal reactions to situations, participants and participant narratives. The use of a reflective journal by researchers has been identified as a criterion to facilitate the rigour of qualitative inquiry (Lincoln & Guba, 1985; Patton, 1990; Strauss & Corbin, 1990).

In addition, during the data analysis process I used writing as a method of inquiry and data analysis, utilising the process to help me think (Richardson & St. Pierre, 2008). While sorting the data using the computer program I recorded analytic and self-reflective memos to document and enrich the analytic process and to make my reflective thoughts explicit (Charmaz, 2006; Miles & Huberman, 1994; Strauss & Corbin, 1998). These helped me to develop and explore ideas and consisted of my thoughts, questions, musings and speculations about the data. Throughout the computer based data analysis process I also used

annotations to make notes about particular segments of data and memos for storing reflective thoughts and ideas. These became progressively more analytic as data analysis progressed and helped to increase the level of abstraction in my ideas and to raise certain codes to conceptual processes.

Throughout the process of data analysis I drew diagrams to better conceptualise the relationships between the data. I recognised that my own awareness and attention to these process elements was critical to the quality of the research product (Patton, 1990). Writing about these process elements formed a significant part of the analysis itself and helped me make connections and develop ideas (Richardson & St. Pierre, 2008).

A further element of reflexivity involved reflecting on my own biography and the experiences and interpretations I bring to the research. The following section provides a brief overview of my background and the assumptions I brought to the study.

Researcher's biography

'Lifeline' is a word that holds multiple meanings and represents a variety of possible interpretations and perceptions. When I began this research project I recognised that I brought my own preconceived notions and ideas about Lifeline. As a health practitioner, with 12 years of counselling experience, I was familiar with the name and had a vague idea of what Lifeline offered to the community. For me, they provided additional support to clients, or perhaps, more specifically, an out of hours safety net that meant I didn't have to be available 24 hours a day.

While my orientation to therapy is strongly influenced by particular approaches I believe that healing is facilitated through a process of genuine dialogue and that the therapist's human qualities and the therapist-client relationship are of primary importance. Furthermore, I see therapy as a collaboration between the therapist and the client, within which they share responsibility in co-constructing new stories and solutions to concerns; that the quality of the therapist's

'presence' plays a crucial role; and that a comprehensive approach goes beyond focusing on intra-psychic dimensions and addresses the social and environmental dynamics that influence us.

Given my knowledge about the mental health field and the challenges of working within this discipline I had certain expectations of the type and quality of intervention I would observe whilst on site, imagining a highly professional organisation with very astute and capable telephone counsellors. Lifeline's high public mental health profile and the community's dependence on their presence and perceived ability to respond to all needs lent further weight to my preconceptions.

I came to this research project feeling enthusiastic and motivated, I couldn't wait to get started and I was determined to avoid the pitfalls I had experienced when conducting past research projects. My initial conversations with Lifeline Melbourne and Lifeline Head Office had provided substantial reassurance regarding accessibility, co-operation and timely collection of the data required. I anticipated collecting my observations and recorded data quite quickly so that I could get on with the job of data analysis. I soon realised that this neat separation was not going to happen as I became immersed in the environment and built relationships.

While I started out struggling to balance the requirements of a PhD project against conducting a piece of applied research that would fulfil the needs of the organisation as well as the conditions of the attached ARC (Australian Research Council) grant, I was also unprepared for the ever changing and emergent nature of a qualitative research endeavour and the many challenges associated with observing and collecting the data.

Understandably I expected that I might have some difficulties as an outsider conducting research in such a highly emotive and sensitive field. I imagined that there might be some reticence about sharing all of the intimacies that this experience encompassed for both caller and counsellor. In talking to both callers and counsellors, listening to the interviews and reading the transcripts numerous times I came to realise that this expectation did not eventuate. However, it is

difficult to know if they would have divulged more information or perhaps a different type of information in a face-to-face interview. It may be that in the case of this specific topic, rather than being a hindrance to disclosure, the telephone interview acted to facilitate it.

While my expectations with regard to taking part in the study and engaging in open communication were not realised, there were other aspects that, unexpectedly, surfaced. For instance, anonymity, or the idea of it, was a facet that I observed to be often zealously guarded. Telephone counsellors and callers rarely exchanged names, even if the telephone counsellor was able to identify the caller, knew their name or had spoken with them previously, they rarely acknowledged this. During the period of data collection I experienced a fierce resistance from many of the telephone counsellors who viewed an invitation to callers to take part in the study as an attack on the caller's anonymity. Much of the gate-keeping role that many undertook was dominated by this concern. I often found this frustrating and, at times, I struggled with the notion of holding the idea of anonymity above all else, especially when, in practice, it often did not exist.

At times, as my involvement with the organisation and the research developed, I found it increasingly difficult to walk the line between being part of the environment and yet also being apart from it. In particular, despite my best efforts to avoid being evaluative, at times I struggled with this. My positioning as a counsellor and also as a researcher influenced the way I saw, heard and interpreted interactions. Particular incidents were especially challenging and during these times I was aware of my counselling stance and associated analytic processing of what had transpired. I was also aware of these factors during the formal data analysis process. A number of memos reflect my experience of these incidents and my reflections on them.

It seemed that I was also perceived by staff as embodying aspects of both counsellor and researcher and, as relationships developed, my feedback from these different perspectives was often sought. For instance, telephone counsellors were eager to improve their skills and wanted guidance, and the organisation was keen to gain evaluative information that would assist them in

improving the service. These encounters challenged me on a number of fronts, perhaps first reinforcing my struggle not to be evaluative. However, they also appealed to my natural desire to reciprocate their eagerness and willingness to assist in the research endeavour yet also required that I maintain a heightened awareness of my role as researcher and the boundaries associated with this undertaking.

My engagement in self-reflection, through written memos and repeated interrogation of the data, highlighted my changing perspectives of Lifeline and challenged my original assumptions and expectations. Initially these were more closely aligned with perceptions of a highly efficient corporate organisation. As time went by this featureless representation was transformed into an image of many caring individuals who strive to help others. While this shift inevitably highlighted their fallibility, it also heightened the level of esteem I felt towards them as I came to more fully recognise the many challenges associated with providing a telephone counselling service accessible to anyone struggling emotionally.

Entry to the setting

I began the journey as a passive outsider; a stranger in the midst of a hive of activity within the Lifeline office, whose reason for being there was to begin the process of data collection. I waited to be invited and arrived at the appointed time. I signed in at the reception desk and attached my 'visitor' badge, feeling my identity as something 'other'. Each time I went to Lifeline I waited to be met and escorted into the protected inner hub. The building and reception area held no hint of the work being undertaken within its confines. No signs adorned the building or the reception area and while all other floors on the building display were clearly labelled with the names of tenants, the floor where Lifeline's telephone counselling took place was unsigned and gave no indication that the offices of Lifeline were located within.

On entry, a reception area blocked any vision of what lay beyond. I noticed a few rooms to the side as I walked through to the main section. This consisted of an

open plan office with a small section of cubicles to one side and a few larger desks. The colours were muted beiges and greys, and all the usual office furnishings were in place. Telephone counsellors worked within the low lying cubicles and each had a computer terminal. Above and on the wall was an LED sign that flashed a message telling counsellors that there were calls waiting and also thanking them for the work they were doing. Some counsellors were busy on the telephone whilst others were typing on their computers. Administrative managers worked at other desks and the shift supervisors' desk was positioned to enable them to hear and observe the telephone counsellors at work. Shift supervisors were constantly alert to the telephone counsellors body language, the occasional hand in the air seeking assistance, as well as the one sided conversations that could be heard.

I was surprised to find this unassuming space, somehow expecting something more sophisticated with many more people busily attending to needy callers. I felt out of place, uncertain of where to position myself and of how I would be received. Initially I was placed in a side office, within sight and hearing of all that was occurring outside, but separated. During my first few visits I fielded a few visitors of my own, some of who were friendly and interested, while others were prickly and defensive. During this initial period I spent much of my time learning about Lifeline, reading documents and wading through masses of information stored on computer and discovering how they came to be, what their daily operations looked like, how the service worked, what the telephone counsellor training involved and what demand there was for the service. As time went on I spent less and less time in the office and more and more time out on the floor where the real work was being done.

I slowly built relationships and rapport with managers, trainers, supervisors and telephone counsellors, enjoying many interesting conversations as well as observing the telephone counsellors at work. In addition to this entry period I spent in excess of 160 hours in the Lifeline telephone counselling room both observing and interacting with the staff whilst ghosting the telephone counsellor participants.

I was aware that as soon as I entered the Lifeline offices and while observing and in conversation with Lifeline staff and participants, I was engaged in critical reflection and interpretation. Data collection, in the form of recorded telephone counselling sessions and follow up interviews, was slow during this period. However, the time spent at Lifeline afforded me the opportunity to become immersed in the environment, build relationships with staff, and gain a deeper understanding of the processes in place as well as the organisational culture. This information, collected as a by product of the research process, facilitated the conceptual development of the study through observations of daily activities, in particular telephone counselling interactions, and through my own interactions with the environment, organisational culture and informal conversations with the staff. For instance, through my observations I developed an understanding of unspoken organisational cultural attitudes and beliefs and was able to witness how these influenced everyday workings as well as individual counselling interactions.

Commentary

A qualitative design utilising aspects of a constructivist grounded theory approach was chosen as the most appropriate methodology because it sat well with the theoretical underpinnings and practical endeavour of psychotherapy. It reflected the researcher's ontological and epistemological positioning and lent itself to research questions designed to explore social interactions and experiences (Kennedy & Lingard, 2006).

In accordance with the aims of the research, the purpose of the analysis was to uncover the dynamics of the telephone counselling interaction in the context of the Lifeline model, and explore how these influenced the telephone counselling endeavour through the exploration of telephone counselling interactions together with caller and counsellor perspectives and experiences.

Chapter 7

FINDINGS

Features of telephone counselling

In the previous chapter the rationale and research procedures used to collect and analyse the data were described. The purpose of this chapter, the first of three chapters on the findings of the study, is to describe the features of Lifeline telephone counselling service and report on both caller and telephone counsellor perceptions. Reasons for calling and the facilitative conditions of empathy, unconditional positive regard and genuineness are also considered. These data comprise observations, telephone counsellors' written comments of interactions and caller and telephone counsellor interviews. Perspectives from these different positions are presented separately.

In order to assist with clarity of presentation, there have been instances where words have been added to quotations that assist in making sense of what is being said. To highlight the points at which this has occurred these words have been put in brackets. This is common practice in the presentation of quotations and the meaning is not changed by the addition of the word (Patton, 1980; Wolcott, 1990). I have chosen to provide each caller participant with a pseudonym in order to remind the reader that they are real people and at the same time to protect their identity. In addition, references to face-to-face counselling practice and literature are incorporated to help situate Lifeline telephone counselling within the counselling context. This intermingling of findings with discussion from the literature is common in the presentation of qualitative research findings, and assists in linking data and interpretations (Patton, 1980). These strategies have been employed throughout the Findings chapters.

Caller perspectives-Accessibility

One of the important features that emerge from the data of Lifeline's telephone counselling service is accessibility. Accessibility reflected a number of facets. These included accessibility from the perspective that telephone counselling was affordable, that it was convenient and easy to access and that it was accessible immediately and at any time. Perceptions that telephone counselling provided a certain level of safety and control together with being anonymous could also be seen as facilitating accessibility. The literature has consistently expressed the belief that low cost, convenience, privacy, control over the session and anonymity are attractive features of telephone counselling (L. J. Haas, et al., 1996; Rosenfield, 1997), however, only recently has empirical evidence been reported to support these assertions (Reese, et al., 2006).

Affordability

An important aspect of the Lifeline telephone counselling service is its affordability with the cost of accessing other mental health care professionals rendering them out of reach for some. Rosemary, an acute crisis caller who makes occasional calls to Lifeline, commented on the financial difficulties of accessing face-to-face counselling:

...I mean, the other alternative really is to see a psychologist, or to seek psychologists' help or whatever it is. But I've done that and it costs heaps, not that I don't want to, I think it is good, but it's just the cost factor (Rosemary)

Given that increased psychological distress is related to low income and that typically these individuals access counselling services less (Urbis Keys Young, 2002), the availability of free or low cost telephone counselling means that this form of counselling provides an important public health service.

Convenience

Callers to Lifeline spoke of convenience as an important feature of the service. This is aligned with the literature that argues that convenience is a major attraction of telephone counselling (Reese, et al., 2006). For Nina using the telephone meant that counselling was within easy reach '...it was easy for me...at my fingertips'. Or for others, such as Brett, the 24 hour service meant that counselling was available during the night when other supports were not.

I could be feeling down at whatever time of, you know day or night, and um it's not really a good idea to, particularly late at night, to speak to someone... I suppose it is that convenience... and you don't want to disturb people at that time of the night in particular (Brett)

The number of calls made to Lifeline during the night suggests that many people experience difficulties at this time. Jane had also felt the need to call during the night.

There's been times where um, I guess, like there was a death in my family and I was awake in the middle of the night one night and was completely lost, and so I rang and spoke to them and they just helped me feel grounded and connected once again rather than sort of being in this limbo land of, you know, emotional limbo (Jane)

Immediacy

The ability to access support as and when it was needed and at any time of the day or night provided more than simple convenience. The ability to address any concerns or emotional distress whilst they were foremost in callers' minds enabled them to better process and manage their difficulties.

This was critically important for many of the callers:

... I've actually got um, to an emotional state where it's if I don't get this off my chest now...I don't know that I can function all that well and I can't wait for a counsellor ...when it gets that kind of um intense. Then it, somehow, I've just got to talk it over. And

*then that actually kind of brings everything back into perspective.
(Tracey)*

Being able to access assistance when she needed it allowed Tracey to address intense feelings and alleviate some of their effects. While this helped Tracey to regain some perspective it likely also reduced her level of stress and potentially allowed her to access and process new material.

Connecting with and working to understand and manage feelings is recognised as an important aspect of therapy (Carter, 2003; Ehrenreich, et al., 2007; Paulson & Worth, 2002). For Diana 'years of intellectualising to cope and survive' meant that she had become disconnected from herself and her feelings. She needed 'something immediate to know what's happening right now' before she engaged her usual defences, for her '(face-to-face) counselling is too retrospective'.

Immediacy was also important for those who utilised the service more as an adjunct to other supports. In Brett and Wendy's case, waiting for their next appointment with their psychiatrist often meant that the opportunity to work through a particular problem was lost.

...sometimes things happen and by the time it's time to go and see him again, that issue has subsided (Brett).

I was just so grateful that he (the telephone counsellor) was there... and that he helped me out, because I don't know what I would have done... because the time that I rang up, I was in dire straits. By the time I wait to go and see my psychiatrist, it sort of, the urgency of it has gone. It's dissipated (Wendy).

Accessing counselling when they deemed it to be necessary helped to ground callers so that they felt more able to cope. In this way they could be seen as utilising counselling and telephone counselling for different purposes. For instance, in Jane's case, face-to-face counselling was more an ongoing process that didn't provide the 'immediate help' she needed. On those occasions when she called Lifeline it was because it wasn't something she could 'leave for a week', she wasn't able to 'understand' what was 'happening' for her and as a result was 'freaked out' by it. Calling Lifeline was often a way of coping with

difficulties between visits to face-to-face counsellors. For Marion, it had helped her through some difficult times:

...it has been fantastic because I have been able to get through, you know, some tough times and um, tough days, you know, where the anxiety level was, you know, too high... 'cause sometimes when you go to see counsellors you can't always see them straight away...the people give you a little bit of advice um sort of leading up to your appointment with your counsellor and it does help because, you know, at that point, sometimes at that point, you know, you are feeling really anxious about something and you think, oh my God how am I going to cope (Marion)

In Lauren's case the ability to access help immediately transformed the service into something more closely related to social support, representing a parent figure, the one who responds to needs as they arise:

...its hard because when you need help that instant, you can't ring up a counsellor and say, can I book you in, and then, you know, they say 'oh you have to wait for two or three days'...It's when you need help, it's just like having your mum or dad around, like you can just say, now I'm really bogged down, I can't wait for um, three, four day appointment to see the counsellor...Because if you make an appointment with the outside counsellor, by the time the appointment comes you probably have just waddled through your problem (Lauren)

'Waddling' through the problem suggests that it is perhaps not resolved to Lauren's satisfaction. Despite this, even in the event that she attends a face-to-face counselling appointment, it seems that Lauren felt that the opportunity to address the problem would be lost.

The ability to connect as they needed to allowed some callers to utilise the service as a preventative measure, for instance in those moments when they might relapse or engage in unhelpful behaviours. As Rita explains:

Like you might have felt like going out and drinking, or might have felt like going over to see you know a particular person who might not be good for me to see. So it's a good sort of stalling sort of tactic as well (Rita)

The immediacy of the intervention allowed Rita to utilise the service as a delaying tactic that helped her to better manage and break habitual or unhelpful patterns of behaviour.

There was also some indication that the immediacy of the intervention somehow changes the way callers process the interaction and its outcomes. For instance, Harry reported that he processed things differently during and after a telephone counselling session from the way he would during or after a face-to-face counselling session. During the telephone counselling session he more often processed the content and interaction immediately and did not hold onto things for a long time afterwards. This was different from his experience with face-to-face counselling:

...see when you walk away from a counsellor, you know, you think about it for a while...I work out what you're saying on the telephone at the time. (Harry)

Another possible interpretation is that telephone counselling is utilised quite differently to face-to-face counselling, accessed as and when it is required to alleviate uncomfortable feelings that, once dissipated, are no longer a concern. In this instance the interaction would not challenge the caller in any way and would require little further consideration. For those callers who access other services different supports might be assigned different roles and engaged with and processed quite differently, depending on the needs they fulfil and the way they are accessed.

While this study incorporated this item under a 'convenience' factor, callers to Lifeline also pointed towards another inherent aspect that the ability to access help as needed provides, a sense of safety.

Safety and control

Safety can be seen as referring to two different domains. The first relates to the knowledge that help is at hand, should it be needed, and the second concerns lowering the risks associated with engaging in a counselling interaction, such as

feeling shame or embarrassment, or being judged. While Lifeline's presence addressed the first concern, the callers' sense that they had some control of the counselling interaction, helped to manage the second.

Concerns around feelings of safety and control were apparent in three ways. In one way Lifeline's presence lent some sense of safety in case of emergencies, perhaps acting as the equivalent of the police, fire or ambulance in that a person is able to call for help at any given time. Individuals expressed this as knowledge that 'there's someone there for you' and that 'you can pick up the phone' at any time, '24/7'. This was particularly important for those callers who believed they had little or no social support.

A second aspect of safety is that callers do not have to cope with seeing and being seen by the counsellor, so that being 'blind' to the counsellor means that they do not have to deal with additional body language information. An extended quotation is presented below to illustrate the way in which a reduction of visual cues and the judgements reduced the level of risk and increased the level of perceived safety.

Like you tell them things about things that have happened, you know things that um, things about yourself, they look at you and you're wondering oh do they like me, am I accepted...am I OK, do I look OK, do you like me, um, what do you think of me. But when you are on the telephone, its more like, it seems to be easier for me personally, seems easier for me to talk on the telephone, than it is to see... face-to-face can be scary. As well as talking about problems on a counselling line can be scary as well. The point is with a counselling line you may never talk to that same person ever, ever again... to talk to somebody over the phone you don't have that contact of being able to see the person... there are times when I couldn't sort of handle people face-to-face... (Harry)

In this way the telephone counsellor's inability to see the caller seemed to increase the caller's perception of control. It would seem that it also reduces some of the perceptual processes in that callers have fewer concerns about the way they are being perceived by the other and are equally less engaged in processing the physical attributes or environmental cues associated with the counsellor. This reduction in visual cues might also help callers to feel less

inhibited and ease disclosure of personal information. For instance, feelings of embarrassment might be more easily dealt with. Control, including the client's desire to control the tempo of the session, has been reported as one of the main attractions of telephone counselling (Reese, et al., 2006) and it would seem to be an important element to consider in terms of the value of telephone counselling.

Another aspect of control was the sense of having the ability to end the interactions should it become too challenging, uncomfortable or threatening:

I went to counselling but sometimes it's, sometimes the... sometimes the counsellor can be quite blunt too, um, when you're face-to-face with them they are blunt to you, I feel uncomfortable because then you can see the facial expressions and you sense that they are tense and that you have paid for that session and you can't end the conversation (laughing). You can't escape (laughing). You have to go in and finish the session. You just say, oh, I don't like your facial expression, can I go now? (Lauren)

Telephone counselling affords the client an easier way out than face-to-face counselling, as Harry stated, "...I'm in control, I can hang up any time". Being able to disengage from the telephone counselling interaction by hanging up requires considerably less interpersonal effort than would walking out of a consulting room. To this extent, clients appear to have more power when using the telephone.

Box 7.1. Reflections on safety and control

Telephone counsellors, too, can more easily end the interaction and perhaps there is some sense of safety in this for them too. While this is perhaps a less common occurrence, during the period of my observations, I did witness it on a few occasions. Often this response from the telephone counsellor was a reaction to abuse or anger on the part of the caller, nonetheless, on at least one occasion a telephone counsellor hung up on a caller out of sheer frustration and anger after a period of conversation during which she struggled to manage the caller, who she considered was being uncooperative.

Difficult clients and those who express feelings of anger towards the therapist are not uncommon. Addressing these feelings and interactions are often the work of therapy. The ability of either the caller or telephone counsellor to easily disengage from interactions, such as these, means that opportunities to explore, understand, and possibly change, callers' feelings, behaviours, experiences and outcomes are missed. In addition, the effects of telephone counsellors disconnecting might reinforce negative experiences and expectations. This aspect of telephone counselling possibly represents a double-edged sword.

Anonymity

Anonymity is a dimension of telephone counselling that might be seen as being closely related to aspects of safety and control that callers might perceive as being helpful. Anonymity, however, appears to be a much more complex and multifaceted phenomenon with both helpful and unhelpful aspects that can influence the type and quality of the counselling interaction and therapeutic relationship.

Anonymity initially engineers a sense of safety so that callers might feel more comfortable and disclose information more confidently:

I just thought Lifeline would be the best to talk to, like anonymously, like they don't know you and you don't know them, kind of thing, and you can talk to them more confidently in a sense (Rosemary)

Anonymity also provides an environment that allowed callers to engage with another person more openly, perhaps helping them to overcome inhibitions, cultural constraints or more easily cope with feelings of shame or embarrassment:

I feel always freer, if I could just have somebody that I don't know, you know, that don't even, who can not put a face...put me to a face. I feel freer I can talk more, I mean I could persuade myself to be more open... but I still haven't come across, I still haven't been able to be open, um, to talk, you know, as intimately as I'd like to (Alison)

While providing some reduction in a caller's anxiety, anonymity alone does not seem to be sufficient for full disclosure. In a face-to-face counselling environment full disclosure often occurs slowly over time as the client comes to trust the therapist. In the telephone counselling setting, revealing anxiety laden issues also remains largely dependant on the therapeutic relationship rather than on staying physically anonymous to the telephone counsellor. The difficulty in telephone counselling is that callers do not develop individual relationships that allow them to incrementally reveal themselves and their struggles to the counsellor. What it does do for many callers is provide a beginning point, an important stepping stone towards fully engaging in therapy. Alison recalls how Lifeline encouraged her to overcome her fear of attending face-to-face counselling:

I remember in the beginning when I was talking to Lifeline I was very afraid. Lifeline always encouraged me to go to counselling, but I was always afraid to do anything face-to-face, I wasn't able to do any of those things... (Alison)

Feelings of safety, control and anonymity, together, also provide an environment that allows those who struggle with disclosure and relationships to engage with another individual on a more meaningful level and yet maintain a certain distance. For Diana, this means that she can suspend this aspect of her difficulties:

It's anonymous, it means that I don't have to deal with the issue of closeness, I don't have to face-to-face see someone and see

how they're reacting to me, so there are a lot of issues about closeness that Lifeline actually helps me to deal with (Diana)

Box 7.2. Reflections on anonymity

While this is a positive element there are also potentially negative elements. Diana is an example of a person who admits that she is constantly challenged where relationships are concerned. In this instance the therapeutic relationship offers the opportunity to address some of her difficulties in a safe environment. Enabling her avoidance of developing, maintaining, experiencing and working on a relationship level may not be helpful in the long term.

Another facet of anonymity is that callers are able to create their own image of the telephone counsellor. Harry makes reference to this aspect of not knowing:

...you, (the telephone counsellor) might be overweight, or you might have tattoos all over you, you might have this, you might have that, you might have a pierced nose... (Harry)

The counsellor's anonymity has been posited as a possible advantage of telephone counselling that allows the caller to construct an ideal view of the counsellor unhampered by their actual appearance (L. J. Haas, et al., 1996). This has potentially negative aspects though, perhaps reducing the telephone counsellor's persona and therefore the quality of their presence and influence. Harry's perception seems to point to this when he says 'they're not real. They're just voices'. Telephone counsellors may have to more actively communicate their presence. Harry goes on to explain:

I just don't want to talk to them without them, I want interaction. I want active interaction (Harry)

The caller's desire here is for the experience of a substantial connection and, although all of the aspects mentioned here have helpful qualities, a major disadvantage is that the power of the therapeutic relationship and the associated

benefits are largely lost. Another disadvantage of this is that those callers who struggle with developing and maintaining relationships are not required to or challenged to do so. As a result they also miss the beneficial experience of, and the therapeutic opportunities, this type of relationship offers (Goldfried & Davila, 2005).

An additional drawback of anonymity is that callers may feel unable to effectively address any concerns they might have in connection with their dealings with Lifeline. At one level this may be related to the difficulty of providing feedback with no identifying information at hand. Another might be associated with the lack of continuity where the caller has little sense of any benefits attached to doing this, perhaps finding it easier to make contingency plans, such as hanging up, in the event they should strike the same, or another, unhelpful telephone counsellor. For Lauren, addressing any difficulties or problems she'd experienced was an additional burden she preferred not to take on:

I'm not sure that I should complain about, you know, everyone because sometimes it's just not worth it. Let other people deal with them, because I have enough on my plate as it is (Lauren)

This means that opportunities are lost for callers, to be able to address negative experiences, for telephone counsellors, to further their learning, and for the organisation, to improve their service. Many callers also expressed the desire to provide positive feedback but felt equally inhibited in being able to carry this through, often taking the opportunity to express their feelings to me during the research interview.

I appreciate everyone, whoever that spoke to me, the several times that I called and whoever that spoke to me I appreciate it very much and, I mean I don't know their names, or whatever, its anonymous, like I said, I appreciate it and I thank you, you know I thank them for it. For listening to me... (Rosemary)

While anonymity might be expected to improve caller feedback, it would seem that it also decreases the likelihood of this occurring. Ultimately, any concerns callers might have may be deemed as minor against the value they place on Lifeline's telephone counselling service.

The anonymity continuum

Although a rule of the service, anonymity runs along a continuum that ranges from complete anonymity to complete recognition. As callers repeatedly reconnect with the service their level of anonymity becomes increasingly eroded. Callers may have a sense that they are recognised and telephone counsellors often recognise the caller and their story, however, they seem reluctant to acknowledge prior interactions. Both will generally defer to the anonymity 'rule' and will collude in maintaining this fiction. No reference is made to any previous discussion, or any knowledge or understanding that the telephone counsellor might hold about the caller's problem, or the caller.

As callers became aware of an accumulating loss of anonymity within the service they also became aware of a shift in their interactions with individual telephone counsellors. Diana describes her experience of this shift and her perception of the reasons behind it:

I think what they do is they have a profile on me at the moment, right, and that profile gives the people that speak to me a guideline of how to answer and respond (Diana)

Protecting the idea of anonymity as an essential condition influenced the quality of the interaction and the therapeutic relationship. It was also an impediment to effective case management, which, although often a necessity, is commonly not openly discussed with the caller. In this situation the caller has little opportunity to take part in an important aspect of their therapy and may perceive the process negatively, as Diana explains. She also sees this process as a mechanism that protects Lifeline:

In a sense I feel that there is an undervaluing of me in that process because I'm actually not participating. It's the gathering of the information about me and the profiling together, but there is no um... it's a protection of lifeline not a protection of me... It's a protection of their workers but it doesn't necessarily protect me and I don't have any input into it, apart from the calls (Diana)

In general, practitioners tend to discuss case management strategies with the client, however, in this particular instance the tension between achieving effective case management and maintaining the façade of anonymity becomes increasingly difficult. While callers gain some sense that they are being case managed, they have little understanding of case management practice, process and aims. Instead they perceive it as being unsupportive:

I know very well that what we talk about gets handed down to supervisors, down to other people, they talk about you, when you've finished. I can't be one hundred percent certain on that but I do believe they say it's confidential, but it's not, they talk between themselves (Harry)

Harry is very much aware that he is no longer anonymous within the service and has also come to realise that the service works as a team. In and of themselves neither of these aspects are necessarily unhelpful, however, Harry's perception of this is quite negative, perhaps because it has not been openly discussed with him, he does not feel part of the process and he doesn't understand the parameters of confidentiality as it applies within this service. As a person struggling with significant mental health problems Harry's perceptions have the potential to reinforce his problems and experiences.

Another potential problem lies with the service incorrectly identifying callers and being mistakenly linked to other caller profiles and treated accordingly. Unbeknown to Harry this was the situation he found himself in. Despite providing a significant amount of information about himself, as recorded by the telephone counsellor in their notes, he was initially identified as another caller and managed according to the other persons profile. As a result the telephone counsellor misconstrued Harry's problem remarking that 'he masked his profile very well'. This meant that Harry's very real problem received no meaningful attention. Harry's 15 minute interaction with this telephone counsellor might have been quite different had a more open and authentic communication occurred.

This lack of transparency has the capacity to breach the delicately balanced counselling relationship as it precludes the customary terms of openness and

honesty that underpin a counselling interaction. While callers may struggle with the effects of anonymity erosion and the façade of anonymity, the repercussions of these conditions can leave telephone counsellors feeling equally disempowered:

... when a caller had thought I'd spoken to her before and I hadn't and she was convinced and she thought that I was...she really thought I was lying to her and I just I didn't have enough bags in my tricks...tricks in my bags to be able to convince her that I hadn't spoken to her before or to be able to really even save the relationship because she thought that I was lying to her (TC3)

For telephone counsellors, maintaining the silence that the façade of anonymity demands, can be a difficult task:

...like one caller that I have spoken to before like I've let slip that I remembered a lot more about their calls than I probably should have ...cause one of his issues is over connecting with the service, it made him feel special and made them feel that there was a relationship there, in that case I think it was quite detrimental um, 'oh you remembered', 'well you do call a lot', I mean, rather than make it seem like it was someone, something, special and I remembered because it touched me in some way, it sounds awful, I mean, all calls touch me in some ways, but, like, I don't want...I don't know it's... yeah, I don't know if that's necessarily information they completely need (TC3)

Both callers and telephone counsellors come to recognise explicit and implicit rules. As recurrent callers come to learn about the effects of breaching these rules they may try to find a way of superficially complying with them while manipulating the conditions. For instance, they might try to vary their topic of choice to avoid being identified. Telephone counsellors come to realise these caller contingencies and recognise that presenting issues may not always be congruent with the caller's real difficulties:

...the message that the organisation kind of gives out is that its not OK to just ring up and have a chat because you're feeling lonely um, people ...you do sometimes get a sense that people create issues so that they are allowed to, you know, talk to someone for half an hour or whatever about something, and in fact that particular issue is probably, you know, something that they've thought of but, you know, they wouldn't... they wouldn't probably um, you know, mark it down as a life um... really

important life changing issue or anything like that, it's just that they want to be able to, you know, have a conversation with someone to get started for the day or to reduce their feelings of loneliness or whatever (TC1)

Despite their best efforts, however, some callers remain identifiable, often because their story does not change significantly. In turn, telephone counsellors curb the degree to which they engage with the caller:

...having that issue does mean that he can talk to someone for half an hour a day or whatever. And actually since ...since he has been identified by the organisation as a regular caller um, I think that um the ...the counsellors aren't as receptive to him and so I think the service is much less satisfying to him, you know, he's much more defensive now when he rings up he says 'oh look you probably want to get me off the phone straight away because, you know, you don't want to talk to me about this, but um this is what I want to talk about' (TC1)

For many recurrent callers the loss of anonymity appears to generate a cycle that creates tensions for both the caller and the telephone counsellor. These may be observed in the content of the interaction and in the relationship that develops between the caller and the telephone counsellor. While denying any knowledge of the caller may be seen as managing the caller's tendency to over connect, it also challenges the telephone counsellor's capacity to be genuine and provides little opportunity for the service to actively address the reasons underlying the caller's behaviour, thereby limiting their capacity to effectively manage these callers.

Connecting

Connecting can be seen as having two meanings, the physical connection, through the act of making the telephone call, and the human connection, through the act of talking and interacting with the telephone counsellor.

Reasons for calling: Connecting

Making connections, and in particular the opportunity to connect with another human being, seemed to be a common need that underpinned callers' reasons for calling Lifeline. Calling Lifeline to make a connection was illustrated particularly well by comments from both Rosemary and Harry who identified the need to connect with someone as an important motivation for calling Lifeline:

I just wanted to let it out and just cry about it, or just wanting to talk to someone and just feeling lost and depressed about it, and just needed someone to talk to really (Rosemary)

Sometimes you just have to talk to somebody...Just so long as you know that somebody else is alive out there...I get really lonely and I just want to hear a voice (Harry)

Callers' needs evolved over time, nevertheless, the core elements revolved around talking and telling their story, being able to talk about feelings and being heard, validated and understood. Unlike first time or occasional users, regular recurrent callers tended to lean more towards exploring those elements that necessitate a deeper connection, such as sharing emotional pain and exploring questions of a more existential nature. In the former case, referral information, advice and exploring for solutions more commonly defined the interaction. This probably reflects the different types of caller, their needs and the different role that Lifeline plays for each. These aspects first influence the quality and depth of the connection.

For many callers, simply knowing that there is someone 'out there' seemed to provide a sense of comfort. Knowing that an avenue existed to speak with another person seemed to be enough to carry some callers through moments of difficulty and provide them with a contingency plan should they feel out of their depth:

I've called in the past, but it has been a long time since I called...I actually got to hear it through the media...I kept the number in my diary, so if ever I'm in dire straits and I need to talk to someone I can ring up Lifeline (Wendy)

On occasion, difficulties getting through to Lifeline seemed to allow the caller time to reassess their problem or change their perspective. After spending some time redialling or on hold their problem did not seem as pressing as they first thought or they perceived other callers as more in need than themselves.

Yeah, that's how I see it, um, if it doesn't get straight through, then um, [I] feel like maybe it's not such a big problem (Marion)

Attempts to get through or time on hold might operate as a holding device, or a stopgap. Perhaps it is as an action that mediates between the feeling and the response, holding the person and helping them better tolerate those few minutes when they're feeling overwhelmed.

Yes, sometimes you can get through straight away, other times you might have to wait even an hour or even a long time... I might feel like, oh well, it's busy I will try again, and then later on you're too busy to try again...But what you can say to yourself, what I say to myself is, if I'm really desperate, no I'll try tomorrow, or I'll try the next day (Marion)

An alternative explanation is that the act of making the call creates for the caller a greater awareness of their problem and a need to consider and prepare for relating this to the counsellor. Although the exact percentage is not known, studies indicate that 15% (Howard, Kopta, Krause, & Orlinski, 1986) to 66% (Weiner-Davis, de Shazer, & Gingerich, 1987) of clients experience positive pre-treatment change. A later study conducted by Lawson (1994) replicated these findings with 60% of the 82 clients questioned reporting positive, complaint related pre-treatment change. Like face-to-face counselling, where the benefits of therapy can be seen as beginning prior to attending the first appointment (Howard, et al., 1986), callers appear to begin the process of therapy before actually connecting with the telephone counsellor. For instance, they might prioritise their concerns or prepare themselves to talk about difficult issues, thereby raising their self-awareness. This was evident on those occasions where the caller had some difficulty getting through. After coming to some understanding about the core of her problem, Alison recalls her preparation and anxiety as she waited to talk about her difficulties for the first time:

'...something in me made me nervous about what I was about to say, that I didn't think I could put it over, if I could or could not, I was having this indecision and this anxiety thing and I thought maybe if somebody picks up the phone then I could talk about it...' (Alison)

At other times, callers' need to connect was much greater and they become frustrated in their continuing efforts to get through. Despite the frustration, for the recurrent caller who was familiar with the system, there was some reassurance that they would eventually get through, even if they had to delay their call until the next day.

This 'holding' property is an unseen element of the service and it may be that there are times when just dialling the number has some beneficial effects. For instance, Alison reported how she had made the call with no intention or expectation of talking to someone. She anticipated not being able to get through and was utilising this aspect of the service as a 'test drive', a way to prepare for being able to talk about her problem when she was ready.

I know there's a queue, and I might not be ready to talk, I might be a little bit chicken and sometimes it's good to be ringing up and say, you know, have to try again and try again and try again (Alison).

When her call was answered immediately Alison considered saying 'thank you very much' and having 'a very trivial conversation' with the telephone counsellor, but she chose not to because the person who answered her call allowed her to 'become more emotional' and 'cry':

I was lucky because I, it was, um, like last time I was lucky I rang and somebody picked up the phone immediately...So I didn't feel hopeless. Most, a lot of times when I do ring um, a lot of the times, I couldn't get through because it's so busy (Alison)

Whilst Alison felt lucky in getting through this was not what kept her on the phone. In this instance it was her connection with the telephone counsellor that facilitated the therapeutic process. Callers phone lifeline in the hope of experiencing an interaction that fulfils their need. This hope seemed most tangible for the recurrent caller, who, despite experiencing both ineffective and,

at times, harmful interactions with telephone counsellors, continued to call in the hope of connecting with the 'right' person.

Oh, I just hang up the phone, I, you know, sometimes, you know, that there are (unhelpful) people like that and sometimes it's best to just hang up and try again and hopefully get a different person (Lauren).

In hoping to get a different telephone counsellor, callers are also hoping that they will eventually connect with a telephone counsellor who they judge to be a good fit:

I'll ring back later to get someone else, because I can sense that that person may not be able to deal with what I'm talking about (Diana)

Expectations

Client expectations are considered by some to be one of the common and third most influential factors associated with therapeutic outcome (Meyer, et al., 2002), influencing the quality of the alliance as well as clients' active engagement (Connolly Gibbons, et al., 2003 ; Joyce & Piper, 1998). In initial face-to-face therapy sessions, therapists usually try to establish a context in which clients can talk about their expectations of therapy. This might include, exploring expectations of each other as well as of therapy, discussing confidentiality and its ethical limitations as well as establishing the boundaries of the therapeutic relationship. For many practitioners, this is an essential beginning to building and developing an open and candid relationship with the client. If nothing else, a discussion about the client's expectations of therapy helps to relieve some of the client's anxiety, ensures that their expectations are realistic and allows both therapist and client to share a common goal (Frank, 1968).

In the Lifeline telephone counselling context this process tends to be condensed and discussion around expectations limited, or in most cases absent. Exploring these aspects of the therapeutic interaction may appear to be peripheral and deemed as unimportant in the light of a time limited one off interaction. Most

clients present for their first therapy session uncertain about what to expect and first time callers to Lifeline are no different. As a first time caller, Anita 'didn't know what to expect'. She recognised that 'there was no solution' to her problem, nevertheless, she felt 'very comforted' by this first experience. Anita had little expectation other than to gain some comfort from the interaction saying 'I guess I needed a bit of comfort that night'. As a first time caller Jackie too was uncertain and initiated her conversation with the telephone counsellor by first checking that she had called the 'right place'.

While callers, even those more seasoned ones, seemed to hold little expectation that their call would result in any significant change for them, there was some expectation that the call to Lifeline would help in some way. However, this hope seemed to be directed more towards what might occur during the counselling interaction rather than at any possible solution or outcomes. As Diana explains:

When I ring lifeline I have no expectations that the other person will solve anything for me, that's never my expectations, maybe some people do, and maybe some people on the other end of the line have that hope too, I don't know but um... for me its ...its about the interaction and about the feeding back probably, looking at things slightly differently (Diana)

Diana's 'hope' had perhaps become eroded or changed over time. It seemed now to be contained within the exchange and the possibility of shifting perspectives. Expectations of the telephone counsellor were another aspect of the interaction that callers held:

Listening and I mean giving advice wherever possible I suppose and, yeah, really, I suppose, just listening mainly... (Rosemary)

Rosemary goes on to explain how her expectations differ between face-to-face counselling and telephone counselling, where interactions are limited by time and continuity.

I suppose if it's one on one, if you're going with a psychologist, one on one, I suppose they are different in the sense that they actually listen to your problems, like each week and then they ask you questions each week, so what did you do, or whatever, you know they sort of give you exercises and things like that to do.

And I mean that's how I think they, what they do..., it's not much difference like in the sense because on the telephone I suppose, because like Lifeline is like you only get, like you know you don't get the same person all the time which means that you can't expect that...on a telephone call you cannot expect them to give you all the feedback, give you all the clinical advice (Rosemary)

Rosemary's understanding of the rules of engagement, that dictate a discrete time limited connection with a different telephone counsellor on each occasion, tempers her expectations of what's possible. Having to pay for psychological services also raised her expectations of outcomes and their durability.

I suppose if you go (to a psychologist) and you pay, you would expect some result in that sense, you know, that you get better...To be better...Whereas Lifeline is a temporary thing I would say (Rosemary)

In Rosemary's view 'it would be silly' to expect any long term change from calling Lifeline. Jane's expectations had shifted somewhat over time. In Jane's case though this was perhaps due more to her changing needs so that what began as an expectation of being kept safe had become one of support and direction.

...it's completely different. I can see I'm really a lot more independent emotionally...and it's more that sort of guidance now rather than the actual, you know, help me stop myself from, you know, hurting myself (Jane).

Alison also had an understanding about the rules of engagement, knowing also that she had to be prepared with a specific problem. Her expectations of any outcomes seemed slight. In addition, she had an expectation that her call would not be answered, which led to a surprising result, as she explains:

It wasn't my intention to get anything out of it because I'm seeing a lot of professional people to help me now, I'm very open to talk about my problems face-to-face. But it was Lifeline who helped me to see the clarity myself (Alison)

The clarity that Alison is referring to is a significant insight about her grief issues that she achieved as a result of her call. It was perhaps her very lack of

preparation and subsequent unedited disclosure that resulted in her achieving this unexpectedly helpful outcome.

Although callers' expectations of telephone counselling and the interaction were not actively sought or explored by telephone counsellors, telephone counsellors understood callers' expectations as revolving around being able to tell their story and being listened to:

...they've got a good idea when they ring up what they are going to get from it and that's really just someone to listen to their story and help them cope in some way, by being able to tell the story (TC1)

Attributes of the telephone counsellor: Core conditions

Therapist interventions encourage, support and empower clients to explore their story and begin the process of deconstructing their subjective position in problem stories (D. Howe, 1993; Wolfe, 2005). The qualities of the therapist as well as their level of competency and skill allow for the depth and richness of client narratives to develop. Empathy and curiosity, unconditional positive regard and genuineness open the way for clients to tell their story (C. R. Rogers, 1957). Wendy recognised these qualities and described how she perceived their different facets:

He (the telephone counsellor) was very patient with me, very supportive, very encouraging. Yeah. It was all good, I mean I was just feeling so um down in the dumps and I thought oh my God, what am I going to do (Wendy)

Callers were encouraged and strengthened by the telephone counsellors supportive, open, accepting and affirming attitude. These aspects are also thought to promote the formation of the therapeutic relationship, the quality of which is believed to be an essential ingredient and often the most valuable part of the therapeutic experience (D. Howe, 1993). In order for callers to let down their defences they need to feel secure enough to do so. The telephone counsellors understanding and acceptance provided a holding environment that allowed callers to be vulnerable.

Empathy

Empathy has been recognised as an important factor in therapy and has been consistently related to positive therapeutic outcome (Bohart, et al., 2002). It is believed to facilitate clients' better understanding and trust of themselves helping them make behaviour changes in positive directions. Empathy is also believed to be fundamental in the formation of the therapeutic relationship (Wampold, 2001), helping clients feel understood, increasing feelings of safety and providing a corrective relational experience (Greenberg, Watson, Elliot, & Bohart, 2001). Experientially, learning that they are worthy of being heard and respected and that their feelings and behaviours make sense empowers clients to express needs and feelings in other relationships (Greenberg, et al., 2001).

Empathy involves verbal, such as mirroring words and feelings, and non verbal communication, such as listening and showing interest, expression. Establishing and maintaining empathy is perhaps more difficult over the telephone where body language cues, such as facial expressions, are absent. In this instance telephone counsellors must rely more heavily on voice, language and vocal responses to help the caller feel understood, accepted and valued.

Observations and reviews of telephone counselling sessions revealed that telephone counsellors often softened their voice and lowered their tone during those times when they were empathising with the caller. The tempo of their speech also tended to slow and they provided the caller with assurances of their attentiveness with frequent minimal encouragers. Telephone counsellors would provide feedback by recognising, acknowledging and validating feelings and the difficulties and challenges facing the caller.

Callers easily recognised these sorts of responses as signs of empathy. For Diana, the telephone counsellor's ability to empathise without the need to hear all of the details of her problem was also a reflection of the telephone counsellor's skill:

She was empathetic um, ...very quickly empathetic, she didn't need me to go in to a lot of explaining, she seemed to understand

very quickly, which to me shows that she was skilled... She said things like 'that must be very hard' or 'that must... I understand that that must be very tough' things like that which, I guess, the empathetic part of that is that 'its OK I'm not judging you' (Diana)

For Diana, signs of empathy also communicated the telephone counsellor's unconditional positive regard. The telephone counsellor's manner was another way callers measured empathy. For Rosemary, signs of empathy were reflected in the telephone counsellor's voice:

...if they sound like really, really friendly, or really, really concerned or something like that then I will open up more (Rosemary).

She finds herself being more cautious when speaking to male telephone counsellors or to 'older' telephone counsellors, perhaps anticipating a lack of empathy and a limited understanding of her. Generational and cultural mismatches were seen as one of the ingredients involved in empathy breaks. Two participant comments that capture these mismatches are provided below:

I did strike one elderly lady once on the phone who umwas really quite rude to me um ...really, really rude... and I think that that was her generation and how she looked at and perceived things from her experiences in that generation (Diana)

I think she's quite a racist and you can hear her, um, the way she talks to you, that kind of um, question that she put to you, it's really mean. It's kind of very racist question and they put to you, either because she's reacting to what I've said...instead of staying neutral, I think she has forgotten that she's on Lifeline...she got pretty angry (Lauren)

On occasions when callers perceived telephone counsellors as not being a good fit, or if they were 'unsure', they tended to 'hold back'. Callers experienced these interactions as unhelpful.

Callers were aware of and quickly recognised the signs of empathy breakdown. Those instances when the telephone counsellor didn't understand the caller's position in relation to their specific problem and instead engaged in platitudes, were also experienced as unhelpful:

Someone had said to me something like um yeah there's light at the end of the tunnel and, you know, things that were way down the track that there's no way that I could see it at the time...And it's like well that doesn't help me right now (Jane)

In Rita's case, her struggle to be understood translated into a battle to try to convince the telephone counsellor that she was not going to harm herself. A struggle she almost lost to the telephone counsellor's conviction that she was at risk of doing just this:

There was one time where I was told that my depression was so severe that they were concerned that I would do something to harm myself, and I kept saying, but I'm not that depressed, I'm depressed but I know I'm not going to harm myself. And I got off the phone thinking, maybe they're right and I will, and, you know, that wasn't helpful (Jane).

Telephone counselling interactions that callers experienced as being unhelpful were generally put down to the telephone counsellor's inability to 'understand' them. On other occasions the caller's perceptions of the telephone counsellor and their disposition interfered with the development of rapport and the caller's experience of empathy. While some callers might choose to hang up in this event, others were apt to challenge the telephone counsellor:

...once in a blue moon, you know, you'll get people who are um, like really tired and they tend to talk a bit louder and I tell them, I say that, what you've had a bad day or something? Um, then they will, he, the person will calm down, and I say it's OK I better let you go because it seems that you are overwhelmed by the phone calls coming in. Sometimes he will just say, no, no, no, I am trying to help you out here, let's talk. Well depending on my mood I just say no, I think you've had a long day, you know, I'll just figure it out myself (Lauren)

Too much emphasis on the technical aspects of 'doing therapy' were also experienced as damaging the connection and was another source of tension in the relationship. A sense that telephone counsellors were going through their paces interfered with callers experiencing a meaningful connection:

It's just a routine...personally I don't want that, I don't find that attractive...its like, they're like robots, they're like tiny miniature robots...There's no, the fact you're talking to a robot, or you're talking to a telephone machine, or you're talking, I know exactly what they are going to say and I know very well they are going to get me upset...you can't hear the heart beat, you can only hear their head working (Harry)

Harry's perspective echoes Beck's warning that an automatic and rigid use of technical interventions leaves therapists appearing to their patients as "robots, busily engaged in uttering clichés or employing 'gimmicks'" (Beck et al., 1979, p. 45).

Callers benefitted most when they perceived the telephone counsellor as being empathic. Interestingly, Lauren experienced her most recent interaction as 'very helpful' and described the telephone counsellor as:

...an extremely wise person who can direct you pretty well. I think she's very um, patient, a very calm person, um. She can show you a way to go and direct you in the um, until you feel enlightenment...(Lauren)

This was despite the telephone counsellor's reported struggle throughout the interaction to maintain empathy and her recorded comment that 'she [Lauren] irritated me'. The telephone counsellor's ability to be aware of and yet contain any negative feelings that might have been directed towards Lauren ensured that Lauren's perception of the telephone counsellor's empathy remained intact.

Alison's perception of the telephone counsellor's empathy was possibly the core ingredient in her experience, which allowed the telephone counsellor to 'draw' out her grief. For the first time Alison felt safe enough to explore her feelings. This was the beginning of the process of connecting and being more comfortable with her grief. Through the validation and confirmation of the caller's story, telephone counsellors communicate acceptance of the caller's experience. This acceptance, often referred to as unconditional positive regard, is understood as being an essential feature of empathic understanding.

Unconditional positive regard

Feeling understood and perceiving the counsellors as non-judgemental increases feelings of safety in the relationship, which facilitates self-disclosure and makes it easier for people to approach difficult personal feelings (Greenberg, et al., 2001; Kirschenbaum & Jourdan, 2005). In this regard, callers were particularly sensitive to any signs they associated with being judged:

...that's a particular issue I have even when I start I'm very sensitive to people judging me. I can very easily pick up if someone is being critical (Diana)

The caller's perception of the telephone counsellor as impartial and non-judgemental was an important factor. Callers had some expectation that the lack of any personal involvement would mean that the telephone counsellor would naturally embody this attribute:

It was also the fact to that um, I guess they weren't connected with me in any way so they weren't going to judge...the issues that I was going through (Jane)

Moments when telephone counsellors struggled to understand the caller did not always result in a loss of empathy and connection. The telephone counsellor's genuineness in the following instance opened the way for a candid interchange, conveyed respect and positioned the caller as the expert:

I've had one person say to me, 'I have no idea what you're talking about, but I will help you through the best I can'... I think that really um, yeah, that really had an impact on me because it was, that person was being really honest with me (Jane).

Telephone counsellor perspectives

Like callers, telephone counsellors were equally aware of callers' need for human connection:

If they feel like they need to connect with a human voice they'll call...(it's about) human contact for people (TC4).

...when they reach out there's someone there and that's... that's the perception, a very strong perception I have on (this), is that (it's about)...connecting (TC5)

Despite telephone counsellors' understandings, however, there are some indications that telephone counsellors and callers perceive the active ingredients of the interaction quite differently. For instance, telephone counsellors seem to perceive the counselling relationship as secondary to intervention while callers appeared to most value a meaningful human connection and weighted the intervention components as less important.

Rather than seeing the therapeutic relationship as a tool that might be utilised as a corrective experience, telephone counsellors more often imagined that it would unhelpful and create dependence:

I think particularly with, um, long time long term callers, 'cause I don't think it would be good for them to...well, I know they're calling for a social connection with an anonymous person, I reckon it would be a lot more inviting if they know they'll call at a certain time and get a certain person and be able to actually connect both up, um, and it'd be a lot more addictive and not helpful (TC3)

The counselling relationship was also not generally perceived to be an especially active component of the counselling interaction:

I don't think the relationship was extremely important. I think the fact that she had some kind of opportunity to talk about what she wanted to talk about was important, but um that she um, you know, was just given an opportunity to talk in a way that she chose and that the, you know, the relationship that developed

was adequately supportive but I don't think it necessarily made a big difference (TC1)

In many ways, these views contradict telephone counsellors' awareness of the power of the therapeutic relationship. At the same time, they do not believe it plays an important part, other than the recognition that it is better avoided. Perhaps this is because they regard an ongoing therapeutic relationship as potentially addictive and, therefore, unhelpful for the caller. It may also be that telephone counsellors view the therapeutic relationship and the conditions under which the interaction is occurring as incompatible.

Some telephone counsellors' believe that anonymity somehow engineers a loss of individual substance:

I sort of always get the feeling like, we're not very tangible, like we're there and we answer the phone, but... because nobody knows who the TC's are (TC3)

Others may be prepared to trade some of their presence for other benefits they perceive anonymity as providing. Since anonymity goes both ways, it seems to impart some sense of protection for the telephone counsellor too.

... I wouldn't... I don't think I'd do it, I wouldn't do it on the phone if it wasn't anonymous ... I think it can be good um for the caller because like, I know, because it ensures the emphasis is kept on them and it's not, cause like we're not people, not for a moment, we are, I mean, we say things that piss them off, but in general, generally they can talk without um without thinking of us as a person um and like, it really isn't, the calls aren't about us at all (TC3)

Being intangible and ensuring that the emphasis is on the caller might alleviate some of the anxiety telephone counsellors' experience in their work. This position, however, reduces the telephone counsellor to a receptacle and denies the influence they might have on the caller.

From this perspective, anonymity can be seen as providing safety for both the caller and the telephone counsellor; however, where anonymity might facilitate caller disclosure of personal information, for the telephone counsellor it ensures a

certain relational distance. For callers, the lower level of psychological intimacy that anonymity and using the telephone provides perhaps enhances the feelings of safety and control. Although affording a sense of protection, where telephone counsellors are concerned, it may also be a hindrance.

In the absence of any visual focus therapists may have difficulty maintaining attentiveness or could become preoccupied with extraneous tasks while on the telephone. One telephone counsellor commented:

I doodled, this might sound a bit weird, like I was doodling on my paper, because I think, like there was definitely like 10 minutes in the call when I don't think I was engaged as well as I could have been, I could have been more challenging, I say that because usually, I didn't realise I was doing it, but when I know I'm...when I doodle, like, I know I'm not 100% engaged (TC3)

Telephone counsellors are often aware of their inner processes, the tensions that are sometimes present, and the challenges associated with maintaining empathy and communicating understanding:

Sometimes your beliefs and inner core values are challenged, and having the ability to work with a caller without um, letting any personal feelings or maybe negatives senses of what's happening in a call...override your um...being able to maintain, being level, being empathic and keeping an open communication...(TC5)

Telephone counsellors also struggled to maintain empathy during moments of frustration or at those times when they struggled to connect with a caller:

There is [sic] repeat callers, um, there certainly (are) regular callers that I get very, very frustrated with, um, and (I'm) certainly not nearly as empathetic with them as I would be with first time callers (TC2)

Feelings of frustration were most often experienced with recurrent callers. Frustrations were often triggered by a perception that the caller was 'unwilling to engage in a counselling process'. However, the caller's status, as recurrent or 'repeat', also played a part in this, possibly because telephone counsellors' perceptions of the service did not fit with their perception of these callers.

Telephone counsellors' initial expectations of the types of callers they would be dealing with changed with experience. Where they might first have expected to be working with people who were experiencing an acute crisis, in time, they discovered that this was more the exception than the rule.

Oh yes, I thought it was going to be all suicide calls but it wasn't, which was good...I was expecting something different...I didn't think I'd have as many regular callers um... definitely didn't think that...I didn't really have expectations about what I would be doing with them and, like how infrequently you intervene...that's my understanding that developed with time (TC3)

This telephone counsellor's perception appears to suggest that gaining some sense of intervention with recurrent callers is more often the exception than the rule. Along with the realisation, that not all callers would be in acute crisis, telephone counsellors acknowledged that the style of intervention they used may need to shift as well. With the suicide caller, the telephone counsellor might be working with 'their current plan' so that they can 'bring them back', whereas with other callers there was a sense that they can't 'really deal with some of the long term, longer term issues'. The best they can hope for is to 'help them create a shift in the way that they think about things, no matter how small' (TC3).

Given the nature of psychotherapy it is not surprising that psychotherapists commonly experience self-doubt and regularly question their effectiveness. These feelings of incompetence are a common source of stress amongst psychotherapists and continue to plague many therapists despite the accumulation of experience (Mahoney, 1991; Theriault & Gazzola, 2006).

Although only a small number of research studies have addressed therapists' difficulties in practicing therapy directly, findings point to three main sources of difficulty that broadly reflect therapist, client and situational variables (Schroder & Davis, 2004). Schroder and Davis (2004) defined therapists' difficulties as sitting on a continuum, ranging from brief and passing problems to enduring problems. Impermanent, or transient, difficulties were identified as deficits in competency while more enduring difficulties were labelled paradigmatic and referred to therapists' idiosyncrasies, or intrapersonal features, such as personality and intrapsychic conflicts. Both transient and paradigmatic difficulties

can be seen as being intrinsic to the therapist. In contrast, although identified as enduring, situational difficulties are extrinsic and defined as difficulties that are inherent in the situation encountered by the therapist. This includes circumstances and clients who are experienced as problematic. These are not reflective of therapist level of knowledge and experience or character and would probably be experienced by most as difficult (Schroder & Davis, 2004).

Predictably, transient difficulties tended to occur early in therapists careers, validating this concept as being related to practice experience. Both paradigmatic and situational difficulties were unrelated to practice length. While further training and experience might alleviate transient difficulties, paradigmatic difficulties call for enhanced self awareness and situational difficulties require acceptance and tolerance (Schroder & Davis, 2004). Indications are that therapists have some level of awareness around the components of their competence deficits and this was also evident in telephone counsellors comments and attempts to shift domains of practice.

While not so abstractly defined, Theriault and Gazzola (2006) describe similar factors as influencing feelings of incompetence. Such as professional issues, relating to the possession of necessary training, skills and experience to intervene therapeutically, process-outcome discrepancy, where therapist feel confident in their therapeutic decisions yet incompetent because of the results appeared to be poor, and relational issues, where therapists are unable to develop a positive relationship with the client (Theriault & Gazzola, 2006). Other dimensions included responsibility and boundary issues in relation to change, movement and progress, communication obstacles, such as a sense of connection, and mutual understanding and projection, which referred to situations when the therapist inadvertently assumed their clients feeling of hopelessness, helplessness and anxiety. Therapists personal struggles, life experiences and events that were independent of the client were also seen as factors that prevented them from functioning at an optimal level (Theriault & Gazzola, 2006). Difficulties experienced are likely to contain elements of more than one type and telephone counsellors can be seen as struggling with a combination of each of these domains of difficulty.

These factors and those in the previous sections begin to highlight the challenges of establishing and maintaining a connection. The threats to empathy are clearly apparent. Nevertheless, even if ruptures in empathy threaten the outcomes achieved through counselling, the telephone counsellor's self-awareness and ability to contain their internal processes means that the relationship need not break down.

Commentary

Lifeline's telephone counselling service provides low cost counselling that is easy to access and convenient. This may be particularly important for those who are unable to access help because of financial pressures, lack of mobility or as a result of the effects of psychological difficulties. The ability to call Lifeline at any time also allows callers' access to help as and when they need it and at the time that they deem it to be most helpful. This feature prompted callers to liken Lifeline to an emergency service in that it provided some sense of safety. Other factors, such as anonymity, added to callers' sense of safety. Repeated use of the service, however, saw an erosion of anonymity within the service. Despite this, telephone counsellors and callers generally deferred to the anonymity 'rule' and did not acknowledge prior interactions. In gaining some awareness of this, most often through a sense of being managed, callers might develop some implicit understanding of the rules and attempt to fit in with them by developing particular strategies.

Nevertheless, the loss of anonymity tended to change the dynamic of both the counselling interaction and the relationship. For instance, telephone counsellors changed the way they managed the content and process of the interaction, possibly in response to their perception that establishing a relationship with the caller would encourage dependency. Callers' reasons for calling did appear to reflect a desire for a meaningful connection and the shift in dynamic often frustrated this endeavour. Callers desire for a meaningful connection appears to support Brockopps (2002) thesis that the ability of telephone counsellors to relate to callers through their 'humanness' is particularly important. Maintaining

service conditions and focusing on technique interfered with their ability to relate to the caller in a 'real' way.

Although aspects of placebo, hope and expectancy were discernible, such as going through the actions of calling, hoping to make a good connection and having some expectation of improvement, for recurrent callers the effects of these appeared low. According to the literature this may influence the quality of the therapeutic relationship (Connolly Gibbons, et al., 2003 ; Joyce & Piper, 1998), resulting in the abandonment of goals and reduction in the probability of a full recovery (Meyer, et al., 2002; Sotsky, et al., 1991).

Chapter 8

FINDINGS

The telephone counselling interaction

The previous chapter described features of Lifeline Melbourne's telephone counselling service and explored callers reasons for calling and the challenges associated with establishing and maintaining a meaningful connection. The purpose of this chapter is to explore what happens in practice in relation to telephone counselling interactions, and the perceptions of both callers and telephone counsellors. These data are an aggregation of evidence from all data sources and methods in the study and comprise observations, telephone counselling sessions and analysis of caller and telephone counsellor follow up interviews. While the integration of information generated from these three sources enhances the trustworthiness of the findings, it also allows a more holistic view of the telephone counselling endeavour.

Although it is important to recognise the interconnected nature of the three data sources, each has been individually elaborated upon in this chapter to facilitate the reader's understanding.

Overview of chapter

Commonly observed processes in telephone counselling practice generally fell into four, non-mutually exclusive, domains, using talk to achieve therapeutic outcomes, engaging, facilitating and elaborating, and ending. A number of skills and techniques were used to facilitate these processes and to accomplish the associated tasks, for example listening and questioning. These are explored in more detail below.

- Using talk to achieve therapeutic outcomes
 - Telling and retelling
 - Managing the callers story
- Negotiating the agenda
- Elaborating
 - Questioning
 - Listening and reflecting
- Supporting and challenging
 - Affirming and positively reinforcing
 - Normalising and empowering
- Attending to feelings and emotional content
 - Containing
- Ending the interaction
 - Referrals
- Mapping change
 - Short term
 - Medium term
 - Long term
- Commentary

Using talk to achieve therapeutic outcomes

Talking and language is what we use when we interact and most therapy or counselling involves people talking. It is the usual medium within which the counselling interaction takes place. Clients engage in therapy because they have a need to talk and tell their story. In the process of exploration, understanding and sense making, stories and framing of experiences naturally evolve. It is in the telling and retelling of their story that experiences are linked, made sense of and reconstructed (D. Howe, 1993). They also change through the direct and deliberate intervention of therapists as they seek understanding, question, clarify and challenge the client (McLeod, 1997). This distinguishes therapy talk from other types of talk, such as social discourse.

In general counsellors tend to hold a position of curiosity, which opens the way for clients to tell their stories. Since each telling involves re-authoring of

experience, a significant deconstructive process has already taken place. This is particularly the case if the problem discourse has placed the person in a position that has isolated or denied them a legitimate voice.

In her first telling of her problem Helen shares with the telephone counsellor this experience:

Extract: telephone counselling session-Helen/TC1

I think the thing is that um... I need to be able to feel that I can talk about it and, because it's been so hidden and um, you know, I didn't even tell my girlfriend (Helen)

The first telling is often the most difficult, however, once this is done it can open the way for people to pursue other supports and treatment, as Helen went on to tell the telephone counsellor:

Extract: telephone counselling session-Helen/TC1

Helen sort of feel that listening to somebody else and just to be able to talk about it

TC1 Yes, yeah

Helen It helps me even though, you know, because I really just want to move on and put it behind me

TC1 Yep, absolutely,

Helen um, I've had enough so, I'll go to the doctors and that's the next thing (laughs)

TC1 Alright, well look, good luck with all of that

Helen Thank you

TC1 Ok

Helen Ok, good night

TC1 Bye

Helen Bye

Talking and telling their story also facilitated other processes for callers. For Diana, connecting with and talking to another person often enabled her to connect with and understand herself. As she explained:

...I'd say 99% of the calls that I would make, it's about trying to connect to myself ...um through talking to another person (Diana)

Being able to talk about problems often puts them in perspective and helps to reduce the caller's distress:

I just know about myself that when it gets that kind of um intense. Then it, somehow I've just got to talk it over...and then that actually kind of brings everything back into perspective (Tracey)

Initial telling of the story is saturated with the effects of the problem. As time goes on the counsellor and client begin to identify aspects of experience that stand aside from the problem story. Many tools are used to achieve therapeutic outcomes, including, questioning, reframing, challenging, identifying repetitive unhelpful patterns, externalising, using metaphors and humour.

Talking with different telephone counsellors each time they call and the usually limited duration of calls tends to reduce the possibility that telephone counsellors can incorporate many of these techniques. Some, such as identifying repetitive unhelpful patterns, generally requires a broad enough and deep enough exploration of the client's problem, while others, such as challenging, rely on the foundations of a strong therapeutic relationship. Both require varying amounts of time and continuity in the therapeutic relationship.

For recurrent callers the lack of an ongoing counselling relationship, or discontinuity in the counselling endeavour, resulted in the need to retell their story on each occasion they call.

Telling and retelling

For callers to Lifeline, telling and retelling their story seemed to have both helpful and unhelpful aspects. At one level the opportunity for callers to go over their story helped them to position themselves in relation to their problem:

It was helping me understand exactly where I am, which is often why I do ring Lifeline, I have to say, where am I on this process? Um how far have I moved along? Um... and that's... that's in the reflection back from people, and also about the issues that I have to bring up at the time, helps me reflect back on how I have changed... and so that's a very useful part of Lifeline for me as well... (Diana).

Diana's interactions with Lifeline have enabled her to develop an awareness of her feelings and emotional needs. As a result, her needs have also changed so that she has become more proactive and utilises Lifeline as a preventative resource. Through the telling and retelling of her story Diana is also able to recognise and measure the shifts and changes in her problem narrative. This process has allowed her to identify how she has moved from a crisis narrative to a coping narrative. Diane explains that for her:

It's the going over that's the important thing, somehowum sometimes it's not even the solving that's important, it's the going over (Diana).

For Diana, the 'going over' helps her to connect with her inner disturbance, while for others, like Harry, telling and retelling their story can become frustrating:

When you ring up Lifeline you have to ring them, you might ring them again and again and again. And you have to explain the whole situation, the whole story over and over again, which really, really, really peeves me off (Harry).

Harry's frustration seems to be associated more with not being allowed to fully disclose and explore his problem; instead he has to try to separate out bite size portions that might be more easily digested during one counselling call:

Maybe I do talk about things, over and over, but there's more than one personality in me. I have more than one way of

thinking...well it doesn't matter because every time you ring they want you to talk about something different...I would like to get involved with, I would like to get involved you know, to ask questions to understand the situation, to talk about the situation...I would like them to get involved in the problem and, you know, hash it around, you know, kick it around...I would like them to talk to me at my problem level...But nowadays you don't get that, you say your piece and they say, ah, um, what are you going to do now like? What are you going to do when we finish the call? (Harry)

With little or no effective intervention there is little sense of movement apparently leaving Harry feeling stuck. Nevertheless, his continued use of the service would suggest that he gains some benefit from the contact or that he isn't ready to extinguish the hope that he might gain some benefit. Lisa describes a similar experience when she explains that she often finds the telling and retelling of her story 'time consuming' and 'disorienting', leaving her feeling like she is 'going around in circles'.

The repeated telling of the story provides little opportunity to delve much below the surface of the caller's problem. As a result the quality and depth of the therapeutic endeavour is significantly impacted:

Yeah it is quite different from face-to-face. Um with the telephone I suppose like you say you know, you talk to different people, different, which means then you cannot really, I suppose you only talk about it, the whole time you are talking about the same situation, the same thing (Rosemary)

Nonetheless, telling their story is often an important component of counselling and hearing themselves talk their story can help callers' to reassess or amend their perceptions. Furthermore, in talking to different telephone counsellors callers have the opportunity to hear different perspectives and different ways of thinking about any given problem, which perhaps offers opportunities for gaining insight. In Brett's experience gaining a different perspective has been helpful and on the different occasions he's called the telephone counsellors have provided this:

'... [I] got different perspectives on different things...it's just, like I said a different perspective on how I'd view things at the time, or

have been viewing things... and there's many times where nothing is really solved...Sometimes counsellors have said things to me that have never occurred to me (Brett)

Discontinuity also provided opportunities to connect with and experience different people.

It's accelerated learning, to a certain extent, because when you're ...when you have to worry about a one to one relationship you have to build up a whole lot of things in that relationship before you learn from the other person and trust one of those things, but if you're dealing, very quickly in depth, on trust issues with a whole lot of different people, you're actually learning very quickly, in a funny way, you're learning very quickly a lot of different ways of looking at the same issue, and so it gives you a choice, its like locating about 20 different or 30 or 100 different parents (Diana)

This aspect provides an alternative to the development of an ongoing therapeutic relationship in as much as it challenges callers to develop skills required to engage with different people. It also challenges those callers who struggle with issues of trust to manage these in some way. A concern here though is that discontinuity limits the counsellor's capacity to challenge the caller or to provide a corrective relationship experience. In this way, rather than providing stable fruitful ground from which the work of counselling might begin, the retelling of the story and negatively reinforcing relationship experiences may act more to cement it, and any dysfunctional aspects of it, into the caller's psyche. At times telephone counsellors address their concerns about this directly with the caller:

Session extract: Annette/TC3

TC3 ...one thing that I am worried about is that Lifeline can be a very good service but one thing that I worry about is when people call Lifeline quite often they have to wait and they are going to have to probably speak to a different person each time so it can sort of contribute to feeling stuck, cause we go over... people often go over the same thing in the call and make the same step of progress and then have another call and do the same thing

Annette Yes, and you can get... like I have had in the past um quite a few couns... well counsellors that have just given me terrible, terrible advice and it's just been awful

TC3 *So has... has there been some.... would you like some continuity then? Like, it's something then that, unfortunately, we can't offer*

Annette *I think so, and that can only be provided for in counselling*

TC3 *In fact face-to-face*

Annette *Yes, well um... yes I think a lot of um*

TC3 *What would it take for you to book that appointment?*

Annette *Oh, well I think probably just talking to you and realising that I do need that continuity and someone there*

Managing the callers story

While all telephone counsellors worked within the Lifeline counselling model, they each had their own style and approach to managing the caller's story. For one telephone counsellor this had translated into an approach that allowed the caller 'to tell enough of their story' so that 'they're pretty much free to talk about what they want to and they feel good about someone listening to them'. This telephone counsellor's aim was '...to listen to their story and help them cope in some way by being able to tell the story'. This meant doing 'less containing things'. While the result was that their counselling calls were 'probably longer than most' of the other telephone counsellors, on balance it made it 'easier to ask probing questions because they're (the caller) feeling supported' (TC1).

Achieving this balance seemed to be a major challenge for telephone counsellors. While they recognised that callers had a need to talk and tell their story they tended to try to contain and focus the caller's story in order to make it more manageable. As another telephone counsellor explained:

...I mean, in my mind I really wanted to contain the caller and I really wanted to just focus on something...(TC2)

The constraints that time limitations and discrete interactions engender place the therapeutic interaction under pressures that are not normally present in face-to-

face counselling practice. Trying to achieve a balance between the competing demands of listening and refocusing conversation, at times created tensions that influenced the telephone counsellor's ability to maintain therapeutic conditions:

I started off the call trying to empathise with the caller and I found it really difficult to contain the caller or focus the caller at all, and found it really difficult to butt in, even, you know, to nicely butt in ...and I guess as that went on I became further and further frustrated (TC2)

It would seem that the telephone counsellor and the caller were struggling with competing needs. For the telephone counsellor, focusing the caller on a particular problem is part of the counselling agenda. The frustration at being unable to do this challenged the telephone counsellor's ability to maintain empathy with the caller. In trying to manage this balance, telephone counsellors try to delimit their role:

...you're not trying to find out what happened in their childhood or help them manage their ...you know, if they have like a psychological problem, they're not really helping them manage that in the longer term or doing that sort of therapy or anything like that, its more about helping them find that next step and talking that through and just, you know, if they're in a lot of distress, managing that distress (TC4)

Negotiating the agenda

An important therapeutic task is for clients and therapists to clarify and attend to their respective agendas for therapy. Once clients and therapists have had the opportunity to explore the client's expectations of therapy, the focus of therapy usually moves on to the client's agenda. Clarifying and setting the agenda minimises the chance of misunderstandings and ensures that both parties share the same long term and short term goals. Mutual agreement about goals, their perceived importance and attainability, is closely tied to the quality of relationship (Raue, et al., 1993). Interactions at this time are typically open and direct whilst being respectful of clients' self-determination, autonomy and freedom of choice.

Telephone counsellors generally try to establish an agenda early on in the telephone counselling session. Often this involves the telephone counsellor inviting the caller to identify a specific problem whilst also trying to limit the parameters of the topic in order to try to make it more manageable within the constraints of the call. This is often a difficult process to manage as the following extract illustrates:

Extract: telephone counselling session-Karen/TC2

TC2 it sounds like there is a lot going on and it sounds like, I guess, that this is a really ongoing situation, so I am wondering what we can speak about now, today, that is going to be helpful for you, because it sounds like its pretty stressful

Karen picks up on the telephone counsellor's final word and after describing her level of stress continues on with another chunk of her story. The telephone counsellor again attempts to set an agenda. The response she gets from Karen does little to focus the discussion:

Extract: telephone counselling session-Karen/TC2

TC2 it sounds like there is a lot going on right now, but I'm just wondering what we can talk about now, that would be helpful for you, I guess

Karen Well for me, helpful is just talking to somebody about it, because if I don't, I keep thinking and I pull my hair out..

Further attempts to negotiate and set a specific agenda were equally unsuccessful. The telephone counsellor's experience of this was that she became more and more 'frustrated'. In the following example the telephone counsellor picks up on the caller's indirect identification of a problem and attempts to shift this into the focus:

Extract: telephone counselling session-Robert/TC2

TC2 you said that you called us today about the money so I was wondering what we could talk about now that's going to be helpful for you

Robert I don't know, it's just hard at times

TC2 Yeah

Robert as long as I'm talking to somebody and not rotating it in me [sic] head and depressing me [sic] self now, it will make me feel good, that I have spoken to somebody, I have cleared it up

TC2 So is it the thinking about it constantly, you said, that is the problem

Robert Oh it drives me up the wall it really does, you know

TC2 So what kind of things do you do that helps you to stop thinking about it when you're like this, when you feel like its driving you up the wall

Robert Well, just get on the phone and talk to you for a little while

TC2 Mmm hmm, sure (speaking gently)

Robert and because I am going to feel a lot better afterwards because, you know, I've done what I have needed to do today

Recurrent caller counselling interactions were quite different compared with those of first time callers, who usually presented with a very specific need. Matthew is a first time caller and can be seen as clearly setting the boundaries:

Extract: telephone counselling session-Matthew/TC1

TC1 ...would you like to talk with me tonight a bit about some of the things that you're going through

Matt Um no, no, look I'm simply just trying to use you as a resource if that's alright

Telephone counsellors endeavour to provide callers with some benefit in the little time they have on the call and they can be left feeling ineffective on those occasions when they judge that this does not happen, for instance when they are unable to focus the caller on a particular problem or when the caller simply wants to tell their story.

The tensions that are often apparent in the interaction can also lead to uncertainty about what's on the agenda and who sets it:

Sometimes, if I want to talk about a particular issue where I just want to speak about that particular issue but then, but then like I get, I sort of, I feel that, that's not the issue that I'm supposed to be speaking, I don't know, I don't know how to explain it. It's really weird. And yeah...I don't know how to explain like for instance they say I've got to, I've got an issue, one big issue but then there is also two issues in that issue, if you know what I mean, and I want to talk about the other issue more than the other one. But sometimes I get the feeling that I shouldn't be talking to the other one and I should be talking about that one (Rosemary)

For some, being asked to set an agenda that doesn't 'fit' with their needs leaves a bitter taste:

Well they won't just talk about nothing, they want to talk about something, a problem, they're always prying problems out of you (Harry)

Callers who know the agenda rule will try to prepare a specific topic prior to calling. While this is an attempt to fit in with what they see as the requirements of the services it is also an attempt to manage the interaction. Interestingly, the occasion when the telephone counsellor wasn't drawn into this resulted in a different and quite significant experience for Alison:

Something in me made me nervous about what I was about to say...I was having this indecision and this anxiety thing and I thought, maybe if somebody pick up the phone then I could talk about it, and I was um hoping ninety percent of my mind is saying that ah, nobody is going to pick up the phone, so the subject was forgotten...I had a specific issue in my mind, but I had forgotten about it... and when somebody picked up the phone it was like, I thought wow, what am I going to talk about now. It

was like that. Yeah and it turned out to be most beneficial...I just completely went the other way, because that lady was able to draw my grief out...it's like a grand plan came into execution without a plan (Alison).

It would seem that, having forgotten her 'specific issue', the way was open for some exploration and both the telephone counsellor and caller were able to engage meaningfully and address Alison's deeper issue. In face-to-face counselling this initial engaging process is seen as important for the establishment and maintenance of the kind of dialogue necessary for an effective counselling interaction. This is not just rapport building through validation of the subjective experience but also rapport building that leaves room for deconstruction. The dialogue must also create the condition for the client to feel safe enough to participate in the deconstruction process.

In the face-to-face counselling context the tasks involved during the engagement ritual may typically include creating a context for therapy, for instance the location, physical set up of the space and administrative operations, as well as procedures followed by the therapist such as the length and frequency of sessions. Other tasks may include recognising and attending to any anxieties client might have about therapy, providing any necessary information about therapy, negotiating agendas for therapy, gathering background information about clients and getting conversations started about difficult or sensitive topics. Even in the case of crisis intervention and debriefings, when the therapist and client might only meet once, these rituals are commonly observed. It is during the engaging ritual that therapists and clients attempt to find a meeting point from which they can build a relationship.

Gathering background contextual information about the client is an important task that helps therapists better situate the person in the broader social context in which they live. Often this is quite an involved process and might include a developing a family genogram and history, identifying the nature and development of the client's problem as well as gathering information about previous or ongoing contacts with other health care professionals.

In the Lifeline telephone counselling context this initial phase is somewhat different. Firstly, the caller determines the location and setting and the telephone counsellor has little idea of what these conditions are. Secondly, session duration and frequency are neither predetermined nor negotiated. Thirdly, the context and conditions under which the interaction is taking place seems to render common expectations and understandings about therapy, and the therapeutic endeavour, secondary to the undertaking of the therapy itself. For instance, the sense of urgency generated by awareness that the contact is time limited focuses the actors on the topic and the lack of an ongoing relationship with any individual counsellor renders the gathering of background information secondary. Consequently, this beginning component of the telephone counselling interaction tends to be truncated and compressed.

In addition, it is often the case that the caller is already distressed when the telephone counsellor responds to the call. As a result there is little preparation for therapy to begin and the telephone counsellor is often trying to catch up with and contain the caller, the caller's emotions, as well as the counselling agenda, so that the caller is immediately engaged. This is most commonly the case for those recurrent callers who have become very familiar with the service.

For first time or occasional callers this initial phase might require a little more input from the telephone counsellor, for instance with allaying any concerns they might have. In most instances, telephone counsellors simply extended an invitation to the caller, such as 'tell us about your situation and how we can help tonight', 'what was it that made you call Lifeline today?' and 'tell me about how I can help you this evening'. Telephone counsellors may then continue the process by asking the caller to further clarify their problem.

Elaborating

Therapists usually facilitate the process of elaborating by eliciting and clarifying through utilising questioning, listening, reflecting, supporting, challenging, normalising, affirming and positively reinforcing skills.

Questioning

Questions took many forms, such as direct, closed, open and reflexive, and served a number of purposes depending on what the counsellor was trying to facilitate. Previous sections have already illustrated examples, for instance when telephone counsellors engage the caller by asking 'how can I help?' or when they try to set the agenda by asking 'what can we talk about today?' Open questions are more often used at the start of the interaction to facilitate conversation. In the following extract the telephone counsellor is asking the caller an open question and is trying to further clarify her problem by asking for a specific example:

Extract: telephone counselling session- Pam/TC1

Pam: Do you understand what I mean?

TC1: Yeah tell me, perhaps I would get a better understanding if you give me an example of something that has happened to you recently.

Pam: What do you mean? What's been happening?

TC1: Yeah, what's been happening to you, what's happened to you recently where you have had these thoughts about...?

Pam: I've been, oh I've just been moody and shitty a lot. I've just been moody and snappy.

Other examples, such as 'how often do you feel like this?', helped to explore the parameters of the problem while questions, such as 'what will make you feel less anxious?' and 'When you're able to cope better, what are some of the times

when you feel less depressed or when the tears aren't there and that you don't feel like crying?' began to explore for solutions.

Exploring the caller's problem by posing questions also challenged the caller to consider different perspectives, as Jackie reported, the telephone counsellor was 'asking obviously different sorts of questions'. Telephone counsellors could then reflect on the caller's responses to highlight inconsistencies:

Extract: telephone counselling session-Annette/TC3

So there are two different sides...this woman is very difficult to deal with, but...in other ways you have empathy for her, so...it's difficult to make sense of the entire situation (TC3)

Or to reframe the situation:

Sounds like there's lots of ...like things are going quite well in many regards, you've got a good relationship with your partner but there's things that are sort of threatening and you're not sure of certainty or ... or where you're going to be in a number of months time or what things are going to be like (TC3)

Telephone counsellors often also utilised the caller's responses to their questions as a measure of the caller's engagement with them:

The fact that she didn't actually um respond directly to the questions that I asked her um as we were talking certainly gave me, you know, an indication that um she wasn't, you know, she wasn't necessarily um engaging with me or um...that we weren't on the same level, I guess, or that there was some sort of miscommunication happening um somehow along the lines there (TC2)

Listening and reflecting

Feeling listened to was an important component of the telephone counselling interaction for callers:

...Listening, listening to what you've got to say, listening to how you feel...(Marion).

Listening skills could be seen as falling into active or reflective listening and passive or encouraging listening. When counsellors engaged active listening skills it helped the caller feel heard and understood. Wendy described the importance of this process and how it develops:

I don't need an awful lot of time, but um, I do need enough time to be heard so they can understand what's going on (Wendy)

Simply being heard is often enough as Brett comments 'the focus for me, or the need for me, is just to be heard by somebody'. One way in which the telephone counsellor demonstrated this was to reflect back to the caller what they thought they'd heard the caller saying. This also provided the opportunity for the caller to correct any errors in perception, add more detail to their story or retell their story with a slightly different slant. The following excerpt illustrates an active listening response as the telephone counsellor reflects what the caller has said:

Extract: telephone counselling session- Pam/TC1

Pam: Oh I'm just a bit, I'm just feeling a bit stressed at the moment because I just have a hard day at work...

TC1: Yeah.

Pam: And I'm just a bit tired and...I just... I don't know.... I just want to go to... I'm in my room, I just want to, just relax, you know. I can't relax, you know.

TC1: You're having trouble relaxing and winding down, winding down after your hard day at work?

Pam: Yes

The caller's affirmation verifies the telephone counsellor's reflection. In the following example the telephone counsellor's reflection summarises a number of different elements of the caller's story. This summary provided the caller with a synopsis of the concerns expressed and also communicated the telephone

counsellor's understanding of the development of the caller's problem, her current struggle and her hope for the future.

Extract: telephone counselling session-Helen/TC1

TC1: Look, it seems that this has been rather an unpleasant episode in your life, you feel that you were targeted because you were perceived as being a vulnerable person

Helen: Yeah

TC1: and that um... although it's something that you, you had some control over you feel that you were, you know, lied to and deceived and used

Helen: Yeah, yeah

TC1: by this person, and that it may take you perhaps a little while to, to kind of put this behind you and, one thing that you have told me is that you're not wanting to be bitter and angry about it

Helen: No, I'm trying not to be

TC1: And that you're hoping to be able to perhaps learn something from it and move on

Telephone counsellors also encouraged callers with minimal prompts such as 'mm', 'yep' and 'OK'. Passive listening encouraged the caller to talk with the minimum of intervention on the counsellor's part. Organising their thoughts as they talk and hearing themselves tell their story was often all that was needed. Having 'someone to listen' was important and the following quote echoes Lifeline's founder:

I think it helps to just be a listening ear without saying anything to that, that's very important I think... I think just being, just um, being, just listened [to] (Lauren)

This helped callers to 'understand', 'process' and position themselves in relation to their problem as well as allowing them to 'share' the burden:

I just feel like um speaking to somebody because it helps me to go through the process and um to be able to sort of like just um by talking to somebody it makes me feel that I'm sharing it with somebody else (Marion)

While portions of telephone counselling sessions were characterised by telephone counsellors' passive listening responses, typically the telephone counsellor was much more actively engaged and the interaction reflected a more equal exchange. Only on those occasions when the caller was particularly verbose did the interaction seem more unbalanced reflecting little commentary on the part of the telephone counsellor.

One such interaction left the telephone counsellor feeling that she hadn't helped the caller and thinking that she may have 'added to her (the caller's) level of distress and added to her level of feeling unheard'. The telephone counsellor reported that she had struggled to contain and focus the caller. In addition, her sense was that the caller had not directly answered her questions and so was not engaged with her. Her experience of their interaction was that it was unsatisfactory:

I don't think that there was really much communication in some ways, I feel like um... that in some ways she just wanted someone to I guess kind of blurt all of this on to and that I could have been a blank wall and, I guess, I feel like in some ways it was, you know, that I certainly wasn't, communicating with her in any way that she found meaningful either or that she found um... that she could um... that she could understand or feel heard by ... I mean I don't feel like we really developed much of a relationship, which is not always, it's not always an issue, but I think when someone has called up with issues around um feeling trampled on, which I imagine is what had happened in this particular case with her son turning up that morning and not listening to her, I think that that is when it's really important to establish a relationship where the caller feels heard...(TC2)

On reviewing the telephone counselling interaction the telephone counsellor's efforts to engage with the caller were clearly evident. While the caller's dialogue clearly dominated the telephone counselling interaction, the telephone counsellor took an active part in the conversation and the caller responded to her prompts and questions. What was clear throughout though was that the caller wanted to tell her story and communicate her frustration so that she didn't always follow

the telephone counsellor's cue. The telephone counsellor reported that she often found it 'difficult to contain certain callers' especially when 'there's presentations around frustration and anger' as was the case with this caller. Nevertheless, just prior to ending the call the caller reported herself to be quite satisfied saying 'I've got it off my chest, I feel a lot better' (Karen).

Supporting and challenging

Therapists both support and challenge clients narratives through the implementation of a number of skills, such as affirming or positively reinforcing the client's strengths; normalising their experience and empowering them by placing them in the position of expert of their own stories as well as validating their feelings.

The support that telephone counselling offers can be experienced at a fundamental level and is often what callers' seemed to be searching for in the counselling interaction. For Brett, this translates into a sense of affiliation:

It's that support and realistically, you know, you're searching for someone to say look, OK I'm on your side really, that's me anyway, that's how I feel (Brett)

It is this sense that the therapist is 'on your side' that enables them to also challenge the client; however, this can be risky and if done prematurely or as an unsupportive confrontation has the capacity to precipitate negative process and relationship ruptures (Ackerman & Hilsenroth, 2001).

Affirming and positively reinforcing

Affirming the caller's strengths helped them to feel safe, comfortable and supported.

she asked me, you know, do I know what I'm good at and I said, I don't think I know what I'm good at... And she said something

about that she knows, and she said that I'm good at, you know, being strong about what I've been through (Alison)

By acknowledging Alison's strength the telephone counsellor is reinforcing her behaviour and her capacity to survive her hardships. Reframing and providing a different perspective is another way that telephone counsellors highlighted and validated callers' strengths.

Extract: telephone counselling session- Diana/TC4

Diane: and um, I don't trust heaps of people to ask them for any of my needs to be met

TC4: mm, so you've been quite independent in you life

Diane: Ahh, I've had to be

TC4: Yeah... right, so you've had to build independence and strength within yourself

Diane yeah, right from very early childhood

TC4: yeah...Ok and that's ... Yeah...and so sometimes that's been pretty hard for you

Telephone counsellors' affirming responses also provide a caring and nurturing experience:

There was a point where... I think I was getting a lot of nurturing from the people... that I was ringing. A lot of 'it's OK to look after yourself' sort of information, which was really valuable um ...because no one has really ever said that to me um... at those points in my life I guess um..... and it doesn't really matter too much that it's a stranger that's saying it, because what I'm talking about is something that usually at the time which is quite deep, and so.... that's quite powerful, you know, to be able to open up at a deep point and to hear back nurturing sort of information (Diana)

While caller narratives are supported through positive reinforcement, they are also elaborated on when challenged. An example of a telephone counsellor challenging a story is reflected in the case below.

Extract: telephone counselling session-Helen/TC1

TC1: Yes, what's your thought on that, what kind of things would make it worthwhile, what kind of things would mean that it wasn't a good idea, have you had thoughts about, you know, the pros and cons of why... why is it a good reason to let her know and what ... why would it be a bad reason, I guess, is what I'm interested to know

Counselling relationships take time to develop and, even when established, challenging clients often run the risk of damaging the alliance. Telephone counsellors understand the delicate balance involved in attempting to take callers outside their comfort zone:

I probably um.... like it's hard to say but um ...it was.... I mean, I guess, a fairly long term situation that she had been dealing with and that, you know, you don't want to be umtoo probing or um take... you know, it's good to take things gently ...yes...it's good to push a little bit um um...when something comes up, but um...it can be unhelpful if um ...you lose rapport or... it can be a bit derailing (TC1)

Managing this balance is often difficult for the telephone counsellor but challenging the caller's story is seen as an integral part of the telephone counselling interaction and a defining component of the counselling relationship:

I see it as being a counsellor and one thing that I sort of have tried to work on um since starting has been to challenge callers a bit more when I feel that perhaps they're not wanting to engage in the counselling process, when they're just wanting either just to talk, or just to, you know, um fill in some time or things like that...I think with a relationship you try and build it more into that of a counselling relationship where you might challenge the caller a bit, you might sort of, reflect on what they have said and maybe pick up on inconsistency that you see or, in a nice in a sort of gentle sort of way (TC4)

Normalising and empowering

One way in which telephone counsellors' normalised callers' experiences was to acknowledge them as common and understandable.

Extract: telephone counselling session-Helen/TC1

TC1: you've had pretty um... pretty nasty things happen to you and some pretty strong emotions have come up as a result of that. I guess, you know, it's not unusual for something like this to have an effect for a little while, is that how you see it, that it might take you a little while to recover from what you've experienced

People often feel vulnerable when exposing feelings and an important part of the normalising process involves validating feelings. Telephone counsellors' communicated their acceptance of the caller's feelings through validation:

Extract: telephone counselling session-Annette/TC3

TC3 I think that would be a very normal ... normal thing to get frustrated about...When you... it can be really common to be exhausted and to sort of feel a bit stuck when so many different mixed feelings are going on...

Normalising and validating the caller's feelings provided callers with a degree of comfort. It also helped to separate them from the event or experience, ground them and provided some perspective. Knowing that she could ring Lifeline at a time like this was essential for Jane and helped her to feel 'safe' again:

The fact that I actually knew that I could ring someone else and say OK I'm safe, even though I don't know why I'm feeling the way I'm feeling...be able to phone Lifeline and have someone to talk to, help me feel um safe again...And to have someone say it's OK you're allowed to feel like that ...that it was normal for me to experience what I was experiencing, so the validation is important (Jane)

Acknowledging and validating callers' feelings also provided a sense of being understood. In the absence of anyone else's recognition and understanding this first acknowledgement and understanding of her grief was vitally important for Tracey:

Validation...It was OK to be feeling what I was feeling. ... I didn't feel like anyone that I could speak with actually understood that, you know, I was grieving. Actually for them there was no reason

why I should even be grieving. So when I called into Lifeline it was like, yeah its OK... And I think the validation went a long way (Tracey)

Attending to feelings and emotional content

In face-to-face counselling, facilitating the client's affective processes enables access to material that might otherwise remain implicit (Paulson & Worth, 2002). The discharge of emotions has also been linked to behaviour change and to the management of stress (Blagys & Hilsenroth, 2000).

Callers are often in a highly emotional state when they call Lifeline and the previous section highlights the importance of attending to their feelings and the emotional content of the interaction. Callers experienced being given the time to openly express their feelings as a 'relief'. It also helped with being able to identify specific feelings and in gaining some perspective. This was critical for both Lauren and Marion who talked about identifying feelings and moods and shifting to a more positive outlook. This process also seemed to open up the possibility of some movement in their narrative:

That person needs to cry. That person needs to um know that that person understands the fact that they need to cry...Because sometimes the crying really, once the crying is out it's a big relief, and it's a build up of stress, and that person that's listening to you, you know, will be able to then move you onto your next sort of journey in regards to where do you want to go from here at this point... (Marion)

Sharing feelings with an empathic and non-judgemental listener afforded some comfort. For Alison being allowed to cry not only provided her with some release from her emotions but also helped her to acknowledge her grief.

The lady who talked to me was able to, with me, you know, become more emotional, I was able to cry and had a lot of release and I felt that was what I needed because I wasn't able to be, you know, because I wasn't able to um, you know to be comfortable with my own grief (Alison)

Facilitating access to feelings also helped callers connect with their feelings, helping them to 'sort out' and 'understand' 'what' was happening and 'why' it was happening. Callers were then able to develop a better understanding of their underlying problem. This was a familiar process for Diana; however, over time a subtle shift had occurred. Once her primary purpose was trying to connect with her feelings, now it was about coping with her feelings:

...when I come home I just have a mash of feelings and sometimes I'm disconnected completely from any sense of a feeling, so what I tend to now do is ring lifeline and talk around something, to find out what it is I'm feeling, but I don't have... these days I can actually identify feelings, it's more when I'm very overloaded and so what that does is actually like a depressurising of feeling overwhelmed and if I'm able to do that I don't actually get as depressed (Diana)

By addressing her feelings Diana is able to reduce the effects they have on her. Reducing the pressure and restoring some sense of coping that talking about feelings afforded were benefits that others identified with:

...unless I kind of get it off my chest I can't seem to function all that well...it would really take the pressure off, um, you know how you get really really, well I don't know, you may not know, but um, it's like it just takes the edge off all the pain that you might be feeling, or all the worry that you've got and all the confusion that's going on (Tracey)

The experience of being 'lost' in emotions was not uncommon and while talking about them helped to disentangle and relieve pent up feelings, callers also gained comfort from having someone 'there':

... it's just so nice to know, It's a comforting feeling to know that there is somebody that is there, you know, when you are crying (Marion)

Marion's rather poignant comment perhaps highlights the fact that in her personal life there is no one. 'Holding' the callers emotions and helping them move forward was part of the process that telephone counsellors also recognised:

...holding those emotions perhaps, giving them, um, helping them find that next step that they need to take. I think that's a definite... actually that's a definite thing that you try and do... its more about um helping them find that next step um and talking that through and just, you know, if they're in a lot of distress, managing that distress (TC4)

Connecting with and managing feelings and emotional content seemed to be of great significance to those recurrent callers whose problem seemed to be more characteristic of a chronic condition. These callers talked more about those aspects in their interviews and their telephone counselling interactions appeared to function on a more emotional level. That is, their needs were more intangible and intrinsic and they more often displayed emotions. In contrast, first time or beginning callers, whose presentation seemed more characteristic of an acute condition, presented with what appeared to be more concrete problems and tended not to explore or display emotions as much. Telephone counsellors recognised this distinct difference between these types of callers.

People who present in an acute way and, say they're first time callers or they have called a couple of times or whatever, there's often a lot more territory covered in a call, you know, like it's a much more 3 dimensional or 4 dimensional conversation, with a lot more ideas in it, you know, like you might have 10 or 20, you know, ideas in it, just because the way that person is thinking maybe, be able to cope with or holding all that, whereas someone who is ... you know, if they're highly distressed, for example, you may not actually be able to do anything, you know, because the person is actually not able to talk. I had one of those the other night and that's not uncommon, you just get people ringing up who just cry and, you know, after, I don't know, 10 minutes or so it becomes, you know, after several attempts, it becomes apparent that there's actually not a lot that can be done (TC1)

While callers have clearly identified the benefits of working at a more fundamental level with feelings, telephone counsellors are often uncertain. Dealing with a caller who's functioning on a more emotional level seems to hold many more challenges. One is not being able to focus on any particular concrete problem, another, is not being able to measure progress:

I think she perhaps just wanted to talk to someone about what she has been going through, it sounded like she's been

having...you know, a bit of a... like she has been using the service a lot over a period of time, but she's been having, you know, a particularly difficult week and a few things are coming to a head, so I think that, you know, there wasn't a lot of real progress or whatever in the call, but yes, I think, you know, I still gave her that support that she was looking for and um...and, you know, helping her get in touch with her feelings, so yes I guess, is that progress? I'm not sure (TC4)

The absolute focus on the now means that telephone counsellors' attention is on progress in the call rather than progress over time. For the recurrent caller, the latter cannot be ascertained due to the anonymity rule and lack of continuity with a counsellor. If progress could be identified, telephone counsellors would not be confronted with a repeated sense of failure and feel so defeated by, and antagonistic towards, these callers.

For callers, like Diana, the opportunity to connect with feelings was particularly important. Diana shared this knowledge with the telephone counsellor during their session together:

Session extract: Diana/TC4

...so opening all of this up is of huge value to me, even though it's painful, even though it's difficult, because without talking to another person it's just always going to be blocked there (Diana)

Diana reported that she experienced telephone counselling interactions when she had been allowed to do this as the most helpful. Recognising the client's feelings as authentic also conveys the message that it is alright to show feelings.

Callers' experiences and feedback point to the importance of emotion and emotional expression in their telephone counselling interactions. Studies indicate a positive relationship between emotional processing and outcome, finding that clients emotional processing was predictive of clients' improvement (Castonguay, et al., 1996). Suggestions are that in-session emotional arousal may be necessary for assimilating new information, reorganising "hot cognitions", forming new implicit meaning structures and enhancing the long-term

effectiveness of therapy (Goldfried, 2003; Mahoney, 1991; Missirlian, et al., 2005).

Containing

Clients are often anxious that once feelings are released they will not be able to contain them. Therapists usually allow time for the expression and processing of feelings as well as time for reflecting on and containing emotions. Containing emotions, particularly prior to the end of a counselling session, is a crucial component of counselling. This was apparent in the telephone counselling setting also, as one telephone counsellor explained:

you sort of open things up and then you close them down towards the end of the call to something more manageable and what they're going to do, you know, when they get off the phone or something like that (TC4)

Containment can be seen as occurring in two different ways, through the containing of the interaction, such as ensuring that callers stay focused on the topic, and through the containing of callers' level of emotional turmoil, such as ensuring that their distress levels are manageable before ending the call. Containing the call, and the caller, are critical components of the Lifeline telephone counselling approach and the telephone counsellor is often engaged in these processes throughout the interaction. Telephone counsellors work hard at trying to contain both the problem content of the call as well as the emotional content:

...early on in the call to try and identify what is, you know, or ask the caller to nominate what is the particular issue that they want to talk about um...because um you know, so then the call can be directed towards that particular issue um hoping to be able to help the caller, you know, um work out a particular issue, you know, that ...that's most pressing for them at the time, you know, kind of within a framework (TC1)

Techniques that contain the call and its contents help to ground callers as do problem solving techniques that are more directive and encourage callers to take action:

...you're so tired that your brain can't function...and then that's when the Lifeline say stop you know, stop, stop for a while and try these steps. If it doesn't work, well just stay calm and do A,B,C,D... (Lauren)

Exploring and defining coping strategies also provide a foundation from which callers can begin to move and build on:

I had rung at one particular time in the past when I was actually suicidal. And I was given the suicide help line number but before they let me go off the phone um they spoke to me about my strategies and coping mechanisms and that sort of thing and I was ringing to say this is how I'm feeling, I don't want to do it, I want to stop myself from going down that way, and having someone actually speaking to me about OK what are your strategies and verbalising the strategies helped (Jane)

Sharing problems and feelings by talking about them and working through them helped callers feel more contained and able to cope:

it does help because you know at that point sometimes at that point you know you are feeling really anxious about something and you think oh my God how am I going to cope...And by speaking to somebody you know you sort of like, you know, they can calm you down and then you can go and get a book and read you know and relax and have a cup of tea (Marion)

Simply connecting was often enough to help others feel more able to keep going, as Judith states 'They sort of bring me back to earth'.

To a certain degree, all of the different facets of the counselling interaction, from the caller reaching out and making the connection to the telephone counsellor 'holding' their emotions, act as a source of containment for callers:

When I ring up I'm basically suffocating in my own tears, you know, and I think gee I can't, I can't allow myself to carry on like this and sometimes just talking to another counsellor can, you know, give you a little bit of um, ah, what's the word I'm looking

for, it can give you a little bit of moral support, you know and give you a bit of energy and just help you think differently so that you don't um, use up all your energy in the wrong way, because that's what I was doing the other night when I rang up...I was, I was very distressed (Wendy)

For telephone counsellors managing emotions and working to reduce affect is seen to make an important contribution to containing both the caller and the call:

[I] hope to at least just stabilise, perhaps a little bit, their emotions at that current time, so it's sort of, during the call trying to sit with the caller and help them manage their emotions (TC4)

In containing the caller, the telephone counsellor is also able to contain the call so that ending the call is part of the packing up process that both telephone counsellor and caller take part in that allows the interaction to come to an agreeable end:

I mean, in my mind, I really wanted to contain the caller and I really wanted to just focus on something ... I can't remember what I said, but I said something that was quite good, I think, at containing the call or something like we're going to have to end the call in a couple of minutes (TC2)

At times, telephone counsellors' attempts to contain the call lead to feelings of rejection for the caller. Such feelings occurred when telephone counsellors' seemed to want to contain or limit the caller's narrative or if they tried to end the interaction before the caller was ready. In addition to feelings of rejection, callers also reported that they felt undeserving of the service, and that their needs were devalued. Feeling rejected was an experience that most recurrent callers reported. For some this was related to being identified as a recurrent caller. The attachment of this label tended to characterise the caller as breaking the rules or, worse, as a nuisance.

Ending the interaction

In face-to-face counselling interactions, part of the process of ending the counselling session is determined by time. Most often both counsellor and client are aware that their scheduled time together is drawing to an end and so both are able to prepare for and engage in the wrapping up process. In the Lifeline telephone counselling scenario, session duration is not predetermined and the wrapping up process must be actively initiated by one or other of the players so that each is able to conclude the interaction and predetermined session duration plays no part in facilitating termination.

Extract: telephone counselling session-Pam/TC1

Pam But I just um...just at the moment I haven't been well a lot but I'm under a lot of stress at the moment, you know.

TC1 Yeah yep (pause).

Pam But anyway I've got to get going.

TC1 OK.

Pam I've got to finish this call.

TC1 Hmm. OK.

Pam I've got to make another call.

TC1 No worries, and so you're gonna [sic]...you've got some things to help you this evening? You've got some things to do this evening when we finish our call here?

Pam Oh probably do some um probably washing, I'm going to do some washing probably.

TC1 Yeah?

Pam Yeah.

TC1 OK.

Pam Have a good night.

TC1 Thank you.

Pam Thank you very much for listening to me.

TC1 You're welcome.

Pam Thank you

TC1 OK.

Pam Bye

TC1 Bye.

Winding up the call is often characterised by particular questions, for instance the telephone counsellor might say:

Extract: telephone counselling session-Diana/TC4

...how are you feeling about facing the rest of the day at the moment? (TC4)

As a result recurrent callers learn the cues to terminate the call and will engage in the winding up process. In anticipation of this, callers often prepare their responses in order to facilitate the process:

They usually end up by saying what are you going to do, and I say, well I'm going to finish reading this book, or I'm finishing this crossword puzzle, or on the ABC (Judith)

The telephone counsellors' utilisation of particular questions signals that the interaction is drawing to a close and can also be seen as facilitating a more collaborative 'wrapping up' process:

And then what they do is they will say to you, so what are you going to do now, now that you've spoken to me, you know, and then you tell them, you know like in my case, you know I would say to them, well after I've spoken to you I am going to go and have a cup of tea, and I'm going to put my feet up (Marion)

This can also act to reassure telephone counsellors of the caller's level of containment and ability to cope:

Extract: telephone counselling session-Robert/TC2

TC2 Mmm, so, so how are you feeling now that we've been talking for a little while?

Robert Oh, look, and this is from my heart, it makes me feel good

TC2 Yeah

Robert you do wonders for me, I'm going to bring in JR, who's me [sic] Jack Russell, we'll put the TV on, I'll feed him, I'll feed myself, we'll go for a little walk around the park, and then we'll go to bed and then get ready for tomorrow

TC2 Mmm hmm, OK, that sounds quite good, so do you feel like you'd be OK to end the call

Robert Oh yes please, oh seriously, it's just me being clear that I have done something, I haven't done anything wrong and... and... you know, just you hearing me...

Ending the call is often a difficult task. While many callers recognise and engage in the process and some, such as Robert, are grateful and seem happy to end the call, others are more difficult to disengage:

...some callers don't want to end the call, and I, sort of, get the impression that they would never want to end the call because of the way they're using the service it's, sort of, much more of a friend or to fill in some time in their day or whatever, a social contact, they would just like to talk all night if you would let them. So some callers I don't think it's ever going to be possible or I don't feel it for myself that it would ever be possible to end the call in a way that they would be happy to go 'yes, OK we'll finish now' (TC4)

Telephone counsellors' perceptions of callers, their needs and utilisation of the service may well play a part in the tension associated with disengaging. Perhaps telephone counsellors' interpretation that callers are not engaging with the service in the appropriate way leads them to terminate calls early. This

circumstance tends to occur more often during interactions with recurrent callers. The following extract is from a telephone counselling interaction that lasted seventeen minutes in total:

Extract: telephone counselling session-Karen/TC2

TC2 It sounds like, I mean, it's quite a difficult situation, we're going to have to wind up the call I'm sorry

Karen Ok no worries [hangs up]

TC2 But hopefully you're...

In this instance as soon as the telephone counsellor begins the process of wrapping up the session the caller immediately disengages and the telephone counsellor is left hanging. While we might assume that this is a sign of discontent on the caller's part she does not communicate any noticeable signs of displeasure, however, other callers find this situation disconcerting:

...what advantage, what advantage is it to open up to somebody when I open up to them and they say, um, times up now, we've got to go, and they leave you in the lurch, they don't give you any feedback, or summary or anything...I just don't find them very sensitive anymore that's the whole problem...There's no human contact, there's no human element there (Harry)

On occasions when the caller is particularly verbose, ending the telephone counselling interaction may require the telephone counsellor to be more direct. The following extract is from a telephone counselling interaction that lasted forty-one minutes in total:

Extract: telephone counselling session-Helen/TC1

Helen and I questioned him (her partner) and, but he always tried to reassure me, or he'd say oh, you know, 'no don...' is there anything going on with you and Sarah and he goes 'oh no she's old' you know, '... she's not my type', you know

TC1 *Mmm, um I guess I'll stop you there and just say, just say that I think we've probably covered quite a bit of ground in the call this evening*

Helen *Yeah, yes*

TC1 *Are you...are... and you sound as though you have been able to talk to me about a lot of the things that you were wanting to talk about*

Helen *Yep*

TC1 *do you think um it's a good time for us to end the call*

Helen *Yep yeah*

TC1 *Yeah, OK*

Helen *and let somebody else have a go*

In this instance the caller engages in the wrapping up process and they talk for a few more minutes before the interactions draws to a close. Callers often made reference to their awareness of other callers waiting and on occasion they actively policed the time they spent talking to the telephone counsellor:

I'm also aware there are other people with probably worse issues than myself, and worse crises than myself, so I don't want to take up much time (Jane)

While many callers have some understanding of service demands and also of others who might be in need, being 'cut short' still left them wanting more:

There was [sic] several times when I just talked, and there was, yeah, so I guess, I don't now, I guess I'm just a bit of a long winded person too (laughs)...You know, [I] can go on and on and on and on I suppose, yeah has to be cut short, I mean somewhere along the line anyway...it kind of makes a difference because maybe I feel like I haven't spoken enough about certain things or I feel like I want to speak more but I can't... Yeah. And maybe there is more I can speak about but I can't. If you know what I mean, because it's cut short kind of thing (Rosemary)

Managing to balance all of the different facets of the telephone counselling interaction requires that the telephone counsellor be aware of and operate on a number of different levels:

...things like a balance between getting details and containing detail, working along, you know, goals. Getting the person to talk about what ...where they want to be heading as well as, I guess, listening to the emotion that is contained in what they're talking about. Trying to pull out themes, people might tell you a number of different strands of their story, they might be intertwined with a particular theme, and kind of, (the) important things is stopping and having a bit of a think yourself every now and then about what is going to be most useful to the caller, and whether in fact the call is useful, and what can you do that would be the most useful, kind of like thinking about how its going...the call, you know, the TC needs to be able to stop every now and then (chuckle) be aware of the process that's happening in a call (TC1)

On occasion, part of the ritual of ending a call involved suggesting or providing referral information.

Referrals

Referrals are an important aspect of the Lifeline service and through their database, telephone counsellors are able to provide callers with a number of different options to follow up depending on their needs. For first time callers, like Jackie, Matthew and Anita, this component of the service seemed to be especially useful:

She told me maybe how to handle the situation if it gets worse. And she also gave me some, um contacts, yeah...for me, and my husband if he would go (Anita)

Anita reported that her husband had subsequently followed up on one of the referral options the telephone counsellor provided. Jackie too had found this element of the service helpful:

I didn't feel as though she was fobbing me off, she certainly, you know, went through all the different places and made sure I had all the numbers written down correctly and all of that sort of stuff. So, yep. And, and talked about which ones would be

better. Like for an example when we were talking about counselling, and she said, you know, this one would be good because it also has the alcohol, you know, rehabilitation side. So she was pointing out positive benefits of different places as well (Jackie)

Perhaps for the first time caller gaining a referral more closely matched their initial need and at times they did not want to engage with the telephone counsellor on a deeper level. This was illustrated by Matthew who was trying to get some relationship counselling for himself and his wife and was 'simply using' Lifeline as a 'resource'.

In contrast, recurrent callers often did not want or need referrals, regularly reporting that they already had a relationship with a health professional. In this instance, attempts to provide a referral seemed to miss the beat and callers did not appreciate being constantly told to pursue this avenue. Recurrent callers often found this seemingly indiscriminate referral practice irritating:

Lifeline will often say this to me, you need to go and get counselling, you need to go and do this, you need to try and do that... (Diana)

And on occasion recurrent callers experienced referrals as particularly unhelpful or rejecting:

Basically she told me I should either ring suicide line or grief line and not to ring lifeline...(sigh) and I was a bit um... yes...anyway that's...that could have just been her individual interpretation of stuff I was saying, and then she had recalled having spoken to me before (Diana)

These experiences had recently brought Diana to the realisation that perhaps she did need to seek more 'professional' services; however, she did not see face-to-face counselling as replacing Lifeline's role in her pursuit of psychological health:

I see in some respects they're right, you know, that I might be, now, at a point where I need to...that I might need to pursue um more intensive psychotherapy. But that doesn't necessarily mean, from my point of view, that... it doesn't mean that I'll necessarily altogether stop ringing lifeline (Diana)

The shift between the first time caller, more often being satisfied with a referral, and the recurrent caller, seeking a more meaningful interaction, perhaps indicates the changing shape of their needs and the utilisation of the immediacy and accessibility aspects of the service. It needs to be remembered that these recurrent callers were at one time the same callers who had been provided referrals as first time callers and had taken up these early referrals with positive outcomes:

...sometimes um, there's been referrals given to me, like Direct line when I was giving up alcohol. That was really, really helpful (Rita)

Even those callers who had been accessing other supports prior to calling Lifeline were able to be connected with more suitable services:

In fact it was through Lifeline that I got hooked into the Augustine Centre. Um, and up until then I was virtually throwing the book at every psychologist I met (Tracey)

In the instance when callers are already accessing other services telephone counsellors are uncertain, and may be wary, of the role that they play. This also influences how and to what extent the telephone counsellor engages with the caller:

Yes, I feel like I do, quite a bit, and I feel like I normally try to keep the phone conversations shorter um... and I don't feel like I try and engage or explore as much with the caller um...I feel like I'm much more, I guess, I'm acutely aware that the caller has ongoing support and that's its not necessarily going to be useful for them to be speaking about this with me rather than with their ongoing support um...so I feel like my role is to refer them back to that ongoing support and to help them get through the time where they're going to see that person next (TC2)

If callers are perceived as misusing the service, or not fitting within the parameters of the service, telephone counsellors might also employ referral options as a tool to deflect the caller. One telephone counsellor commented on her attempts to steer a caller towards other supports:

A big goal of mine was to get her to see another counsellor, get her to see a counsellor, and to be able to say, OK these things aren't OK, these things do come up everywhere and I can't ...and these... the best way to deal with these isn't on a 60 hundred, I don't know, 60 half hour phone calls, because no matter how many times she's called, she's going to talk about the same things or very limited bits of them again before we get the conversation of, do you want to go for a walk or having some tea, what can you do to keep going for a little while? ... I tried to get her to think a few things, oh and tried to get her to realise, OK I need some other support and trying to link, like, some of the insecurities, insecure...feeling insecure at work and feeling insecure at home and trying to link that so like she, sort of, feels like, OK this is a, sort of, a pervasive thing um and that I've felt this way before and without...what I've done so far hasn't worked so, I've sort of got to try something new (TC3)

In this instance the telephone counsellor perceived that the caller's needs were unlikely to be addressed within the parameters of the service, recognising that the model allows little opportunity for the narrative to progress. During the telephone counselling interaction the caller had communicated that she was considering attending face-to-face counselling and that she had already been provided with referral options on a previous call:

Extract: telephone counselling session-Annette/TC3

Annette Um, not really, but um... yes... I think there is a lot of external pressures on me at the moment

TC3 Sounds like there are, and sometimes the external pressures they...they push our ability to cope, and make us end up feeling like ...like crying all the time

Annette Yes, well that's right, and because I feel like I'm just overwhelmed with issues at the moment with.... I just feel bombarded um instead of getting angry about it like I used to, now I've just stopped getting angry and it just internalised, so it becomes like a form of depression like a low mood

TC3 When you... with depression... when you have had depression in the past, and you have stress or concerns, what do you do to help yourself feel better and get through those?

Annette Um... I guess I... I actually just um... let myself just be and I just um... try to sort...um I guess I use Lifeline a lot um and talk to somebody

TC3 So, some part of counselling is quite helpful, you thought counselling was helpful with your partner and lifeline counselling has been useful in the past

Annette Yes, it has and I have booked in to um see somebody um for counselling

TC3 Oh great

Annette Through lifeline and they put me on to

TC3 Oh that's great

Annette A few counsellors in the local area so I am following that one up at the moment

TC3 Do you have an appointment?

Annette Um well, I haven't yet but I am just wondering whether I should actually endeavour to really book one soon because these issues are fairly deep issues

Although Annette seemed to have a growing understanding of the depth of her struggles she had not yet made an appointment to attend face-to-face counselling, yet had continued to call Lifeline. The telephone counsellor focused much of the interaction on trying to facilitate Annette's uptake of the face-to-face counselling referral, asking her questions, such as, 'what would it take for you to book that appointment' and 'what stopped you from making the appointment so far'. Together they discuss a plan to ensure Annette calls for an appointment and prior to ending the call the telephone counsellor seeks assurance from her that she will carry this through.

Extract: telephone counselling session-Annette/TC3

TC3 It sounds like it's a big acknowledgement, and something that I hope that you will be able to make an appointment with the counsellor tomorrow, is that something that you would be able to do tomorrow

Caller Yes, I'm pretty sure it would be, yes

- TC3 *Do you have the numbers with you still*
- Caller *Yes, yes, I've got the numbers there, it's just a matter of ringing up, but I think I have hit the nail on the head, it's just that I um... nothing was resolved or finalised, I mean the job isn't, nothing ...you know, then I've got the ex with all these issues with settlement and divorce and all this business and um... you know, it's quite frustrating when there is no closure to things*
- TC3 *Without, without, leaving the nailing on the head, we have got a plan and a more ongoing plan to contact the counsellors, and is there time for you to do that tomorrow*
- Caller *Oh definitely I can ring up at work anyway and arrange an appointment at my lunch time*
- TC3 *OK, so lunch time at work you have got a task for tomorrow, which is a difficult task and it can be one easy to put off um, tomorrow to make things a bit different for you when you come home, like your really enjoying work, but once you're out of work that's when these...some of these symptoms and these feelings can come back quite strongly. What's something that you can do tomorrow that will reduce or make it less likely that you will feel as depressed as you did today...*

Referring callers onto other services is seen as an important component of the Lifeline service and telephone counsellors recognise the benefits of the referral resource. Nevertheless, it is also essential to recognise that, while Lifeline is often recommended to the public in the event of traumatic events, Lifeline also often acts as an ancillary support for many individual practitioners and community services and callers are often referred to Lifeline:

Um, I was ah seeing a counsellor at CASA and they informed me about it...It was more of an additional support for after hours or between counselling sessions...before my, um, you know, what I learned is if all my skills didn't help and I needed to talk to someone in the middle of the night or something, it was um, yeah, to give them a call if um, the CASA crisis line wasn't available (Jane)

Mapping change

Whether in relation to emotional dysphoria, dysfunctional thought processes or maladaptive behaviours, the aim of any counselling endeavour is to achieve some form of change. People enter into counselling because they want their lives to be better, that is, to change. Thus the concept of "change" is basic to any counselling practice or theoretical discussion. To understand therapeutic change we must understand what "change" means to the actual people who are undergoing counselling, rather than looking at the nature of change merely through the perspectival lens of a particular psychological theory.

Callers held little expectation of change, most simply reporting that their need was to be heard and understood. It is not surprising then that most talked about short-term emotional relief as the most common form of change. However, more enduring changes, in the form of enhanced coping, insight, actions and behaviour change were also evident.

Callers' perceptions of individual therapeutic interactions incorporated experiences of both helpful and unhelpful outcomes. The effects of interactions were most often talked about as short term and specific to a particular counselling interaction. Most often mentioned were immediate effects, such as feeling contained or feeling rejected. Other outcomes, which might be seen as falling into more medium term effects, such as changing perspectives and gains in insight, were not as apparent. Callers' awareness of longer-term outcomes tended to be mapped as their changing use of the service over time.

Short term

Immediate effects were most often short term in as much as they acted to reduce the symptoms associated with the caller's difficulties, whether these were emotional distress or loneliness. First time callers talked of both emotional relief, in the form of affirmation in relation to their assessment of a particularly difficult

situation regarding a third party, and a new sense of direction in managing the situation, with the provision of strategies and referrals.

For both Jackie and Anita this helped them to find a way forward and to feel more in control of the situation.

I spoke to the person on the phone, suggested that we were going to talk to my dad and he had identified that he had a problem, so that she reassured us, well that's kind of a bit of a door opened and that's a good opportunity if you feel comfortable talking to your dad...So we did act on that...after I had spoken to her (the TC), I was at work, but I felt a lot better...I certainly felt as though I could be more in control of the situation I suppose because I had had that reassurance that by talking to Dad that that was the starting process, so that was good knowing that, I was on the right track, to improve the situation and just the confidence I suppose knowing that it is the right sort of step forward (Jackie).

Gaining strategies to help deal with relationships difficulties and third parties also provided them some comfort:

I'd never made a phone call, I didn't know what to expect and I was very comforted. She put it in a different way so I was able to understand it, even though in my mind I understood it, but to hear somebody say it...was very comforting...after talking to the person at Lifeline... I decided that's how we should go about it, and I did speak with him, we did have a confrontation, not a confrontation, but a discussion on the weekend...so some good came out of it because it came to the surface... And he has gone for a session today at Gamblers helpline (Anita)

For both callers the reassurance that they experienced allowed them, and their families, to move forward with 'confidence' and take action to address a difficult situation that had been having a significant impact on family relationships. The third party in both cases had made contact with referrals provided by Lifeline and had accessed these support systems within days of the initial call. In both of these cases the recognition of a problem, the action to address the problem and the potential for longer-term change may well be measured as significant outcomes.

'Reassurance' was an immediate effect that recurrent callers reported also; however, recurrent callers appeared to be struggling with deeper, perhaps more chronic, emotional needs. Outcomes for them were more often experienced on an emotional and relational level and at times it was simply the human connection that provided some relief:

...having someone to talk to was such a big relief because I didn't feel alone (Marion).

Sharing psychological pain and emotional struggles had the capacity to help callers '*feel safe again*' and alleviate some of the suffering. While for others it was a reminder of coping strategies and a way of getting back on track:

I think being positive is good because then you just say, oh yes, I have got a bit negative this few days and they just say, oh you have to be positive again, you know, just reminded me, like, oh you should get back on track and be positive. It does help a little because sometimes you need a little nudge from behind to say....oops you're negative now, you have to stay positive...it just makes your brain say stop being negative now, you know, just trying to be positive and just help a little bit. Then when you become positive a little bit often you become, you tend to want to be more positive. (Lauren)

Making a connection with another person was often a profound experience and in every sense it provided a 'lifeline' for many of the callers. While the suicide call is often the most clearly defined crisis call, and may be seen in relation to short term outcomes, helping someone stay alive usually requires ongoing support. In some instances Lifeline's role becomes even more critical, such as in Judith's case where she struggles with isolation and finding a reason to keep going:

...I don't think it's worth carrying on. All my family have predeceased me (Judith)

Most often the caller who was once clearly suicidal shifts to a less critical form of crisis and their use of the service changes, as do their needs. Nevertheless, these callers continue to enjoy the short-term benefits of calling.

In face-to-face counselling, therapists most often have the benefit of an ongoing relationship with a client, which enables them to assess the suitability of their approach and interventions and measure the effects and outcomes of therapy. For telephone counsellors the lack of any ongoing relationship makes this particularly difficult. For most, the only measure available to them are noticeable changes in emotional dysphoria, for instance reduced levels of distress that are observable within the time frame of the call.

I guess when there is a big change in um the emotional tone, so people are quite agitated or distressed at the start of a call and then seem to be a lot lighter at the end, that's an indication that that person...that person's, you know, found the call useful (TC1).

Telephone counsellors interpret a number of signs as success including the caller's willingness to engage and their level of cooperation:

I guess if you feel like.... like the emotion in the callers voice has perhaps changed, um, for the better, like if they were perhaps very anxious, very uptight or if they were very upset, and if you feel that that's changed, that can be feedback that perhaps you're on the right track, um their willingness to, sort of, answer the questions that you ask and focus on the things that you're asking them is another way you sort of know, oh right this person is on the same page here and that's sort of a good feedback that you're, sort of, on the right track and that um.. that the caller, and not all callers do this, but that they're happy to end the call as well. That gives you feedback that they feel that they got what they, sort of,...they got what they came for or, you know, like that they have sort of, happy to end the call now and go on and do something else (TC4).

While reducing emotional dysphoria was perhaps a key means of measuring effect, the counselling endeavour often taps into feelings and encourages the open expression of emotions, so that this is not necessarily a reliable measure of success. A good example of this was reflected in Diana's interaction and her need to 'connect' with her feelings and 'cry'. Utilising similar measures in these cases would result in a sense that the interaction had been unhelpful.

Telephone counsellors are largely left to surmise and hope that they've helped the caller achieve some small part of what they need. An example of some of the changes telephone counsellors hoped might have occurred included:

I mean I guess I would have liked the caller to have finished the call feeling like um that this is a really stressful situation and that it is normal that I am feeling frustrated and angry um and um...that that's ok, and that um, and that by, you know, um that by having, you know, the conversation with me that that um that level of frustration, well that sense of feeling overwhelmed by it all had dissipated a little bit (TC2)

While normalisation and enhanced coping were apparent there was also hope that some level of insight would be gained:

Normalisation...38 minutes of not feeling as anxious...some comfort...an instigator towards change and thinking about there could be a common theme throughout her concerns...(TC3)

But ultimately telephone counsellor held little hope of any ongoing long-term change:

I don't think it made that much of a difference to her life overall, the bigger picture of her life no way, maybe in that afternoon it might have made her feel understood (TC3).

While telephone counsellors struggled with measuring or knowing the degree of effect, callers repeated use of the service seemed to reinforce telephone counsellors' sense that caller gains were limited:

There are plenty of calls where, um, while they're in the call the person's helped, but, you know, obviously with people who are presenting in a chronic way then um, you know, it may help a few hours and then they may need to ring up again in a few hours to settle themselves down again or get back on track or whatever. So... in terms of the thing about how far into the future the call effects someone, it may be just a few hours or it may be a bit longer but, um, its difficult to judge (TC1)

In some instances, telephone counsellors felt that they had little influence or impact on the callers' processes or outcomes:

I don't think that um, you know, like there was...that the caller had insight, you know, any massive insight or anything during the call. I think she ...most of the things that she was talking about were things that she had already thought about and pretty much

decided on so...I think at some stage she did kind of indicate that oh she had realised these three things and she was going to write them down. I kind of ...even though she had said that, I kind of felt that these were things that she'd already decided to do and that um, you know, like the call hadn't been that significant (TC1)

Perhaps for those telephone counsellors who clearly see their role as crisis management there is less ambiguity:

...I feel like I am a crisis counsellor right now, while I am in the room and doing telephone counselling at Lifeline, I am a crisis counsellor, um and my role is to get you through this crisis right now and to help you look at short term coping strategies until you can find that ongoing support (TC2)

This perspective allows the telephone counsellor to be clear about the purpose and to have realistic expectations about the lasting effects of such an intervention. This position perhaps helps telephone counsellors better manage any sense of hopelessness or helplessness that they inevitably experience in trying to help callers deal with, oftentimes, lifelong psychological problems in a one off time limited telephone interaction. However, clearly for some recurrent callers who are isolated and lonely, ongoing support never happens, except for Lifeline.

Medium term

While immediate effects were most often related to gaining some relief from uncomfortable feelings, gaining insights about the 'what' and 'why' of feelings can be seen as providing deeper understandings:

I've always had that um, that outcome of having been able to talk to someone and helping them, helping me sort out what I'm feeling and to understand what's happening to me, and why it's happening to me (Jane)

On occasion, unexpected insights later lead to other realisations. Alison explained how this transpired for her after her call to Lifeline:

I was determined in my own mind that I am not going to pretend that I'm happy when I'm not happy. I said I do not have to be happy, if I don't feel like being happy and that is OK, I don't have to smile because I'm breathing the air the world has for me. I can be miserable, I can have a miserable look for all that time that I'm driving to the park, and I was maintaining this um, this, this face, this unhappy face that I refused to be, you know, a happy person. And then suddenly, you know, suddenly the sun started, I started to feel the sun on my eyes and on my face, it was as though the sun was laughing at me and said to me, look Alison if you could just see yourself, you know, you must have enough of this look (laughing). This sad miserable look that I pulled, you know. I proved to myself that I'm capable of being sad and miserable, and that's acceptable. And then I started cracking up (laughing). And I thought that was really funny, and that I shouldn't be upset by an unhappy face, by myself having an unhappy face, that was my hang up. So that was important for me. To realise that, you know, that I could laugh at myself. Yeah because for all this time that my hang up was (I was) too scared, you know, since a little girl, too scared to be a miserable person, too scared of being unhappy or, of letting the world know that I'm an unhappy person, that there was nothing to, nothing that I could brag about, that I could be happy about. But, um, of course that is not the truth (Alison)

This was a significant insight for Alison with the potential to lead to other important understandings of herself:

I actually found some clarity...as a result of that conversation, she actually made me realise that I have to learn to be comfortable with my situation, so I can move beyond it...

Long term

In connecting with their feelings and gaining insight and greater understanding about their feelings callers were better able to manage their feelings. For Diane calling Lifeline allowed her to connect with another person as well as helping her to connect with and experience her feelings. Diana was able to map her progress from her initial suicide calls through to crisis calls and more recently to crisis prevention calls. For Diana, being able to call Lifeline in the moment helped her connect with her feelings and prevented her sliding into anxiety and depression.

I don't generally, these days, ring so much in crisis, and I'm usually able to pre-empt a crisis and to ring before I get into it,

and that's... that's largely to do with Lifeline um.... so its good to have had that ongoing contact with them because I can see the difference (Diana)

For Diana, there was progress that she could see which, because of the model, was probably hidden from Lifeline. Diana is now better able to recognise and act on her needs in a timely manner. As a result of this, her presentation, needs and utilisation of the service have undergone a significant shift. Most importantly for Diana she has been able to develop a level of emotional literacy:

...that's what Lifeline has actually helped me to do is to build up a repertoire of what the feelings are, so that I can slowly work at that and not be overwhelmed by what's happening outside (Diana)

Diana is able to recognise the degree to which she has 'changed' and the effects of these changes in her daily life:

...in the more distant past, I'm talking maybe two years or so ago and I've actually rung there feeling suicidal um.... and really, really agitated, I mean, agitation and anxiety, and depression were pretty standard. I mean, I'm talking probably clinical depression, um, where it's very difficult for me to get up and move around and do things um... to function, to go to work (Diana)

Jane too was able to track her use of the service from suicide prevention to crisis intervention and more recently to utilising the service more for guidance.

At first it was very much like a life line it was very much, you know, um, contacting someone to make sure that I wasn't going to harm myself and I wasn't going to um, um, I guess I would cope knowing someone was there to help me get through the emotions I was dealing with at the time whereas now its more supportive, um, if I experience something new and I don't understand it, I ring up and say oh can I talk about this...yeah it's completely different. I can see I'm really a lot more independent emotionally...and it's more that sort of guidance now rather than the actual, you know, help me stop myself from, you know, hurting myself (Jane)

While the urgency, intensity and frequency of Jane's calls had significantly reduced over the previous two years, from about once weekly for several months

to about twice during the previous year, from her perspective this shift and the changing nature of her needs had not diminished the importance of her calls.

Commentary

The domains of practice identified are reflective of face-to-face counselling practice. Talking about problems, telling stories and expressing feelings were all fundamental components, as were telephone counsellors listening, questioning, reflecting, affirming, normalising and containing. Other processes were also evident, such as those that were engaged in at the beginning and ending of interactions.

These elements are common factors shared by all forms of talking therapies. More specific factors were also evident in the form of intervention techniques such as those designed to focus the caller on a particular problem. Callers reported having the space to tell their story and express emotions as most helpful. Callers, particularly recurrent callers, were often frustrated in their efforts to do this, because telephone counsellors generally curtailed callers' attempts to fully disclose and worked at containing the story and associated feelings, perceiving a more problem focused approach as being most helpful for the caller. This disjuncture was one element that tended to interfere with callers experience of a meaningful connection with the telephone counsellor. For callers, achieving a meaningful connection was central to facilitating the counselling process and outcomes.

Connecting emerged as a central element evident at a number of levels, for instance, as part of the act of making a call, as part of the desire to connect with another person and as part of the process of connecting with self, through story telling, attending to feelings and developing understandings. However, context begins to emerge as a mediator and moderator of *connecting* through the influence it exerts on the telephone counselling process and experience. Of particular note are the pressures that are applied to the counselling interaction, to the relationship dynamic and to the counselling advance. This results in a

truncating or compressing of counselling process, a ceiling of the counselling relationship and in uncertain, indistinct measures of progression.

Examples of the influence of context can be seen in the sharing of the problem narrative. For instance, while talking and telling their story facilitated important processes for callers, at times the need to repeatedly 'retell' resulted in callers feeling 'stuck'. McLeod (1997) suggests that the feeling of being stuck and 'going around in circles' is likely a symptom of the expectation that the story will change and the inability to effectively deconstruct the problem story and develop new meanings. The focus on technique and on containing emotions, and telephone counsellors' inability to map caller change, are other examples of the impact of context.

Another dimension that emerged in association with *connecting* and *context* is the manifestation of caller typologies. These are most easily defined in relation to a broad measure of first time versus recurrent caller; however, Lifeline data indicate that the majority of callers fall into the latter category. Further delineation of the recurrent caller category appears to hinge not only on caller utilisation, but also on the nature and longevity of the callers presenting problem and the perceptions that develop within the organisation as a result of these factors.

Chapter 9

FINDINGS

Caller Typologies

The previous chapters have provided an understanding of the Lifeline telephone counselling context and how telephone counselling is similar to, and different from, face-to-face counselling in the practices adopted by the counsellor and in the expectations of callers. Perceptions of telephone counselling from both the callers' and telephone counsellors' perspectives were also considered. This chapter presents an overview of the caller typologies that have emerged from the data and provides an illustration of these in the form of two case studies that interweave description and interpretation. The case study presentation better reflects the dynamic interplay between the caller, the telephone counsellor and the system.

Caller typology

While there is no formal diagnosis of callers, analysis of Lifeline data together with telephone counsellor and caller interviews highlighted patterns in the data that seemed to point to a number of defining features. The majority of callers identify themselves as being in crisis, however, the nature and longevity of the crisis state can be seen as placing them along a crisis continuum that runs from 'acute' to 'chronic'. Characteristically callers can be broadly defined as falling into at least three general categories that fall along this continuum, the acute crisis caller, the chronic crisis caller and the social needs caller. The following caller typologies are derived from the data and broadly reflect presenting needs.

Acute crisis caller: The 'acute crisis' caller is the caller who identifies as suicidal. Other callers who might fit this description are those who classify as having a

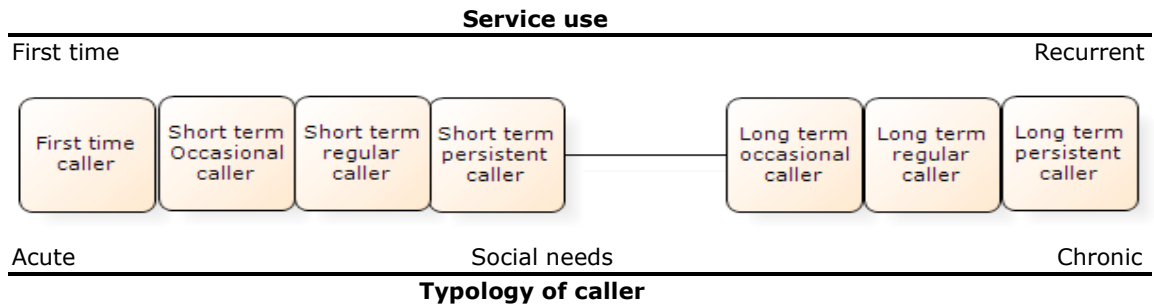
specific clearly identifiable problem. These callers might call only once or perhaps intermittently while trying to resolve their difficulty. Their presentation might also be seen as running on a continuum, from the worried well to the suicidal. Callers in this category might present with concerns or difficulty coping with a particular event or experience to suicidal ideation.

Chronic crisis caller: The 'chronic crisis' caller falls towards the other end of the crisis continuum. This is the caller who suffers ongoing long term difficulties of a more complex nature. These callers are oftentimes struggling with significant mental health issues of a historic nature and might call on a regular basis, perhaps weekly or daily, over a period of months or years. This category can also be identified as running along a continuum from the minimally to severely affected. Callers in this category might present with one or many psychological problem or disorder such as anxiety, depression, PTSD and schizophrenia.

Social needs caller: Between these two sits the social needs caller whose crisis tends to be one of social isolation. While these callers present as having no specific problem or mental health issue, theirs is a social disease and their struggle is with loneliness. Where they sit on the continuum of loneliness might influence their call patterns with the more extremely affected calling in frequently, sometimes habitually on a daily basis and at set times.

Caller typologies are useful in clustering the types of callers to Lifeline. The needs of the individual influence the way the service is used. For example, the social needs caller will tend to ring Lifeline on a regular basis for support whereas the crisis caller may call only once in an acute crisis situation. The figure below illustrates service utilisation in relation to caller typology.

Figure 9.1. Caller typology: needs and service utilisation



There are also combinations of these caller types and their call patterns, for instance mental health problems are often associated with isolation and loneliness.

Caller type may also be seen as evolving. Even the long term psychologically affected 'chronic crisis' caller who connects with the service on a daily, or more than daily, basis was once a first time caller. Regardless of what drives them to call or how frequently they call, callers talked about calling Lifeline out of need, not out of choice.

The following table positions each of the participant callers in this study by type. The table identifies where each of the callers fits in relation to their use of Lifeline and their classification as type of caller.

Table 9.1

Participant callers utilisation and classification (N=22)

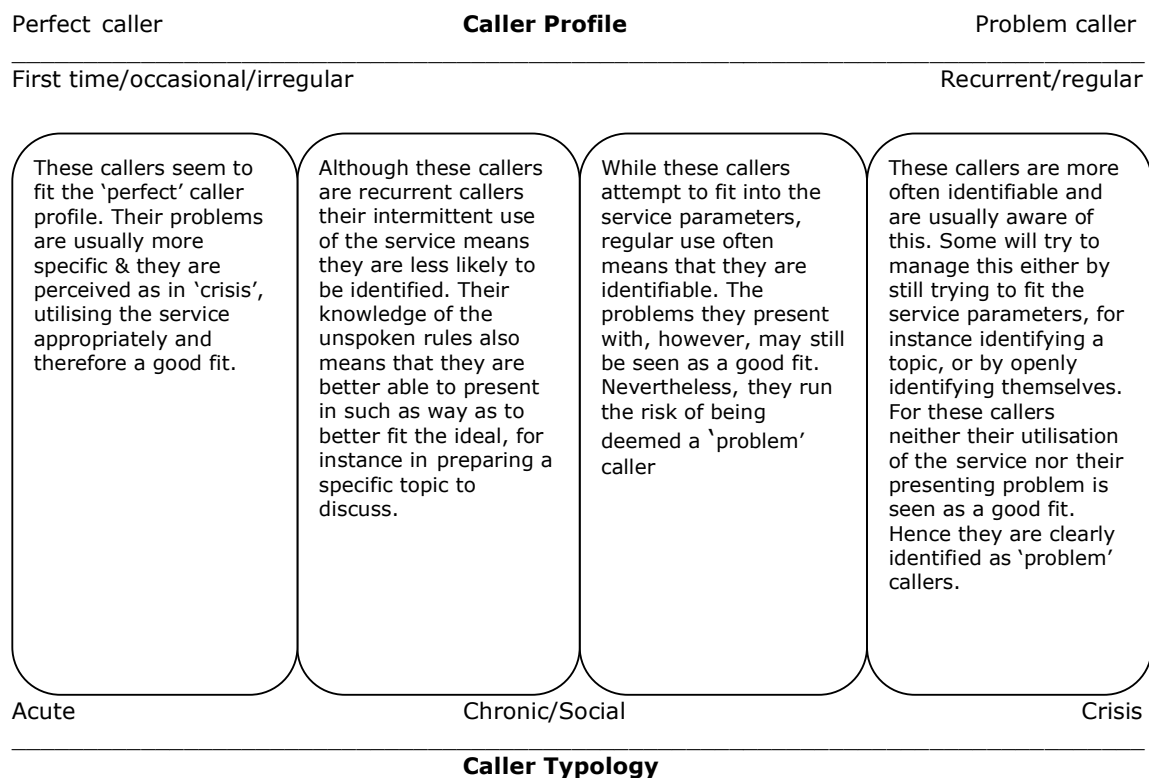
Calling behaviour	Acute crisis	Chronic/Social crisis
First time/ Occasional & intermittent	Anita (FTC) Jackie (FTC) Matthew (FTC) Helen Rosemary	Alison Marion
Recurrent irregular	Brett Lisa Rita Karen	Jane Lauren Tracey Wendy
Recurrent regular	Annette	Nina Pam Judith Harry Robert Diana

FTC = First time caller

Earlier chapters highlighted how the parameters of the Lifeline service and the counselling model appear to be more closely aligned to the one time crisis caller whose presentation and utilisation of the service seems to more closely fit the ideal. In this way callers who are seen as fulfilling these requirements may be perceived as representing the perfect caller. While some provision for the recurrent caller is made, the focus appears to be more on service management of these callers rather than on enhancing treatment. Recurrent callers are perceived as not fitting within the bounds of the service model, this, together with their continued and regular use of the service, tends to mark them as problem callers. The depth, breadth and chronicity of these callers' problems also represent a significant challenge to telephone counsellors.

The following figure illustrates the 'perfect' caller and 'problem' caller profiles in relation to presentation and service utilisation.

Figure 9.2. The 'perfect' caller and 'problem' caller profile



As callers move along the anonymity continuum, towards becoming more identifiable, perceptions of them, their use of the service and their suitability as a client of the service, changes. They may inadvertently become a 'problem caller'. This affects the way telephone counsellors respond and interact with them. For instance telephone counsellors might perceive them as abusing the service, one telephone counsellor reporting 'I felt this call to Lifeline was more about alleviating his boredom than anything in particular that was an immediate crisis'. These perceptions might influence the telephone counsellor's attitude to the caller, for instance hearing the caller's problem narrative as 'jibberish', and lead to conflicts in the therapeutic relationship, as was reported by the telephone counsellor in this instance.

Despite the fact that Lifeline has a counselling model specifically designed to deal with callers experiencing less defined and more chronic problems the perception seems to be that that these callers are not a good fit with the service. The 'acute crisis' caller, whose presentation may be seen as fitting more easily into Lifeline's crisis counselling model, may be viewed as the 'perfect' caller, whereas, the

'chronic crisis', caller whose problem and needs appear far more complex takes on the role as the 'problem' caller. The 'chronic caller', however, represents the majority of callers to Lifeline.

The following section provides two case studies that express features of the typology that define 'the perfect caller' and 'the problem caller'.

Case studies

The two case studies presented below provide an in depth exploration of the telephone counselling interaction from the perspective of a first time caller and recurrent caller to Lifeline. The cases illustrate the 'acute crisis' (perfect caller) and 'chronic crisis' (problem caller) typologies and are inclusive of the complete triad data set of recorded telephone counselling session, caller interview and telephone counsellor interview. The case studies are presented separately and include my reflections on the data. In addition, in order to communicate some of the temporal shifts in the telephone counselling interactions references to points in time have been interspersed.

The perfect caller: Jackie

Jackie represents the perfect caller to Lifeline. She is a highly functioning young woman with a specific problem. She has no mental health issues and is not currently receiving any support or accessing any treatment or counselling. During the interaction she briefly mentions that she had tried to access support through her employee assistance program at work. She was unable to talk to anyone directly and had left a message for the service. She then decided to call Lifeline.

This is the first time Jackie, a 35 year old single female, has ever called Lifeline. She was aware that the service existed and found the number via the Internet. Jackie makes her first call to Lifeline from work on a Monday morning at 0857am. Her call is briefly placed on hold and she hears the on hold message

before her call is answered. When her call is answered she talks with a female telephone counsellor for 19 minutes.

Telephone counselling session

Making the connection

The telephone counsellor begins the counselling interaction by asking Jackie to share with her the reasons she has called Lifeline. Jackie easily takes up the conversation and the telephone counsellor spends the next two minutes exploring the parameters and effects of Jackie's problem by asking her several open questions. For instance, the counsellor asks Jackie to comment on the memories Jackie has of the problem and what effects it is having on her at the current time. There are no introductions and no names are used throughout the following session.

Managing the connection

Jackie's voice is even and reflects little emotion as she explains the situation in a matter of fact manner. The telephone counsellor's voice, perhaps intentionally, mirrors Jackie's in tone and timbre. Jackie's problem is presented not as an individual struggle but as a family crisis. Her father's long term alcohol abuse has begun to reach a critical point, he has lost interest in many of his usual pastimes and there is a distinct possibility that her mother's tolerance has run its course. Jackie thinks her mother may be considering leaving the relationship. Jackie tells the counsellor that her mother has already begun to 'move away' from her father and has been staying with another family member. Jackie thinks she and her brother need to 'do something'. Her concerns revolve around broaching the subject with her father and facilitating his active involvement in getting some help. She would particularly like some referral options from the Lifeline counsellor. The telephone counsellor suggests that what her parents need is 'couples counselling really isn't it?' Jackie is unsure but goes on to explain the effects her father's drinking and behaviour are having on her mother.

This initial interaction is characterised by short exchanges that consist of questions and answers as the telephone counsellor begins to gather information. As the exchange continues Jackie's part in the dialogue expands to take up only slightly more than the telephone counsellor's and these segments are interspersed with a more interrogatory exchange. The tempo of the interaction is slow and there is little emotional content or expression. Jackie's manner reflects a very pragmatic approach that is congruent with her desire for a practical outcome.

While Jackie is clearly concerned about the current difficulties she no longer lives with her parents and is somewhat removed from any direct experience of the problem. Jackie explains the situation, reporting that both her parents struggle with communicating their feelings 'she's not very good at saying how she feels, and he's not a very, you know, open and forthcoming person in that area either, (TC5: Yeah, yeah.) so I think we need someone to facilitate'. The telephone counsellor questions how her father might '...handle the prospect of going to see a counsellor'. As Jackie begins to reflect on how this might be managed the telephone counsellor begins to search the Lifeline database for possible referrals. She checks which area Jackie's parents live in and can be heard typing. There are some spaces here, short periods during which there is no dialogue, as the telephone counsellor searches for a suitable referral. On occasion she tells Jackie what she is doing or reads some of what she is seeing on her computer screen. During this time Jackie interjects, asking 'While you're still checking, can I just ask you a question?'

Extract: counselling session: TC5 & Jackie

TC5 Sure

*Jackie Do you think, I mean I was going to go down to see my
Dad tonight...*

TC5 ah ha.

*Jackie: Is it worth, sort of, sort of, trying to start that
conversation? Like, 'cause my mum is not there.*

TC5 *someone's got to start it.*

Jackie *Yeah, (short, light laugh)*

TC5 *(laughs)*

Jackie then answers her own question and articulates what she thinks the parameters of her involvement might be, discussing the timing and suggesting how the conversation might begin. She then seeks some reassurance from the telephone counsellor saying '...I just didn't know whether or not that was the right attack'. The telephone counsellor seems to hedge her response stating 'Hmm. Hmm. OK, OK. Well, I mean, you know your dad better than I do, obviously'.

The telephone counsellor then reconsiders her response and observes that Jackie's earlier reported conversation with her father might have provided an opening for her to broach the subject with him of him attending counselling. She goes on to suggest a way in which Jackie might start this conversation. The telephone counsellor seems a little hesitant in providing this feedback and the suggestions; laughingly making a comment 'You're asking me!'. Jackie then explains her uncertainty about her role in the face of her mother's absence:

Extract: counselling session: TC5 & Jackie

Jackie *No, no, no. It's just like, I didn't want to, you know, I didn't want to, 'cause mum's not there at the moment, either, because she's away...*

TC5 *yeah*

Jackie *... So I didn't kinda want to get him all, you know, I don't know.... I mean I'm just scared really, I mean I want to say something, I mean, I want.... I think we all...*

TC5 *You just don't want to open something up.*

Jackie shares her regret at not having done something 'years ago'. The telephone counsellor questions if Jackie's mother is aware of what Jackie is doing and Jackie reports that her sister plans to tell her before they have the

conversation with their father. The telephone counsellor states: 'OK. Yeah OK. Well I'd say that sounds like you've got a bit of talking to do before we make any sorts of an appointment or anything like that'. They return to the search for a referral. During the search the telephone counsellor asks Jackie 'What prompted you to call here?' Jackie tells her that she'd '...heard of Lifeline obviously before...' she '...was on the Internet and that was one of the ones and I just decided to call you guys first'. She continues on to say 'And I didn't know whether or not my problem was serious enough' the telephone counsellor assures her that 'every problem is serious'.

The telephone counsellor can be heard typing. While she searches for a referral the telephone counsellor engages in dialogue with Jackie that appears to be aimed at maintaining her connection with her and is perhaps also an effort to avoid silences and to reassure Jackie that she is still on the line.

(8mins 46secs)

The remainder of the interaction is taken up with the telephone counsellor searching for and providing Jackie with a number of referral options.

(16mins 15secs)

Less than two minutes before the end of the call Jackie returns to a discussion of the problem. She recognises her father has a long road ahead but thinks the relationship counselling is a good first step as he '...needs to know how she (her mother) feels...'. Jackie recaps on earlier information that she sees as contributing to the problem. Her father is retired, has no interests and shows no inclination to engage in any pastimes. The telephone counsellor interjects with minimal encouragers but she doesn't attempt to gain any further information nor does she encourage Jackie to elaborate. The voices of both reflect light laughter as the session draws to a close with the telephone counsellor commenting 'so you're going to give dad a wake up call?' and Jackie responding 'yeah. I think so (laughs)'. Jackie says 'thank you' and the telephone counsellor wishes her 'all the best' before their final 'bye'.

Interviews: Maintaining the connection

Caller interview: Jackie

Five days pass before I manage to interview Jackie. It's been a tumultuous week for her and as a result my first two attempts to contact her were unsuccessful. We talk for 24 minutes. Jackie tells me that she has never called Lifeline before but she had been aware of the service through advertising and through community work she has done. She says she was 'a bit anxious' calling up and concerned that her problem was not as 'urgent' as others' and she 'didn't want to take up their valuable time as well'. Nevertheless, she really 'wanted some information' and 'needed to speak to someone' because she 'didn't have the answers'. She tells me that she needed some reassurance about how she might manage the situation. Jackie's account reflects her pragmatic approach to both the problem and her use of Lifeline.

In Jackie's view, the most important reason for calling was to develop a strategy that would assist her in her efforts to speak to her father about his alcohol abuse. Her father had identified that he had a problem and the telephone counsellor had 'reassured' her that this was a good opportunity to talk to him, 'a good starting point' and 'the right step forward'. In light of this she and her siblings 'did act on that' and had spoken to her father 'that night'. The telephone counsellor had also provided her with some referrals for counselling and 'rehab'. It was good for her to have these as 'resources' and, even though she hadn't yet told her father about them, the option was there should he need them. The telephone counsellor's ability to access local resources was 'important', although it was difficult 'not knowing some of the suburbs'.

Talking through the problem was also helpful for Jackie and she found the telephone counsellor 'positive' 'reassuring' and 'knowledgeable'. She described the telephone counsellor as having a 'very warm voice' that she felt 'comfortable talking to' and as 'very friendly and very supportive'. Jackie recalls that when she mentioned her uncertainty about calling Lifeline the telephone counsellor had made her feel that her problem was 'important' and that 'regardless of the size of

the issue she certainly didn't downplay' it. Jackie 'didn't get fobbed off' and the telephone counsellor 'spent the time' ensuring that she had all the referral details correctly recorded and discussing which were a better match.

Other than providing referrals Jackie sees Lifeline's role as being '...the first point of contact' for people, to 'reassure them, and to talk through any concerns...' It's 'access to information and support' and a non-judgemental 'ear'. She had since encouraged her mother to call Lifeline and had told her brother-in-law:

...even if we can't get mum you know, to a counsellor to a face-to-face counsellor, then you know there is always telephone counselling, and that's a good starting point.

Jackie tells me that 'a lot has happened in the last few days'. She remembers she was 'very nervous' about seeing her father that night but as 'she (the telephone counsellor) said the door's open and it was our chance'. When she mentioned to her father that she had called Lifeline he had said 'oh I don't want Lifeline, like I'm not that desperate'. Jackie tells me that she had felt 'a lot better' and 'more in control of the situation' after the telephone counselling call. It gave her '...the confidence...knowing that it is the right step forward'. She would certainly call again if she needed to.

Telephone counsellor interview: Kelly

My interview with Kelly occurs three days after her telephone counselling interaction with Jackie. We talk for 35 minutes and she tells me that she has been with Lifeline for less than a year but that the number of hours she has completed in that time is the equivalent of a two year commitment. She hasn't had any other counselling experience but describes herself as having a 'strong sense of community'. She explains that she chose to volunteer with Lifeline because she was interested in 'helping others' and was motivated by her own challenging life experiences. Kelly is in her mid 20's and has completed 35 telephone counselling shifts with Lifeline.

Her initial expectation when she started at Lifeline was that she would be dealing mainly with 'acute calls' rather than with 'chronic calls', which she has since learnt is the more typical type. The Lifeline training has helped her to deal with this and has 'enhanced' the way she works with callers. She describes how 'working with modules' provides 'a lot of structure...to work from'. At times she might need to mix the 'modules', incorporating aspects of the 'acute', 'chronic' and 'suicide self harm' modules 'because each call is completely different'. Kelly explains though that:

The common thread with all of the modules is sitting with the here and now and the present and the caller's feelings in all of them, it's just how you direct and manage the call depending on your sense of their presentation... generally you are really working with using a lot of empathy.

Her experience has left her with a 'very strong perception' that it's the 'connecting' and the 'instant connection' that callers need 'when they reach out'. She describes how many callers 'say things like, "I have no one else, you're always there"'. She explains that 'people don't feel that sense of aloneness when they are talking to someone on Lifeline'. From her perspective 'empathy and connection' are the most important facets of what Lifeline offers. Although building 'rapport and a feeling of trust' with a caller can sometimes take longer, in most cases the relationship happens 'instantaneously'. This was her experience of her recent call with Jackie during which she felt 'there was an instant relationship' and 'that connection'. Kelly explains:

I think there was an instant empathy with her presentation, which I think she got straight away... I think the sense of communication was...obviously the desire to help and to ask questions to familiarise myself with what exactly she was dealing with in terms of her presentation, so I could give her the best possible referrals that she was looking for.

Although she doesn't always use it, Kelly sees the referral service as an 'invaluable asset' that helps callers to feel that '...this isn't the end of the line for them and that there's someone else out there'. So that Lifeline is sometimes 'helping' people 'build bridges', an 'initial port of call'.

Kelly described some of the interaction with Jackie and the approach she took, however, she also expresses some concern about what she might have missed:

I was getting a lot on how, what was happening with mum and what was happening with dad, um...so I validated her being very forthright, being good for trying to be proactive with, you know, in trying to head things off, but didn't quite check with her, how she was sitting with everything that was going on.

So that, on review, Kelly felt some dissatisfaction with her handling of the call. In general the 'counselling session' was more about 'finding direction' and she describes Jackie as being 'open for suggestions' and 'more than open to be directed along either path, in terms of different places she could go or different options for her to source out'. Despite the 'problem solving' focus of the call Kelly thinks that the relationship was still a key factor. Overall, Kelly thought that 'being able to discuss what was happening in the relationship with her mum and dad' was important for Jackie. Having the referrals also 'gave her something that she could go on with, so she would have that sense of still feeling empowered herself and be proactive herself'.

Kelly and I talk briefly about her experience of being recorded as part of the study and she admits to feeling 'quite nervous' and being a little 'conscious of the amount of time' during the call. As a result Kelly thinks that she 'didn't entirely check her (Jackie)', 'didn't really delve into her, how she was feeling'.

In general her experience of working as a telephone counsellor is of 'a constantly moving changing entity' where 'everything is done differently at every call...nothing is the same (and) the counselling process is moving the whole time' so that she is 'constantly learning something new'. One of the benefits of working at Lifeline is that:

...the hunger that you have for knowledge, because everything is so different and so broad, you're constantly being fed this mountain of food that you can really use, really well, within the counselling experience

Kelly believes that 'being open', 'empathic' and 'non-judgemental' are important qualities for a telephone counsellor to have. She also thinks that 'keeping an

open communication' is an essential skill. She tends to rely on her 'sensory intuitive' sense on 'what's being said' and 'how it's being said', as well as the tone and breathing patterns of the caller. By honing other skills she tries to compensate for the lack of body language. These skills also help her to maintain her focus.

Researcher's reflections

Jackie's case clearly illustrates the 'perfect caller' to Lifeline in a number of ways. She is a first time caller who has simple expectations of the telephone counsellor and a clear and achievable preset goal for the interaction. In addition, she is highly functioning, has a specific problem, appears to have no mental health concerns and expresses little or no emotional distress. Overall her presentation lends itself to the development of a positive counselling relationship that is likely to encounter few challenges.

Expectations of Lifeline

In the case study described above, the caller is clear about what she expects to get from her contact with Lifeline. Jackie's need was 'to speak to someone', gain 'some information', in particular about referral options, and also get 'some reassurance about the way forward'. Her needs and perception of Lifeline, as being 'the first point of contact' where people can gain reassurance, 'talk through any concerns' and access 'information and support', were closely aligned with Lifeline's perception of their role. In addition, her lack of previous contact with Lifeline meant that her expectation of receiving help and support remained intact.

Jackie's expectations likely influenced not only her approach to the interaction and her constructive engagement with the telephone counsellor, but also her perception of a positive outcome. Reflections of these components of Jackie's expectations can be seen in the literature and research about client expectations. Jackie had clearly already begun to mobilise her resources, considering how she

might approach her father and discussing with her siblings her plan to call Lifeline. In addition, she developed a positive alliance with the telephone counsellor and anticipated that she would receive the help she needed and that this would enable her to address the problem. The influence of these expectations is particularly evident in Jackie's attempts to gain advice in relation to how and when to approach her father were concerned. Despite the telephone counsellor's apparent reluctance to advise her, Jackie's perception was that the telephone counsellor provided what she needed, which facilitated her desired outcome, enabling her to take action.

Although Jackie's main reason for calling initially appeared to be to gain referral information, and this had been the main thrust of the counselling interaction, she had not yet utilised this information and seemed unlikely to do so.

Perhaps another important aspect was that the caller and telephone counsellor expectations about Lifeline's role in this scenario were closely matched. For instance the caller reportedly saw Lifeline as 'the first point of contact', which closely aligned with the telephone counsellor perception of Lifeline as the 'first port of call'. This agreement undoubtedly provided a common ground on which they could build.

Therapeutic goals and tasks

Common expectations facilitate agreement on treatment goals and tasks. This session seems to be focused on the problem and the solution. In general the feeling is of a quite superficial interaction made up of the telephone counsellor posing questions aimed at eliciting factual information with a view to matching caller and referral. There are no instances of open questions that explored the caller's experience of the problem. However, the caller is also very focused on the problem and, although on a couple of occasions she appears to want to engage in a deeper discussion about the issues involved, the telephone counsellor does not reciprocate and the caller does not pursue this line.

The telephone counsellor makes comment that, on reflection, she was aware that she had not explored the caller's experience. She seemed to see this as a failure on her part. The caller, however, makes no reference to this. It is difficult to determine whether this is because she had no expectation of this occurring and was happy to receive whatever assistance was offered or because this was not her primary need. The telephone counsellor's lack of attention to the callers experience or feelings in relation to the problem was most likely influenced by the caller's pragmatic approach and self-contained presentation. As a result the caller required no containing on the telephone counsellors part and would have appeared to be low risk.

It is interesting to note that, despite the problem focused approach, the telephone counsellor viewed the relationship as the most important factor. The literature points to common expectations as facilitating agreement on treatment and goals. Jackie presented with a specific problem that was clearly identifiable and attainable and that both saw as important. These are identified in the literature as being the central features reflecting the cognitive and behavioural aspects of the relationship.

The therapeutic relationship

It would appear that many of the aspects identified in the literature as being central to the therapeutic alliance were reflected in this case. The caller approached the interaction with positive expectations of both the interaction and its outcomes and, except for a degree of reticence on the telephone counsellor's part regarding the provision of advice, there was agreement on tasks and goals. Additionally, a willingness existed on both sides to assume appropriate roles with the caller as the one seeking help and bringing concerns and the telephone counsellor as being genuine and credible.

This meant that the telephone counsellor was better able to manage the depth and breadth of the interaction. The caller's presentation also represented few challenges and engendered an empathic and positive response from the telephone counsellor. The result was most probably a lowering of the telephone

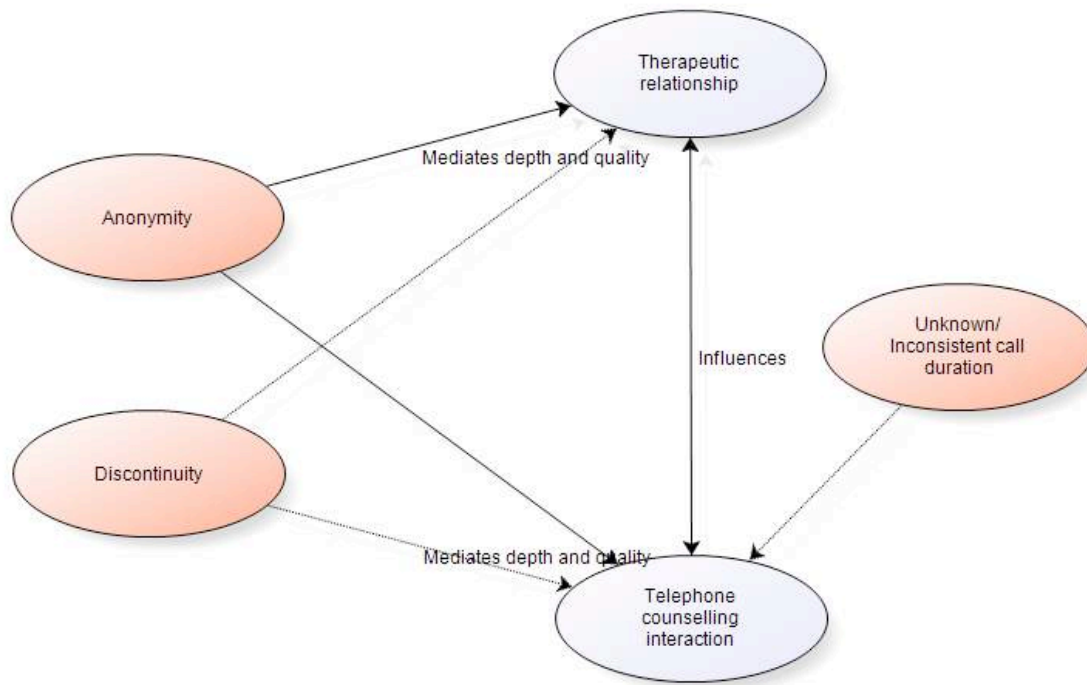
counsellor's anxieties. The telephone counsellor was also not challenged in relation to her ability to be genuine with the caller. As a first time caller there were no tensions related to the erosion of anonymity and the resulting difficulties associated with the lack of transparency.

Where the caller was concerned anonymity did not appear to be a concern and she makes no mention of this at all throughout her interview. This is most likely because she did not perceive any threat to her anonymity or possibly was not highly concerned about this feature of the service. She was comfortable with and trusted the telephone counsellor and allowed her to drive the interaction and promptly acted on her counsel.

'Perfect' caller dynamics

The following diagram depicts the service conditions and illustrates the dynamics these facilitate in relation to the 'perfect' caller interaction. For instance, both discontinuity and anonymity mediate the depth and quality of the therapeutic relationship and the counselling interaction. Since this is the caller's first telling and the caller's anonymity remains intact, these conditions create little tension. Instead, they probably increase the telephone counsellor's cooperative and active engagement with the caller. This, in combination with the caller's perception of safety through anonymity and the telling of their story for the first time, facilitates a greater degree of relief and comfort for the caller. The counselling relationship and counselling interaction suffer fewer challenges as a result. While unknown and inconsistent call duration is associated with the telephone counselling interaction, first time callers have no knowledge or expectations about this and generally leave the management of this to the telephone counsellor, so that these uncertainties exert little or no influence on the counselling relationship.

Figure 9.3. Diagrammatic representation of dynamic tensions associated with 'perfect' callers.



The problem caller: Diana

Diana represents the 'problem' caller to Lifeline. Although Diana is highly functioning, she presents as having significant long-term mental health issues. The telephone counsellor's post session record identifies Diana's struggles as 'Life - direction and purpose, personal growth and search for meaning' and reports that Diana's presentation was complex and her issues chronic. She has been seeing a therapist for face-to-face counselling for some time. Diana is a recurrent caller to Lifeline and has called several times in the past month. She's been calling into Lifeline regularly over the past few years.

Diana's call comes in at 1042am on a Saturday morning and she talks with a female telephone counsellor. Diana is a sole parent with a 15 year old son. She is aged between 45 and 54 and agrees to take part in the research project she says

'...because you (Lifeline) provide a lot of help to me and it's a minimal way I can put back'. The call lasts for 34 minutes.

Telephone counselling session

Making the connection

After attending to the ethical considerations of the study the telephone counsellor then immediately asks Diana 'So what was it that made you call Lifeline today?' The depth and breadth of Diana's difficulties are immediately apparent in her response to this question when she says 'well, it's an ongoing issue for me'. There are no introductions and no names are used throughout the following session.

Managing the connection

Using numerous minimal encouragers and a soft voice the telephone counsellor encourages Diana to tell her story. Diana goes on to explain her problem saying 'I'm struggling, I'm struggling not to contact someone because I've...I've set a boundary to do with that relationship which is important for me to keep'. At first it appears that Diana's problem is quite specific. However, although she doesn't clearly articulate her reasons for this separation, it emerges that the relationship she is referring to is the only significant relationship she has and possibly the only one of its kind she has experienced. The telephone counsellor explores the parameters of the story by asking 'how long... when did you put this boundary in place?' As Diana continues to relate her problem, the telephone counsellor works on building rapport and identifies Diana's struggle as a conflict between her desire to maintain the boundary and her emotional need to make contact. The telephone counsellor couches this in positive terms, identifying and reinforcing Diana's strength in doing this whilst also recognising her underlying struggle with the deeper issue of trust.

Diana then goes on to explain that she struggles to trust most people, and has done since childhood. Even maintaining a physical connection with herself is difficult and she often feels disconnected from her feelings. She follows this up saying that she has trouble separating her identity from another, for instance, when her friend is sick, she believes that she might be sick too. Diana recognises this as a 'boundary' issue. She reports that she has few social supports and struggles to maintain relationships. This particular person is her only support.

Six minutes into the call the telephone counsellor attempts to establish a focus for the session:

Extract: counselling session- TC4

yeah .. gosh OK, so these are really big things we're talking about at the moment. So what was it in our phone call this morning that you were hoping we might be able to work through?

Diana responds to this by talking about what it is she needs, describing it as a 'holding position' and telling the telephone counsellor that she has no one else she can talk to. Diana's voice reflects her emotion as she becomes teary. She tells the telephone counsellor '...if I can talk to you that holds that position for me'. The telephone counsellor then invites her to 'talk a little bit more...' and they return to Diana's story.

Diana's voice continues to communicate her emotional distress as she delves deeper into the underlying feelings that are associated with her struggle. The telephone counsellor again uses minimal encouragers, occasionally seeking clarity and identifying a feeling, 'that's a pretty scary situation to be faced with...'. During this phase Diana's voice becomes firmer and regains its strength.

Throughout the interaction, voices and ringing telephones from within the Lifeline office can be heard in the background.

Diana goes on to tell the telephone counsellor that she has been receiving ongoing face-to-face counselling and that she had a very emotional session with

her counsellor the day before. She talks about how this relationship is drawing to a close and that a time has been set for her therapy to end. It appears that the impending loss of this relationship, too, holds some anxiety for Diana. The telephone counsellor does not explore this aspect of her concerns nor does she encourage Diana to extrapolate.

Diana has gained some insight into her problem and tells the telephone counsellor that her struggle is about '...closeness and how to deal with closeness'. Almost twelve minutes into the call the telephone counsellor summarises and reiterates the depth and breadth of Diana's struggle.

Extract: counselling session: TC4 (11mins 43 secs)

'Right, gosh, they're some of the biggest things there are to deal with ... that everyone does, about forming closeness with people and then dealing with loss and dealing with all the emotions that come with trust and, and some of the vulnerabilities that come with that as well. They're really big things to deal with'

Diana agrees and explains that she has a 'predisposition' to disconnect from her feelings. She finds it difficult to connect with herself, her physical body, with feelings, with another person; however, she says she has made some improvements on this front. Diana sighs as she tries to explain what this is like for her and the telephone counsellor gentles her voice in response. Diana relates how this impacts on her current situation:

Extract: counselling session: Diana

'so that that disconnection is not always there, and so what I'm struggling also with this particular situation is to keep connected (TC: mmm yep) and to keep the closeness there, but to make decisions which will allow him to have space (TC: mmmm) and... um for that closeness to be still there'

The telephone counsellor once again identifies the difficulties of the situation:

Extract: counselling session: TC4 (13mins 41 secs)

'Gosh, that is a really difficult situation isn't it? It's a very complex thing that you're trying to do, but it sounds like you've really sorted through and it's something that you need to do but it's... I can see how that would be a really difficult situation'

During the following three minutes Diana explains her situation in more detail. The telephone counsellor intersperses with numerous minimal encouragers. She also asks Diana what strategies she's put in place to help her cope with keeping the boundary in place. Diana identifies a number of mechanisms that she's already put in place and others she plans to use on a daily basis. In what seems to be an attempt to lighten the mood, and is possibly the telephone counsellors first attempt to 'wrap up' the session, the telephone counsellor's voice communicates some mirth as she likens the process to 'clearing out a cupboard'. There appears to be some disjuncture here between the telephone counsellor and Diana. Whilst Diana agrees with the telephone counsellor's analogy her voice does not mirror the telephone counsellor's attempt to shift the mood, instead Diana's voice is flat as she says '...but there is... (sigh) an emotional side of that'. The telephone counsellor agrees and goes on to provide some information about the grief and loss process. Diana says she's holding on to the hope that she will have worked through some of this in the next two months (presumably before her face-to-face therapy ends).

(17mins 50secs)

The telephone counsellor again attempts, unsuccessfully, to 'wrap' things up and shifts the discussion away from Diana's struggles, asking Diana '...what did you have planned to do today? Let's just maybe talk about, you know, right now, and what you're going to do today'. Diana accommodates her request and relates her plans for the day. The telephone counsellor's voice again reflects a light humour as she makes comments and laughs during this discussion. There is no answering humour or change detectable in Diana's voice. Instead she relates her concern about how her personal struggle impacts her family life and relationships and the discussion returns to her original presenting problem.

(23mins 48secs)

At this point the telephone counsellor again attempts to shift the focus; however, the question posed is quite vague and she later broadens this further:

Extract: counselling session: TC4

'Right, so how do you think you might go about working some of these things through? You're going to give yourself a bit more time obviously and that's really good, a bit more space, and you've worked out these boundaries that you're wanting to stick with. But have you thought about the process within that, those sort of boundaries, about how you might go through working out these things'

Diana asks for clarification, saying 'with this person or with myself?' and the telephone counsellor responds 'more generally yeah'.

Diana then explains that she is trying to understand how her current difficulties 'impact on' and are 'translated into other relationships and other situations'. Once again Diana's voice becomes choked and shaky as she becomes emotional. Once again she tells how no one else has ever provided her this experience of closeness, and she becomes progressively more emotional as she explains that even the counselling relationship has boundaries and can 'only go so far'. The telephone counsellor agrees and reinforces the limits of a counselling relationship.

Diana goes on to identify the growth and change she's experienced and the understandings she's come to as a result of having had this relationship.

(26mins 55secs) Sounds continue to be heard in the background coming from the Lifeline office, a doorbell ringing, the sound of movement and voices.

In the following section Diana makes a statement and poses a question, in response to the telephone counsellor's observation, that may be seen as expressing the very core of her current struggle:

Extract: counselling session- TC4 & Diana

TC4 mmm and yeah certainly (you) are talking about a very deep sort of...sort of... feeling or a situation as well

Diana so I guess what I'm looking at is trying to... (sigh) make sense of those experiences in that relationship to...to, know how, to... partly to get close to other people, but partly it's... I've never really felt, and experienced, anything good coming out of being close to another person

TC4 yeah OK yeah... so it's trying to move on from those experiences and see what good can come from being close

Diana well I think I have had good experiences in that relationship but (TC4 'mmm') if he was to die or that relationship stops then does that mean that 'that' in my life stops?

While the telephone counsellor validates the magnitude of Diana's struggle she avoids engaging with her question and draws the session to an end. The session continues:

TC4 mmm, OK

Diana so... (voice choking)

TC4 gosh that's big stuff that you're having to deal with here, isn't it?

Diana so... so (pause) you (pause) (teary)

TC4 Yeah, OK

Diana (crying) so essentially ...(struggling to talk through her emotions) it's about um... what place other people play in my life

TC4 mmm, OK yeah... and that's very very, um, deep and serious sort of stuff. OK, so we've been talking for a while now today about these things, and um, you mentioned that you've got a few things on for the rest of the day (Diana: yeah) how are you feeling about facing the rest of the day at the moment?

After Diana identifies her deep feelings of sadness the telephone counsellor comments on how 'the sorts of things' people want to talk about are also the things that bring up 'sad emotions'. Diana responds that this 'is not a bad thing' and states:

Extract: counselling session- Diana

I mean I think, I think sometimes, with Lifeline, people (telephone counsellors) get afraid, on the other end, that they're opening something...

The telephone counsellor explains that at Lifeline they do feel worried about opening up something that they can't 'properly' deal with. Diana goes on to explain that, for her, although opening up these issues is painful, it is 'of huge value'. She expresses her hope that some day she will be able to connect with and manage her feelings as they happen:

Extract: counselling session: Diana

...like everyone else, that I'll have the feeling at the time and I'll know how to deal with it (TC4, mmm) that it won't just all build up (TC4, yep) and that it won't be a 100 years of sadness (TC4, mmm) it'll just be the sadness at that time.

(32mins)

As the telephone counsellor attempts once more to end the session, Diana wonders if the telephone counsellor has found being recorded for the study 'constraining'. The telephone counsellor reports that she'd 'forgotten about it' and asks if it had been on Diana's mind, she says 'a little'. They have a short discussion about the study and the telephone counsellor checks again that Diana is still 'willing' to be involved. Diana answers 'I can't donate millions of dollars to LifeLine, so I can do what I can do'. She says 'thank you' to the telephone counsellor and they say 'goodbye'.

(33mins 50secs) call ends.

Interviews: Maintaining the connection

Caller interview: Diana

My telephone call to Diana occurs in the evening two days after the recorded telephone counselling session. The interview lasts for one hour and 11 minutes. Diana is initially quite prickly towards me. Her tone is slightly aggressive and she asks me why I 'chose' her. Once I explain that she has not been singled out her demeanour quickly changes and she explains her response, telling me that she'd had a 'bad' experience that morning when she called Lifeline again. She doesn't immediately expand on this instead she provides some background information regarding her struggles. Less than four minutes into our conversation she tells me she has a history of childhood sexual abuse and a family culture that tended to punish any expression of feelings. She wasn't allowed to have feelings or express them and when she did she was punished or rejected. Diana explains:

...I never went through the normal developmental processes that most people do in how to manage feelings, how to feel them, what they are, what the feeling feels like in your body'.

She explains that when she calls Lifeline:

"...sometimes they get frightened, that they are over stepping what they can do and so they close you down, which is reinforcing, for me, (it) reinforces what happens to me in my life and so I have to constantly forgive people (TC's) for not understanding'.

The call earlier in the day was one of these and she tells me what transpired:

Well, basically she told me I should either ring suicide line or grief line and not to ring lifeline.....(sigh)

Despite these experiences Diana continues to call because she is so 'very very very' isolated and at times her need feels so great, like it is 'pushing' her inside. Being able to connect with the service as her need arises helps her to work through and connect with her feelings when they are present. It acts to

'depressurise' her feeling of being 'overwhelmed', which then prevents her slide into a deeper depression. It also helps her to understand '...what's happening right now...'. Waiting for her face-to-face counselling appointment means that it's '...retrospective and intellectualised...' and that '...the counsellor can't get close.... and I can't even get close...' Over time Lifeline has helped her to 'build up a repertoire' of feelings.

Diana explains that when she first began calling Lifeline she was suicidal '...all I was in was a crisis. I was feeling suicidal I didn't know why, I didn't know what the feelings were that lead to that...'. She struggled with this and with depression for many years and had difficulty functioning and going to work. She has since come to understand there is a process involved. Lifeline has helped her to identify her 'triggers' and she's learnt to call earlier now, before she becomes too 'overloaded'. She comments that her depression has lifted over the past month because she's been using Lifeline 'better', as a 'preventer', calling before she is in crisis.

Her therapist encourages her to call Lifeline as a support. She also explains to Diana how Lifeline might 'perceive things' to help her manage any feelings of rejection. On those occasions when telephone counsellors challenge her use of Lifeline she often experiences this feeling:

Well, I tend to take it as a rejection, and a judgement and ...I try very hard to see it in the context that they might be seeing it

It's difficult for her not to feel 'rejected' and 'undervalued' at times. Diana doesn't see calling Lifeline as a 'choice'. She recalls that she didn't perceive herself as the sort of person who would call Lifeline. She saw herself as 'better, in terms of mental health' and ringing Lifeline was a last resort. She senses that there is an '...assumption that people are abusing things because it doesn't suit the system...' and thinks this '...is a little bit down putting of people...'. Nevertheless, the ongoing contact has afforded her the ability to reflect back and it provides a sense of 'movement', of changing needs, from calling 'in crisis' to calling to pre-empt crisis. She is aware though that 'they' (Lifeline) don't see how

much she's moved on and so that if she is experiencing a difficult period and 'starts ringing too often' 'they' (Lifeline) feel that she is not moving:

...Lifeline might see that the issues I ring up about are repetitive or when I'm stuck ...um and I actually... you know that's the thing... comments that they have made to me, um, but I actually think it's a lack of their understanding... of who I am and where I've come from and where I want to go, and that what they perceive as the stuckness is their own frustration of not feeling like they can help me

Diana has little hope or expectation of the telephone counsellor solving anything for her. What she needs is the interaction and the different perspective. She tells me 'it's the going over that is important, not the solution' and explains what this process is like for her:

...A bit like grief, you know, sometimes it's just the talking out and then all of a sudden it's gone. ...um so that's, you know, there's a pressure off me if I know that I'm not talking to someone about the same topic too many times because that's when people start to reject you (breath) usually

In this way, while not being able to build a relationship with any one telephone counsellor can be seen as a 'negative', not talking to the same telephone counsellor each time she calls has the benefit of allowing her to 'go over stuff'. In her experience '...if it's the same person they say 'oh but we have been over this before' and 'why do you need to do it again' 'you must be stuck'...' It also offers her a range of different perspectives from which she is able to pick and choose:

...It's accelerated learning, to a certain extent, because when you're ...when you have to worry about a one to one relationship you have to build up a whole lot of things in that relationship before you learn from the other person and trust one of those things, but if you're dealing, very quickly in depth, on trust issues with a whole lot of different people, you're actually learning very quickly, in a funny way, you're learning very quickly a lot of different ways of looking at the same issue, and so it gives you a choice... I can choose what's valuable and what's not.

This experience has also taught her that 'some people can empathise and some can't' and that 'you have to accept that, and get whatever you can out of that call at the level of that person'. She equates this to 'real life' and thinks that this

is 'probably a good experience' for her and 'a safe one too'. It's hard to achieve this in ongoing face-to-face counselling particularly because her struggle with personal boundaries often means that she adjusts to what her therapist needs of her. She has a tendency to do this with friends also, so Lifeline offers a unique opportunity where she is more able to preserve some of her identity.

Diana explains how anonymity too has its benefits. It protects her from having to deal with the intimacy of a face-to-face counselling situation, of not having to '...see someone and see how they're reacting...'. To a 'certain extent' it allows her 'not to have to censor'. She recognises, however, that her anonymity has become eroded:

I do know there are profiles um...part of that problem for me is ...um the interpretation that that person gives is to whatever that the um...the way they interpret what's being said on the profile. So one person may interpret it in one way and another in another way, and that's their skill level so that's up for very ...so I may hear what the person is saying as a rejection.

Perhaps it is the telephone then that offers her the comfort of reduced intimacy and not anonymity itself, since it seems that, despite there being no names exchanged, Diana has become identifiable. She perceives this case management approach and her lack of involvement in it as an undervaluing of herself and a protection of Lifeline.

There are other times when telephone counsellors acknowledge that they 'remember' her and provide some positive feedback perhaps saying 'oh you have moved a long way'. She finds this encouragement especially valuable:

there's been one or two that have remembered and have just been so encouraging...and you know that that person is not getting anything out of being encouraging, except just to be that way, you know, there's nothing in it for that person to be positive, you know what I mean, so um... and that makes life bearable actually to be honest with you...those glimpses...I think they're glimpses of humanness in a way, beyond the mechanics of things...it's not the skills so much, it's the, you know, if someone can give you a genuine hope about your life, when you're feeling quite hopeless, that's a huge thing. And, you know,

I mean, that's when people will ring an anonymous service when they're feeling that hopeless that they can't talk to anyone else.

Diana's final comment makes an important distinction and highlights that it is not necessarily that there is no one else, but that feeling hopeless may preclude talking to them.

Those times when she's experienced the human connection over and above the 'mechanics' of the telephone counselling interaction have been the most valuable. Her most helpful experiences being those occasions when a telephone counsellor has given her 'lots of hope' and has been 'very encouraging'. Those telephone counsellors have tended to have a more 'nurturing' approach, focusing on self-care and validation. Diana recalled a period when her calls were most often met with this more nurturing response and she tells me how 'powerful' this was, to simply be told 'it's OK to look after yourself'.

In Diana's experience, her interactions with telephone counsellors are also influenced by other factors. For instance when she talks to a male counsellor she's aware that she speaks with a different 'voice' and 'tone'. She finds that talking to male telephone counsellors does not have as much impact as the age of the counsellor does. If she connects with a 'young' telephone counsellor who is 'struggling' and 'a bit insecure' she won't talk too much but will ring back later to connect with someone else. She also has difficulty relating to 'older' telephone counsellors and she recalls an experience when an 'older lady' was 'really, really rude' to her. Overall, she tries to remember that the telephone counsellors 'don't have to be there', that they're there because they 'care' and sometimes this overcomes any perception she has of their 'lack of professional skills'.

Whilst Diana wasn't sure that the telephone counselling session recorded two days prior was 'directly helpful', she reported that she found the telephone counsellor 'empathic, very quickly empathetic'. Diana recalled the telephone counsellor saying phrases like 'that must be very hard' and 'I understand that must be very tough'. She had allowed Diana to cover a broad range of her issues and she 'didn't need a lot of explaining' and 'seemed to understand very quickly'. Diana didn't feel that the telephone counsellor was 'judging' her and she helped

her feel understood and valued. Diana described her as 'different' and 'more skilled' than most of the other Lifeline telephone counsellors.

What emerged from the interaction for Diana was a realisation that she has 'substantial', 'deep issues' that are 'too much, too hard' for her to manage on her own. The telephone counsellors 'reflecting back' and her own 'summarising of a lot of issues' helped her to see this more clearly:

It just helped me see, just where I was struggling, um and what I am struggling with, and that they are substantial issues.

Although this was a difficult and painful realisation for Diana she had acknowledged that she needed to pursue more 'intensive psychotherapy' with a professional and skilled therapist. She had already contacted her doctor to this end.

Telephone counsellor interview: Natalie

My interview with the telephone counsellor takes place four days after the recorded telephone counselling session. We talk both generally; about her experiences as a Lifeline telephone counsellor, and specifically, about her call with Diana. Our discussion lasts 44 minutes. Natalie is in her late twenties and has been a volunteer with Lifeline for a year. She's completed 35 telephone counselling shifts during that period.

She tells me that she sees Lifeline's role as providing 'emergency support and human contact'. Within this she views her position 'as being a counsellor', providing callers with 'a sounding board', 'helping the caller come up with their own ideas' and letting 'them know that someone has heard them'. Occasionally she's 'providing information and referrals' but, she says that, 'that wouldn't be the majority of my calls'. Generally, she is trying to 'manage' callers' 'distress', 'stabilise...their emotions' and 'talk through...their next step'. From her experience, callers tend to fall into two categories, those who have a 'discrete problem' and those who have 'deeper, more complex issues'. She finds the latter much more challenging. For these callers she sees herself as:

...someone there at the end of the line for someone who is perhaps, um, having a tough time, maybe they always have a tough time, and Lifeline is part of that coping strategy that they have where if they feel like they need to connect with a human voice...sometimes I feel like I'm that human voice that they're connecting with and those calls can be quite challenging

Calls, and callers, who fall into the 'chronic presentation' category, challenge her in a number of ways. First, she finds it 'harder to be a counsellor', second, she says 'they can be difficult calls in some ways in terms of working out what your role can be' and third, 'they can be challenging to really feel like you actually help more than just listening... you don't make a lot of difference'.

Managing the connection

The difficulty in maintaining her role as 'counsellor' is associated with her perception that callers 'want you to be a friend'. She explains that:

you sort of try and change the relationship into more of a counselling relationship than a friend type relationship, which is perhaps what they want, but you're sort of fighting the caller all the way when you're doing that because they don't really want you to be necessarily a counsellor

In these instances she tries to:

...challenge callers a bit more when I feel that perhaps they're not wanting to engage in the counselling process, when they're just wanting either just to talk, or just to fill in some time

Overall, her aim is to develop a counselling relationship that allows her to 'challenge the caller', 'reflect on what they've said' and 'pick up on inconsistency'. She also tries to provide the recurrent caller with a fresh experience and so will often ask herself 'how can we make this not just like every other time that caller rings up and goes through their story again'.

Uncertainty is Natalie's constant companion. Not knowing what each call will bring and trying to balance the caller's needs against what can realistically be

achieved during a single telephone counselling interaction generates a certain amount of 'worry' and 'anxiety' and can often leave her feeling 'lost'. Natalie explains what this process is like for her:

you don't know what you're going to get on the end of the line and then you, you start speaking to someone and you're sort of going 'OK, OK' and then it sort of starts getting bigger and you sort of think 'oh my gosh what am I going to do, how am I going to, you know, work with this caller in a way that's going to... going to make some... you know, give her what she wants' but also... give me... make sure that's realistic

At times a caller's needs appear to be so great that it doesn't seem 'it would ever be possible to end the call in a way that they would be happy to go "yes OK we'll finish now"'. Natalie finds that ending the call in these instances can be difficult.

...so some of those callers I do have to really be quite strict and just sort of actually hang up after we have sort of spent a fair time on the phone, and that's not easy and so I, obviously that's not good feedback for myself, but I also think, you know, that's what you have to do sometimes

A caller's 'willingness to end the call' is one way in which she measures the effectiveness of a call, changes that reflect a lowering of 'emotion in the caller's voice', whether this is anxiety or distress, is another way. Her sense of the caller's level of cooperative engagement with her also provides an indication of success.

(the caller's) willingness to answer the questions that you ask and focus on the things that you're asking them is another way you sort of know, oh right this person is on the same page here, and that's sort of a good feedback that you're on the right track...That gives you feedback that they feel that they got what they...they got what they came for

In general measuring any change is difficult in a context where body language cues are absent, the counselling interaction is time limited and there is no ongoing relationship. Natalie describes the difficulties that this presents:

It is really hard and it's not hard just because of the limited sort of feedback you get, but also because it's, sort of like, it's probably like the first time that you have ever spoken to that

person and it's probably going to be the last, so you don't have anything to compare it to either. So you don't know what they're normally like, so that makes it harder as well.

Connecting with different people also means that she has to 'adjust' her 'style' 'depending on the type of caller'. In her experience males are generally harder to connect with and have a different way of expressing themselves. They tend to be 'less expressive' than females, who tend to be 'too expressive'.

Females are sometimes the ones that just want to talk and you are just there to listen and maybe go 'ahuh' every now and again but that's really what they want

The sound of a male voice and the chance that it 'could be a sexual harassment caller' also tends to turn on her 'radar'. This can have some impact on her interactions with male callers. Where older or younger callers are concerned she will often change the sort of language she uses. More importantly, and the thing that most 'changes' her 'opinion', is 'whether a person seems like they're there for an actual two way counselling process or if they're there for just a chat'

While dealing with the uncertainties and tensions 'takes a lot of energy' and 'can be really quite exhausting' she enjoys 'helping people' and describes her time as a volunteer at Lifeline as the 'best thing that I have done in many ways'. The experience has afforded her a lot of personal growth and has raised her level of self awareness, making her more aware of her own values and how they impact on the way she reacts to people. Her work with Lifeline also helps her to 'keep things in perspective' as well as providing her the opportunity to test her ability to 'cope' in a counselling situation and to develop her counselling skills. In addition, there are also those rare occasions when she feels like she makes 'a bit of difference' to someone else, which is a 'pretty good feeling'.

The professional support she receives from the Lifeline supervisors is especially valuable and having a supervisor in the room means that she is able to work through any struggles she has, for instance with feelings of frustration. It also allows her to review and discuss what she might have done differently during a counselling call. On those occasions when she is challenged 'an immediate debriefing is important'.

Natalie tells me that 'a lot of people with chronic presentations' call on a Saturday. She recalls how she had 'tried to do a double shift' on a recent Saturday and says she had '...a lot of callers I'd had to just hang up on because they were just never going to end the call'. She laughs wryly as she tells me '...and then I got them back again...it was just a really long shift'. Diana's presentation and her call, received at 1042am on the previous Saturday, clearly fall into '...the category of someone who has a more chronic presentation'. Natalie tells me that 'it wasn't an easy call'.

Throughout our discussion about their telephone counselling interaction Natalie refers to Diana only as 'the caller'. Her perception was that 'the caller' wanted 'just a connection...just to talk something over, but it wasn't a real crisis situation'. Natalie explains that 'the caller definitely needed some space to talk a bit about the more abstract things that she is dealing with'. Natalie had, however, tried to '...focus the call much more on the real...what caused the call in this moment'. While '...she (the caller) was talking quite abstractly' Natalie attempted to '...bring it much more into more concrete terms about well "what's that actually involve in your day"'. In this way she tried to 'challenge...the caller' or perhaps, she says, it was '...just asking her to be a bit more grounded'. Natalie explains that:

It's not as easy as it sounds when I say it now, because you have got the caller wanting to talk about the bigger issue things and so you can sort of find like 'this is not really what I want to talk about'

On review Natalie thought the call could have been 'a bit shorter', but she'd 'made the mistake of asking a question that opened it again' and so they began '...re-going over the ground that really we couldn't do a lot with'. Her sense was though that she '...still gave her (the caller) that support that she was looking for...helping her get in touch with her feelings...'. Natalie is uncertain, though, about the impact of this and poses the question '...is that progress? I'm not sure'. She's uncertain also whether 'the caller' would have thought they had 'made a lot of progress' but then states '...I don't necessarily think that she wanted progress on her issues'. Natalie goes on to explain that:

She (the caller) has had some big things to deal with and she's really making some progress on them. I could also, you know, see that she had a long way to go.

Natalie was also uncertain about the relationship they developed and 'how good the connection was'. She felt that she was '...part of a much bigger story than just that call' because 'she calls quite often'. Nevertheless, Natalie recalls with interest their exchange when she voiced her concerns to 'the caller' that '...talking about this stuff isn't going to open it up too much for you'. She was surprised at the caller's explanation that getting 'in touch with her emotions' and 'feeling sadness' was what she needed and that Lifeline helped her to do this. This was a new perspective for Natalie and she tells me that she '...hadn't really thought of it that way before'. She had learnt something new from this frank exchange with 'the caller' and thought that it had also provided '...something that made that call perhaps a bit different than some of her (the caller's) other calls'.

Despite this, there is perhaps some sense of resignation as Natalie remarks on the fact that 'the caller':

...did call back the next day, which in some ways is alright, but, you know, other times I've spoken to someone who's had a similar type of presentation in that they've had a lot of bigger, bigger, bigger, bigger issues and have sort of wanted to talk more meaning of life type questions, and I have sort of given them, you know, their 20 minutes or half hour call and then sort of within 15 minutes I can hear another TC (telephone counsellor) on the phone and what they're saying is very... sounds very familiar and I sort of realised that, yeah, you've hung up the phone and they've called back someone else, sort of straight away, and that really...in that situation you really don't feel that you make a difference, because (chuckle) they just call back straight away anyway

Scope for making a difference with recurrent callers is a source of anxiety for telephone counsellors'. Natalie's comments communicate some degree of helplessness and hopelessness, feelings that are perhaps often a part of many callers' struggles when they call into Lifeline. However, while callers might have the benefits of being able to recognise some measure of change in themselves as

a telephone counsellor Natalie rarely has this opportunity, and even if she did the conditions of the service limit any sense of personal achievement.

Researcher's reflections

My interview with Diana is much richer than my interview with Jackie. This is a reflection of the amount of information and perspectives shared. Diana's experience with calling Lifeline means that she has a vast store of information from which she can draw. It also means that Diana has accumulated a significant amount of knowledge in relation to Lifeline and the working of the service. This knowledge emerges during the counselling session and enables Diana to drive much of the interaction. For some callers their relationship with Lifeline outlives the period of time that many telephone counsellors maintain their volunteer commitments with the service. Recurrent interactions and the accumulation of knowledge and experience may well place Diana, and other callers like her, in the position of expert in understanding and managing the system.

The depth and breadth of Diana's problems appear to be significant and soon after the start of her interview with me she disclosed her history of childhood sexual abuse. Interestingly, she made no direct reference to traumatic childhood experiences, which likely play an important role for her, during the telephone counselling interaction. Nevertheless, the telephone counsellor does appear to allude to them on a couple of occasions, for instance when she says 'because of your past experience', suggesting an unspoken understanding of Diana's underlying issue, or at least where her current struggles might stem from. Diana was not required to share any of her personal struggles with me during our interview together and I'm uncertain why she chose to disclose this very personal information. Perhaps her sense that the telephone counsellor understood and was empathic somehow made the telling of it redundant. Alternatively, it may be that her understanding of the rules of engagement and the associated requirement for presenting with a specific topic played a part in this. If this is the case then this may be unhelpful for both the service and for Diana.

Diana's case clearly illustrates the 'problem caller' to Lifeline in a number of ways. She is a recurrent caller who has been calling in regularly over a number of years. Diana reports having few expectations of the telephone counsellor and her goals for the interaction seem unclear, abstract, and unattainable. In addition, although she is highly functioning, her problem is complex and chronic, she appears to have ongoing long-term mental health concerns and she becomes emotionally distressed a number of times during the interaction. Nevertheless, she also displays much greater psychological insight into the nature of and reasons for her distress than the telephone counsellor. She also appears to be more articulate about her difficulties and actively drives the interaction. This is perhaps an indication of the knowledge she has accumulated about her problems, Lifeline's rules of engagement and the usual course of telephone counselling interactions.

Expectations of Lifeline

In the case study above the caller's needs appear to be far more complex and dynamic, are clearly less problem focused, more difficult to define and present no simple solutions. While Diana presents with a relationship focused problem associated with boundary issues, her underlying needs seem to be more clearly defined by her need to 'connect' with 'understand' and better 'manage' her feeling. She has had numerous interactions with telephone counsellors at Lifeline and has learnt that mostly, for one reason or another, they do not enable this process. She has also had experiences that have been unhelpful and believes that they have a profile on her and perceive her as abusing the system because of her repeated use of the service. Her recurrent use of the service has also meant that she has developed some understanding of how it works, recognising its parameters and its rules of engagement. As a result, she approaches each interaction with little hope or expectation.

What expectations Diana's has probably influence the way she approaches the interaction, her engagement with the telephone counsellor, as well as her perceptions of the telephone counsellor, the interaction and its outcomes. Her history, too, would most probably play some part in this and her expectations,

overall, might be quite mixed. In this way, Diana's expectations might offer little positive influence as far as constructive engagement, therapeutic process and outcome are concerned.

The telephone counsellor's expectations revolved largely around her role as a counsellor. Within which she tries to manage, 'contain' and 'stabilise', callers' feelings. In this regard, the telephone counsellor's and caller's desires are at odds with each other, one wanting to explore feelings and the other wanting to contain them. It is also uncertain how much the telephone counsellor's expectations are influenced by other factors, for instance the expectation that Saturdays are more often defined by calls from recurrent callers with chronic presentations, and the anxiety or challenges she experiences in dealing with them.

Therapeutic goals and tasks

Mismatched expectations clearly hindered the development of an agreement on treatment goals and tasks and the interaction suffers some tensions. Both the caller and telephone counsellor strive to achieve their individual, disparate, objectives. Other than to offer empathy, the telephone counsellor does not actively explore any of the caller's feelings and on those occasions when the caller becomes distressed the telephone counsellor attempts to contain her emotions.

In general, it would seem that there is some danger that Diana's experiences of rejection in her daily life and her history of being punished for expressing feelings might get re-enacted and reinforced in her telephone counselling interactions. By breaking the rules and calling 'too often' she risks rejection and by attempting to utilise the service as an emotional barometer she risks being 'shut down'. Aspects of both of these can be seen in the telephone counselling interaction between Diana and Natalie.

Diana has developed some insight into her problems as well as a certain level of self-awareness. She shares some of these, and may even be seen as feeding

them into the conversation with the telephone counsellor during their interaction. The exchange seems somewhat stilted though, perhaps as a side effect of the rules within which each are operating. For instance, each is aware that anonymity within the service has been eroded for Diana, yet this was not openly acknowledged.

The occasions when this rule was disregarded and telephone counsellors acknowledged past interactions while providing positive feedback stood out as encouraging and hopeful experiences for Diana. Those occasions, however, when telephone counsellors acknowledged past interactions and challenged her use of the service tended to be viewed as unhelpful or even negative experiences. Perhaps because Diana perceived the telephone counsellors' response in this latter circumstance as punitive or possibly because the individual relationships with telephone counsellors was not sufficiently robust to withstand this type of intervention. Interestingly, despite her anxiety about relationships, Diana seemed to respond most to the telephone counsellors 'humanness'. The telephone counsellor's skills, technique or capacity to solve her problems were not as important or as helpful as those telephone counselling interactions that she characterised as 'nurturing'. This is perhaps what Diana is constantly looking for in each of her calls. If this is not provided she calls again. She may also perceive the telephone counsellor's inability to provide her with what she wants as rejection, hence, reinforcing the cycle and her views regarding her inability to trust relationships.

There are a few significant aspects of Diana's difficulties that come to light during the telephone counselling interaction. Her life in general reflects social difficulties and a reduced capacity to establish and maintain relationships; she also struggles with self identity and lacks social supports. These struggles are reflected, and seem likely to be exacerbated, by her current situation, which revolves around the anticipated ending of her primary relationship as well as the planned termination of her therapeutic relationship. Diana mentions to the telephone counsellor that she is receiving counselling and the telephone counsellor, in her records, reports this, although she states that Diana does not clearly articulate what this is for. Interestingly, the telephone counsellor does not ask her either, neither does she explore the impending termination of this

relationship with Diana or address the significance of this and what it might mean for her.

The therapeutic relationship

The therapeutic relationship is influenced by a number of factors. The major ones highlighted by this case include the telephone counsellor's perception and assessment of the caller's characteristics, needs and utilisation of Lifeline, the caller's perception of the telephone counsellor and the conditions under which the service operates. These things together generate a complex recursive interaction.

Caller characteristics, such as Diana's, tend to create a perception of the caller as a problem. Her presentation is complex as are her difficulties and she utilises the service in a way that is seen as being contrary to service provision and objectives. This means that telephone counsellors might connect with her and assess her difficulties in different ways. For instance they might struggle to empathise or feel out of their depth, or as Natalie reported 'lost'. Particular disjuncture's, inherent in the opposing perceptions of and assessments of Diana's needs, were evident. For instance, Diana experiences her current difficulties, the loss of her two primary relationships, as a crisis, while the telephone counsellor's assessment was that 'it wasn't a real crisis situation'. Also apparent were the opposing aims of the interaction, Diana's to experience feelings and the telephone counsellors to contain them.

Diana's needs are so great and her difficulties with boundaries so pervasive that managing these is difficult both for her and the service. These factors and the history that Diana brings as well as her past experiences with calling Lifeline means that she carries her own level of tensions prior to engaging with each individual interaction. Add to this the conditions of the service, such as discontinuity, anonymity and unlimited, unrestrained access to the service and undetermined call duration, and the tensions that this combination creates begins to emerge. The resulting tensions that configure the therapeutic relationship influence the type and nature of the relationship that develops with

each individual telephone counsellor as well as with the organisation. It would seem that for Diana many of the aspects identified in the literature as being central to the therapeutic alliance are under stress.

The combination of these factors results in a variety of tensions during the counselling interaction. Particularly noticeable, as illustrated in Diana's telephone counselling session, is a degree of conflict associated with the management of the depth and breadth of the interaction. Where Diana is clearly attempting to undertake intrapersonal exploration, the telephone counsellor is responding by lowering the level of facilitative conditions. While Diana lowers her level of functioning in response she also makes several attempts to re-engage with the explorative process. Interestingly, the literature points to the client's level of functioning as a significant predictor of the level of self-exploration (Holder, 1967; Traux, 1965). In this instance it would suggest that Diana's level of functioning was independent of the conditions offered by the telephone counsellor, nevertheless, both Diana and the telephone counsellor were attempting to drive the interaction.

Having unlimited access to a number of different telephone counsellors hinders the capacity of the service to effectively manage Diana, her needs as well as the telephone counsellors and service needs. Discontinuity is useful in some ways for both Diana and the organisation. It allows Diana to hear many different perspectives as well as ensuring that no one counsellor holds all of the responsibility for any one particular caller. Nevertheless, it limits the development of a therapeutic relationship ensuring that Diana is not challenged on this front. This robs her of the opportunity and challenge of establishing, building and maintaining a positive (therapeutic) relationship, within which her needs, as well as any difficulties, such as her boundary and self-identity struggles, can be openly acknowledged and addressed. A further disadvantage is the likelihood of creating dependence.

For Diana her anonymity within the service has become eroded. This in itself is not necessarily a problem, however, the individual telephone counsellors' and the service response to this plays a significant part. Diana makes reference to this and how the different responses, that is acknowledgement or avoidance, of

telephone counsellors impacts on the interaction and outcome. The impact of anonymity is not limited to the counselling interaction. Telephone counsellors, too, are sometimes hindered by the inability to be open and genuine with the caller. Limited discussions with callers about their needs, (mis)use of the service, struggles or progress leave them blind. It also impacts the telephone counsellor's ability to evaluate their individual skills and development as well as depriving them of any positive feedback or sense of achievement. Overall, it hinders the effective management of Diana and her needs.

Interestingly the lack of ongoing contact with individual telephone counsellors seems to change the focus of the therapeutic relationship. Diana refers on a few occasions to a collective 'they' or 'you' when talking about Lifeline. Even when she is talking to an individual telephone counsellor she ascribes them to the collective, so that her relationship appears to be with the organisation rather than with the individual telephone counsellor.

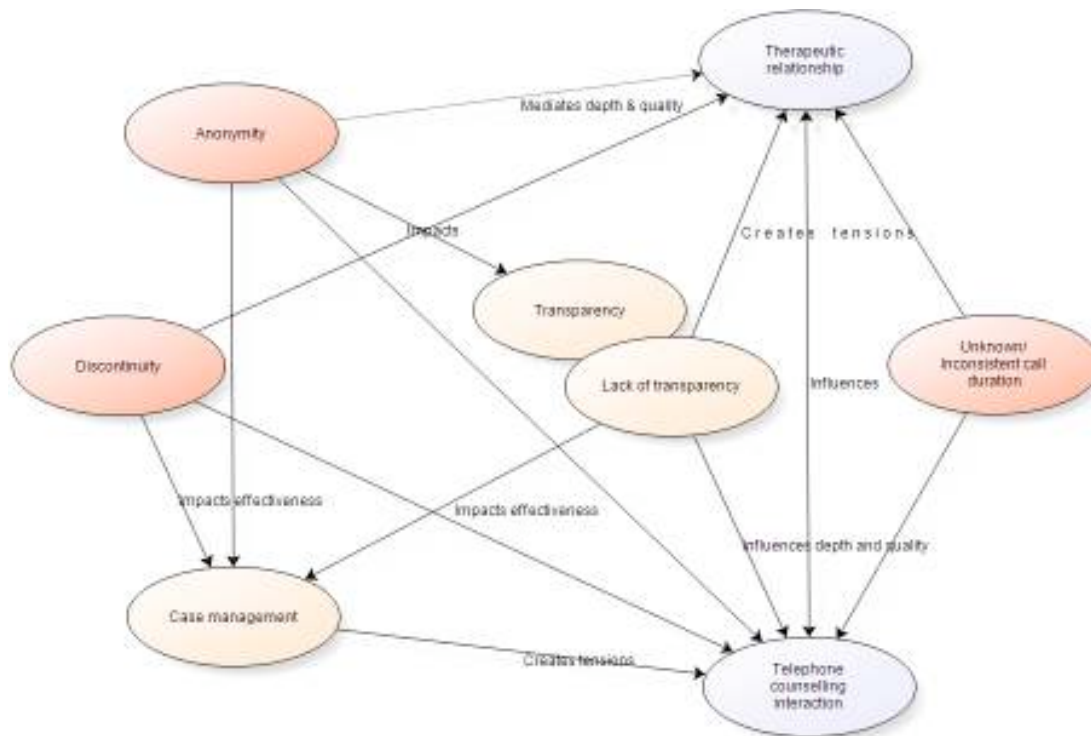
'Problem' caller dynamics

The following diagram depicts the service conditions and illustrates the dynamics that these produce in relation to the 'problem' caller interaction. Unlike the 'perfect' caller, 'problem' caller dynamics can be seen as reflecting many more tensions. Like the 'perfect' caller, anonymity and discontinuity mediate the depth and quality of the therapeutic relationship for the 'problem' caller, however, unlike the 'perfect' caller, these conditions impact more directly on the effectiveness of the counselling interaction. The caller has told their story many times, possibly to the same telephone counsellor, and their anonymity within the service has been compromised. Tensions arise on both fronts, in the maintenance of the façade of anonymity, in the telephone counsellor's perception of the caller's problem as 'chronic' or of the caller as a 'problem' caller, in the callers struggle to meet their needs and in the requirement to repeat their story. In consequence, the effectiveness of the counselling interaction is reduced and the counselling relationship experiences a number of challenges.

Unknown and inconsistent call duration also influences the telephone counselling interaction and creates tension in the counselling relationship. Recurrent callers have some knowledge and experience about temporal shifts and markers and attempt to more actively influence the counselling process. Telephone counsellors equally attempt to drive the interaction, however, their goals may be in conflict with the callers', thereby additional strain on the interaction and in the development of the relationship.

Furthermore, the interaction of the 'problem' caller tag and service conditions engenders the development of other factors that manufacture additional tensions, such as the organisation's 'case management' response and the effects of maintaining the façade of anonymity, which impacts transparency. Lack of transparency creates tensions in the relationship, influences the depth and quality of the interaction and, like anonymity and discontinuity, impacts on effective case management. Other tensions reflect the incongruity between the model, that favours technical intervention over relationship, and recurrent callers' needs, that favour relationship over technique.

Figure 9.4. Diagrammatic representation of dynamic tensions associated with 'problem' callers



Commentary

In some ways the characteristics of the 'perfect' and 'problem' caller are not all that different. Both are mature women and highly functioning, however, they appear to differ significantly where problem type is concerned and also in their utilisation of the service. In presenting for the first time with a specific problem that is definable, Jackie represents the ideal caller who does little to challenge the telephone counsellor or the parameters of the service. There is little tension associated with her interaction or with her relationship with the telephone counsellor and service. As a result the perception of both telephone counsellor and caller are positive and the outcome is felt to be satisfactory.

As a recurrent caller struggling with more abstract and complex issues that are not so easily defined and do not appear to lend themselves to discrete interventions, Diana represents the problem caller. Her struggles challenge both

the telephone counsellor and the service and there are distinct tensions associated with the counselling interaction and with her relationship with the telephone counsellor and service. Consequently, outcomes are less definable and both the telephone counsellor and callers are more likely to experience a sense of dissatisfaction.

The case studies highlight the challenges involved in the provision of a telephone counselling service designed to cater for diversity in caller needs and presentations. Crucial to service provision is the importance of understanding caller typology and needs as well as the effects of service conditions. In addition, it seems that common understandings of the parameters of the service are important.

These case studies illustrate the different domains of counselling approaches. While one can be seen as a specific problem requiring a more educational approach, the other can be seen as sitting within a more relational context that requires a more humanistic approach. Each relies on quite different aspects of the counselling interaction and requires quite different interventions.

Perhaps these, too, can be seen as sitting at either end of a continuum in relation to a variety of different aspects such as treatment period. These differences reflect aspects of Lifeline Melbourne's model, which draws on both Crisis Intervention and Person-centered approaches. The case studies illustrate tensions in the integration of the two approaches and their practices. They also highlight the difficulties in the provision of this model within the limited contextual conditions associated with the telephone and the principles underpinning Lifeline's service.

Chapter 10 Discussion

A review of the literature revealed that the bulk of the psychosocial knowledge about telephone counselling was obtained through descriptive or evaluative studies that focused on specific sub-populations or particular types of problems. The current study was designed to gain insight into telephone counselling through the use of interpretive methods that have not commonly been adopted in previous research. The aim of this study was to explore the dynamics of telephone counselling in the context of the provision of services offered by Lifeline Melbourne.

The study utilised a qualitative research design based on a constructivist epistemology, which drew on the principles and techniques of the methodological processes of Grounded Theory. Data were collected in a number of forms including interviews with telephone counsellors and callers, observation of calls, analysis of Lifeline documentation including the organisation's history and objectives and training offered to telephone counsellors, and analysis of existing de-identified caller records. This range of data sources and methods generated a rich data set that facilitated a holistic view of the telephone counselling endeavour within the context of a generalist telephone counselling service.

Tensions emerging from the findings, however, indicate that some measure of goodness of fit applies. Some callers are preferred over others and although this is not explicitly stated in any Lifeline's policy or practice documents, it can be inferred from the different treatments callers receive.

The key research questions orienting this study were:

- How are traditional counselling theories applied in the telephone counselling context?
- How do telephone counsellors and callers experience telephone counselling?
- What are the factors that influence telephone counselling service provision and how do these affect caller satisfaction and outcomes?

Lifeline's role

Lifeline provides a free generalist telephone counselling service to individuals living within Australia. Individuals can self refer and are able to access the service 24 hours a day. The organisation has a strong presence in the community. However, ambiguity exists concerning Lifeline's role within the community and whether it is a crisis management service, a counselling service or an adjunct to other services. Lifeline's telephone number is provided to the public by the media, often following major events or catastrophes, such as the 2003 tsunami and most recently during the bush fires in Victoria, when reporting incidents of murder suicide, or after reports of vehicle accidents. The media also promotes Lifeline as an available option for people experiencing problems they cannot resolve alone, and for those suffering depression. In addition, mental health professionals often refer their clients to Lifeline for out of hour's assistance, and university ethics committee's frequently cite Lifeline as a resource available to participants so as to minimise psychological outcomes associated with participation in research. The Australian longitudinal study of women's health also directs participants with any mental health concerns to Lifeline.

The accessibility and convenience of Lifeline enables people in the community to engage with a counselling service. Lifeline can be accessed from a variety of different locations bridging barriers, such as geography, and providing

convenient and easy access to support that would otherwise not be available for many people, for instance the aged and disabled.

Lifeline's original mission, as determined by the late Reverend Dr Sir Alan Walker, was to provide a 'listening ear' and a place where the lonely and troubled 'could be heard'. Over time, individual Lifeline centres have developed their own objectives that often reflect a more strategic mission, such as to 'alleviate distress and optimise coping through its telephone counselling service' (Lifeline, 2004b). Revisions of key statements also reflect the changing culture of the organisation, perhaps echoing a shifting perspective of their model and their role, for example, 'contributing to the mental health and well being of Australians' (Lifeline Australia, 2008). Changing mission statements, role perceptions and counselling models represents a considerable move away from how Reverend Walker originally conceptualised the service. Long-term recurrent callers' recollections mapped this shift; in particular they spoke of a move away from a spontaneous conversational dialogue to a more structured interaction.

Synthesis of Key findings

Connecting with Lifeline

On a more abstract level, callers' awareness of Lifeline represented a connection with the organisation rather than with an individual telephone counsellor. For some callers, particularly those recurrent callers whose relationship with Lifeline spanned a number of decades, this connection with the organisation was most evident. These callers were not seeking solutions to their problem. Their need resided more in the realms of human contact. For them, the interaction was less about intervention and more about connection.

'Connecting' was a central theme that emerged from the interviews with callers and telephone counsellors and was reflected at a number of different levels. Individuals could make the connection through the act of physically making a call to Lifeline or through seeking a more meaningful interpersonal connection with a

telephone counsellor. However, the study identified a number of factors that influenced the quality of the 'connection' achieved during the telephone counselling interaction. These emerged as tensions in both making and maintaining meaningful connections.

Knowing that 'someone' was there or going through the actions of calling, or trying to get through, seemed to play an important part not only in holding the caller but also in being part of the helping process for callers. In some way, Lifeline's 'presence' acted as a holding device for many people, just knowing that Lifeline was there and that they could call if they needed to, functioned as some kind of containment. The organisation might be seen as playing the role of a 'transitional object', providing a sense of comfort and 'holding' in difficult times, that acts as a defence against anxiety (Winnicott, 1953). When considered from this perspective, the act of dialling the number and/or interacting with individual telephone counsellors can be viewed as falling under the broader, more inclusive, term of 'transitional phenomena'. Carrying the service's phone number, either physically or in memory, allowed people to better tolerate difficult periods because they knew help was literally a telephone call away when and if they needed it. Going through the actions of making a call with no intention of engaging, and making a call and talking to a telephone counsellor, potentially become necessary patterns of behaviour at times of loneliness or when anxiety or depression threaten.

Some callers had a long-term history of calling on Lifeline and, depending on their needs, utilised the service in different ways. For some, calling Lifeline had become entrenched as a coping mechanism and they had called in regularly over a number of years. These callers tended to be either struggling with significant mental health problems, such as Harry (with a 32 year history of calling) who reported a diagnosis of schizophrenia and bipolar disorder, or were extremely isolated, as was the case with Judith (with a 33 year history of calling). Often callers identified that they were drawing on other professional supports, such as psychiatrists, psychologists and counsellors. In this case Lifeline fulfilled a different need, for instance the ability to address their struggles and feelings in the moment as opposed to waiting for their next face-to-face counselling appointment.

Other callers utilised the service intermittently during times of difficulty or periods of isolation. They might have episodes during which they call in regularly interspersed with, perhaps quite long, periods of time when they do not feel the need to call. Callers, particularly recurrent callers, maintained the hope of connecting with a telephone counsellor who understood them and their problem and was able to help them, even if this was only in the short term. Callers expected that they would experience some benefit from calling. However, even when this expectation was not met, many recurrent callers remained hopeful that at some point in the future Lifeline would provide a telephone counsellor who could offer them a meaningful connection and valuable assistance. Many long term recurrent callers recalled a time when achieving a meaningful connections with telephone counsellors was more often the rule than the exception and lamented the loss of this.

Tensions in Lifeline Melbourne's model

Lifeline Melbourne bases its model on face-to-face therapy theories, in particular both the Person-centered and Crisis Intervention approaches. However, there are many challenges associated with adopting and adapting therapeutic approaches and practices that are designed for application in particular contexts or conditions and applying them in different circumstances. Further, integrating approaches that have quite different therapeutic practices that target different concerns probably creates some confusion regarding therapeutic objectives and when implementing and applying different aspects of these divergent approaches.

Lifeline attempts to fashion its approach and interventions to be responsive to callers' diverse concerns. However, the conditions of anonymity, discontinuity and undetermined duration of session, frequency and treatment period surrounding the interaction mitigate against this. The effects of these conditions create tensions in the counselling interaction and relationship, influencing the quality, depth and breadth of the counselling interaction, the exploration and addressing of problems, as well as caller and counsellor perceptions of the

counselling experience and its outcomes. These tensions and their effects are most evident in the case of the long term recurrent caller to Lifeline.

Part of the tension that exists for Lifeline is that they have grown out of a philosophical base that valued and utilised a Person-centered approach, usually characterised by longer term therapy that focuses on the therapeutic relationship as the active ingredient and applied it in a one off, discrete, anonymous, telephone counselling context. Where Lifeline Melbourne is concerned, the integration of the Person-centered and crisis intervention approach, characterised as a short term, technique oriented intervention focused on addressing a specific issue, creates an additional tension. Further tensions that emerged were the mismatch between this model and the needs of the majority of Lifeline's callers and the influence of organisational culture on telephone counselling interactions with and management of recurrent callers.

Tensions in Lifeline Melbourne's Philosophical base

Lifeline Melbourne's model can be seen as integrating aspects of person-centered and crisis intervention approaches, as well as reportedly incorporating techniques from solution focused and cognitive behaviour therapies. These approaches, or their techniques, were adopted in response to their perceived fit with answering the needs of callers. There was an assumption that such approaches would easily adapt to the telephone counselling environment as well as to the particular conditions, such as anonymity, that comprised the telephone counselling practice model. This approach to the adoption of interventions, not because they are informed by theory, but because it is thought they may work, is not unusual (Chen, 2005; A R. Hornblow, 1986).

Integrating a Person-centered approach and a crisis intervention approach presents a number of challenges. The major difficulties are that they hold quite different theoretical assumptions, treatment approaches and practices and can arguably be seen as targeting different needs. These differences have the potential to create major conflicts for the therapist or counsellor, which can be further exacerbated by the conditions under which they are occurring.

There are a number of implications associated with integrating these different models for Lifeline and their telephone counselling practice. From a broader perspective, adopting therapeutic approaches specifically designed for use in face-to-face counselling practice fails to consider the unique qualities inherent in telephone counselling. On first consideration, a clear difference between face-to-face counselling and telephone counselling is that telephone counselling eliminates non-auditory cues. Nagy (1987) particularly highlighted the way in which the telephone "impoverishes the normally rich array of nonverbal exchanges" (p. 3).

Furthermore, in addition to the lack of physical presence and resulting reduction in non-verbal communication associated with telephone interactions, the conditions associated with Lifeline's telephone counselling model are significantly different from those normally associated with face-to-face counselling. Of particular note are the conditions of anonymity, the lack of an ongoing relationship with a particular therapist, the lack of any formula relating to the duration of counselling sessions and frequency of counselling interactions and the lack of shared expectations that have been discussed and agreed upon.

When considering these conditions and the theory underlying the Person-centered approach, tensions become apparent. The approach has an emphasis on the quality of the client-therapist relationship and sees the relationship as the curative factor in psychotherapy. Extensive research supports the value of the relationship dimension with positive outcomes attributed to the quality of the relationship. This finding is evident across a wide variety of clients, therapists, theoretical orientations and contexts (Kirschenbaum & Jourdan, 2005). The expectation is that the therapist and client will develop a relationship and work together over a period of time. The conditions associated with Lifeline's telephone counselling model restrict the development of a therapeutic relationship, thereby influencing and inhibiting its power as a therapeutic tool and the beneficial effects believed to be associated with a positive therapeutic relationship experience.

An anonymous, one off intervention of undetermined duration more easily fits within a crisis intervention model, however, adopting this approach assumes that callers, and their needs, not only fit within the parameters of the crisis intervention model but also that callers are responding to their crisis experience in a timely fashion. Callers tended to utilise Lifeline when they felt they were in the moment of the crisis. Definitions of crisis, however, appeared to be somewhat different for the actors involved. The organisational culture seems to hold more closely to a clinical definition that points towards a specific event or problem that overwhelms a person's capacity to cope for a discrete period of time. That is, it sees callers as ordinarily adequately functioning individuals reacting to, and seeking help for, a recent experience of a specific stressful event. If these assumptions are invalid then it's likely that the effectiveness of the intervention will, at least, be reduced.

The vast majority of Lifeline's callers do not easily fit within these categories, the caller having mental health concerns reflecting more complex, deep seated and long term psychological problems or their concern not fitting within the easily defined and discrete definition of crisis. Current crisis theory is limited in its understanding of illness symptoms. Indications are that individuals are prone to episodes of crises that are not necessarily brought on by an external precipitant and that their methods of resolving and preventing crises diverge from traditional crisis theory (Ball, et al., 2005).

The combination of tensions between counselling models, counselling models and service context and conditions, and service conditions and caller utilisation, presentation and needs, point to major discrepancies that influence the telephone counselling interaction and relationship, potentially reducing its effectiveness.

Factors influencing the telephone counselling interaction and relationship

The findings illustrated that anonymity, discontinuity, session duration and session frequency are characteristics of Lifeline Melbourne's telephone counselling service that set the parameters of the counselling intervention and

serve to influence the counselling interaction and relationship. They do not, however, preclude the callers' desire or need for a meaningful connection. In some way these factors may well accelerate the relationship process, whether this is defined by positive or negative elements. Callers need to make quick judgements with regard to trust and 'fit' and are required to disclose personal information and feelings with more urgency than would normally be the case in ongoing face-to-face counselling.

The quality of the counselling relationship emerged as a key component of the telephone counselling interaction. Many of the same critical ingredients of face-to-face counselling were also evident in the telephone counselling interaction. For instance, talking and telling their stories was central and callers wanted their stories to be heard. Similarly, conditions that assist in the work of face-to-face counselling, such as empathy, unconditional positive regard and genuineness, were also essential in the telephone counselling interaction. Some telephone counsellor tasks also mirrored face-to-face practice, such as negotiating the agenda, questioning, exploring the caller's story and validating feelings. The conditions of the service, however, appear to either condense or curtail these counselling processes.

The conditions under which the counselling interactions were occurring influenced the connections that were made, how they were made, how they developed, how they were managed and how they were experienced. McLeod and Machin (1998) highlight the importance of context, whether this be the cultural beliefs of the actors involved, the layout of the counselling room, the emotional climate of the agency or the organisational, social and cultural context within which the counselling interaction is embedded. The authors suggest that the actions and meanings of what happens during the counselling endeavour are shaped and informed by a range of contextual factors. While the counselling room represents the more tangible of these, more abstract factors, such as the organisational culture and climate of the agency, also shape practice. In the case of Lifeline, there is no such thing as a counselling room and anonymity, inconsistent counselling session duration and lack of continuity seemed to be the core conditions that interacted to create a unique counselling environment and organisational culture. The interaction of these conditions created loci of

dissatisfaction that often had a deleterious effect on both the counselling relationship and interaction.

For convenience of exposition the conditions of practice are discussed separately, although, in operation, they function simultaneously and interact with each other.

Discontinuity

The data highlighted that engaging with a different telephone counsellor on each occasion results in a lack of continuity in the counselling relationship and a lack of continuity in addressing the caller's problems. This manifests in a number of ways, firstly, by reducing the quality and depth of the therapeutic relationship, including each actor's investment in the therapeutic relationship, secondly, by impeding the therapeutic endeavour requiring the caller to repeatedly tell their story on every occasion they call, and thirdly, by acting to protect the telephone counsellors from 'engagement'. All of these exhibit helpful and unhelpful aspects.

One benefit of discontinuity is that it shifts the focus away from the relationship with the individual telephone counsellor alleviating the pressure on any one counsellor to provide and maintain a safe and effective therapeutic environment or relationship. This allows the responsibility towards callers to be shared by all telephone counsellors. Possibly, the anonymity rule was also partly devised to protect telephone counsellors from a sense of sole responsibility in the event that a caller did commit suicide.

The therapeutic relationship is believed to be an essential component of the counselling endeavour (Goldfried & Davila, 2005) and indications are that, where crisis intervention by telephone is concerned this is also the case (Kalafat, et al., 2007; B. L. Mishara, et al., 2007b; B. L. Mishara & Daigle, 1997; Reese, et al., 2002). However, the study findings indicated that, where discontinuity is a condition of the service, processes that usually occur throughout a therapeutic relationship either do not develop or are required to be compressed into a one off, time limited interaction. For instance, where trust is concerned, callers either

address their struggles at a level that balances with the level of trust, or lack thereof, that is immediately present or they have to push through any fears they have in relation to trust if they are going to address their problem on a meaningful level. This also opens them up to the possibility of unhelpful experiences that in turn reinforce the struggles they may already experience with relationships.

From the Person-centered perspective, the therapeutic relationship is fundamental to effective treatment and, indeed, virtually all schools of thought now accept this notion. Research also points to the importance of the therapeutic relationship for treatment outcomes. Consigning the relationship to a secondary position may not be beneficial. Evidence from the interviews with telephone counsellors and callers suggests that discontinuity tends to discourage telephone counsellors from challenging callers and also reduces the possibility of the caller responding positively to being challenged by the telephone counsellor. Discontinuity also eliminates the challenge of establishing and maintaining a relationship with a therapist. This means that callers need never be outside of their comfort zone and can avoid being challenged or challenging themselves at problem, relationship or personality level, thereby, reducing opportunities for change.

Discontinuity also acts to constrain the quality and depth of the counselling interaction. The client's telling of their story is an important component of counselling (Kalafat, et al., 2007; A. L. Mishara, 1995; Rennie, 1994) and hearing themselves talk their story can help callers reassess or amend their perceptions. However, for callers, the need to repeatedly tell their story provided little opportunity to delve much below the surface of their problem narrative, effectively creating a 'revolving door' with the caller repeatedly calling in an effort to achieve some movement during each discrete and time limited interaction. The result of this is that the quality and depth of the therapeutic endeavour may be significantly influenced.

The anonymity continuum

In usual face-to-face counselling practice the condition of anonymity is not a feature of the counselling relationship. Clients are able to actively choose who they engage with and both therapist and client are recognisable. Confidentiality, however, is an important ingredient and in order to further substantiate the open and honest nature of the therapeutic relationship, understandings about confidentiality, and its conditions or limitations, are often explored with the client.

Anonymity is generally considered to be an all or nothing category but in the Lifeline telephone counselling context, it appears to run along a continuum whereby only the caller who calls Lifeline for the first time is closest to being truly anonymous. Callers who make a second and third call or those who call in frequently or over a long period of time continually reduce their level of anonymity within the service as their stories become recognisable and they begin to re-connect with the same telephone counsellors.

In an effort to shape the interaction in a way that best suits their needs or achieves their goals, both callers and telephone counsellors attempt to manage the conditions surrounding the counselling interaction by engaging in particular behaviours. It seems that telephone counsellors hold strong views about the importance of anonymity beyond the context of Lifeline's rules, processes and practices. Even in the event that callers have a sense that they are now recognised and, equally, while telephone counsellors might recognise the caller and their story, both seem reluctant to acknowledge any prior interactions. In this event despite many callers' loss of anonymity within the service and their knowledge of this, the façade of anonymity is maintained.

Maintaining the fiction of anonymity does not assist the caller or the telephone counsellor in effectively managing their needs. While there is clear evidence that the telephone counsellor knows who the caller is and recognises the story, they do not acknowledge this. One reason for this was a perception that it would create a stronger connection and more dependency in the caller. Recurrent

callers, too, are aware when the telephone counsellor recognises them, the perception often being a sense of the counsellor shutting down or shortening the conversation, not encouraging them to share their story. Callers attempt to circumvent this by presenting with a different story.

Maintaining the rule of anonymity, particularly when callers become known to the service, influences the quality of the counselling relationship and potentially prevents the agency from keeping track of an individual's progress and shifting needs in their use of the service. This is a missed opportunity given the high proportion of recurrent callers who utilise Lifeline.

Genuine dialogue

Both caller and telephone counsellor generally defer to the anonymity 'rule' and will collude in maintaining this façade. This means that no reference can be made to any previous discussion, or to any knowledge or understanding that the telephone counsellor might hold about the caller or the presenting problem. This, in turn, precludes the customary terms of openness, honesty and transparency. These conditions are associated with the counsellor's genuineness that is seen as an integral component of any counselling interaction, particularly in the case of the Person-centered approach.

While denying knowledge of the caller and the power of their story might be perceived as managing the caller in some way, this experience also challenges the telephone counsellor's own capacity to be 'real' with the caller. Being able to be 'real' or provide open communication is another essential component of the counselling interaction and relationship. This is sometimes referred to as congruence, or genuineness, which implies that the therapist does not hide behind a false front (C. R. Rogers, 1957). In addition, if telephone counsellors' belief, that callers have a tendency towards 'over connecting', is correct, then addressing this may be an important aspect of the counselling intervention for those callers. Not exploring this issue likely reduces opportunities for the caller to gain insight and to actively address this particular problem.

Anonymity may also act to disempower the counselling interaction in that neither the caller nor the telephone counsellor need be meaningfully invested in the individual relationship. This means that both can more easily disengage from the interaction, for instance if it does not meet the caller's needs, is perceived as being negative, or becomes too challenging, they can more easily terminate the interaction or disregard it. This might be helpful in those instances when the caller experiences the counsellor as unhelpful or the interaction as harmful, however, on other occasions when the core matter of the counselling work is emerging, this ability to disengage from the interaction and its content may not be helpful.

The circumstances that the façade of anonymity engineers may well impede both callers and telephone counsellors and do little to help them along in their journey towards a desired outcome. Both the telephone counsellor and the caller engage in a dance that encapsulates avoidance, influencing the nature of the interaction and the issues discussed, which in turn influences the experience of the interaction and outcome for both parties. Both struggle to manage the interaction and oftentimes both are left feeling dissatisfied with the outcome. This creates a tension between the telephone counsellor and caller that acts as an impediment to effective case management, which, although often a necessity, does not end to be openly discussed with the caller.

Call duration and frequency

Clearly defining the therapeutic space and the boundaries around the counselling session helps to reinforce the interaction as that of a therapeutic, time limited endeavour bounded by common understandings about expectations, goals and conditions. The relationship that develops between the therapist and the client is largely contained within this space.

In face-to-face counselling practice, session duration is usually predetermined and is a factor clearly understood by both therapist and client. In many ways this may well be an important aspect of therapy. In the first instance, it clearly defines the space and boundary around the therapeutic interaction and

relationship. It also allows the therapist and the client to drive the temporal shifts in the breadth and depth of exploration as well as helping them to manage the shifts in the level of emotional intensity throughout the interaction.

In the Lifeline context, there is no set duration and counselling call duration can fall anywhere in the region of a couple of minutes to several hours. While some of the calls clearly fall within the crisis intervention category and are more suited to this approach, such as suicide calls, the majority of the calls are characterised by more general life struggles that fit more comfortably with other counselling approaches. The unique features of telephone counselling in the Lifeline context, however, create quite different parameters. Telephone counsellor and caller do not engage in a discussion about, or agree on, the duration and frequency of counselling sessions and there is no set interval between counselling sessions, as might be the case in face-to-face counselling. The ability to engage with the counselling process as and when they wish to, as frequently as they desire and for undetermined duration, necessarily changes the dynamics of the counselling endeavour and relationship. In particular, the bounds of the interaction and relationship are not so clearly defined. The effects of this can most clearly be seen in callers' utilisation of the service, particularly evident in the case of callers who call daily or more often, and in the management of the counselling interaction.

How telephone counsellors and callers manage the interaction

Organisational culture is a strong influence on practices and processes, even if these are not visible or documented in organisational protocols or procedure manuals (McNiff, 2000; Noonan, 2007). Like all organisations, Lifeline's organisational culture is partially documented, but implicit rules and assumptions underlie practice. A number of these emerged from the data, such as, the number of times a caller can access the service and how often, the amount of time that can be acceptably spent on the telephone with each caller, the parameters of, or types of problems callers should present with, how they should present and the temporal structure of the counselling interaction.

Both telephone counsellors and recurrent callers developed an awareness of the 'rules of engagement' and engaged in certain strategies in an attempt to fit in with these. This resulted in a number of consequences, for instance, at the level of the presenting problem the focus may not be on the issue at the core of the caller's difficulties, and on a relational level tensions arise as both actors attempt to manage the interaction to meet their needs, which may be in conflict with one another. For recurrent callers, anonymity, or lack thereof, together with the rules of engagement, created a degree of conflict between caller and telephone counsellor.

Recurrent or 'problem' callers come to understand the rules and try to manage the system in an attempt to meet their own needs. Some recurrent callers might try to fit in with the rules and manipulate the conditions, for instance they might prepare a topic for discussion and also vary their topic of choice, to avoid being identified, while others may try to appeal to the telephone counsellor by portraying their call as something other than a call for help. Judith's 'thank you' call can be seen as fitting within this latter category. Recurrent callers are also able to recognise telephone counsellor signals, such as particular questions, that intimate the wrapping up process and manipulate the interaction accordingly.

Interestingly, in understanding the rules of the system, callers seem to have the ability to engage in protective behaviours. First, by exercising their power to disengage from the interaction by hanging up, second, by cognitively restructuring their perceptions of the interaction and shifting their focus to the individual telephone counsellor and third, by calling back and talking with another telephone counsellor in the hope of making a more meaningful connection. This ability to manage the system in order to try to fulfil their needs points towards a resilience and an emotional literacy that may be unrecognised. It also speaks to the dual power experienced by both the telephone counsellor and the caller during the interaction. Lauren provided a good example of these strategies in shifting her perspective to the individual telephone counsellor, in viewing the telephone counsellor as the 'unhelpful' one and in hanging up and calling back:

Oh, I just hang up the phone, sometimes you know that there are (unhelpful) people like that and sometimes it's best to just hang up and try again and hopefully get a different person (Lauren).

Telephone counsellors equally try to manage the interaction in order to meet their own and the organisations needs. The consequence of this is evident during the telephone counselling interaction where each struggles to manage the interaction. One, or both, can be left feeling frustrated. For the telephone counsellor the resulting feeling may be one of dissatisfaction at their inability to help the caller and doubt about their effectiveness and the outcome of the call, while the caller may be left feeling frustrated at their inability to fulfil their needs or, worse, struggling with a sense of rejection.

Labelling recurrent callers as problem callers

As was evident in this study, both callers and telephone counsellors experienced consequences of the tensions and each tried to manage the effects in different ways. An example of this could be seen in callers' tendency to repeatedly call in an attempt to fulfil their needs and connect with a telephone counsellor who they deemed to be a better fit. Increased call frequency, however, eventually erodes the caller's anonymity within the service, which in turn leads to them being identified as not being a good fit for the service. Suggestions are that the categorising of callers may interfere with telephone counsellors' ability to accurately conceptualise individual caller problems and needs, therefore, influencing their level of performance (Bobevski & McLennan, 1998; McLennan & Culkin, 1994). The reluctance to acknowledge the loss of anonymity and the developing of caller profiles may also lead to callers being mistakenly linked to another caller profile and treated accordingly.

In some sense what occurs for the recurrent regular caller who is perceived as not being a good fit is something akin to the demand-withdraw cycle, where the service begins to pull back from the caller, frustrating the caller's efforts to achieve their needs and prompting them to call again, thereby reinforcing their position as a 'problem' caller and eliciting a greater withdrawal response from the service. In this way the cycle becomes self perpetuating. One side effect of this is

that, what appears to be a problem or deficiency of the model Lifeline uses gets transferred to being seen as a flaw or problem that resides in the caller. Consequently, the model or system is, literally, above scrutiny and, therefore, is never reviewed or critiqued.

Other factors that may influence the labelling of callers as good or bad possibly lies in telephone counsellors levels of anxiety in dealing with different callers. In her 1960 classic psychoanalytic analysis of hospital social systems that focused on nursing, Isabel Menzies (2002) identified a number of socially constructed defence mechanisms associated with the struggle to manage the effects of anxiety. Menzies (2002) saw the core of the anxiety as lying in the nurse-patient relationship and identified a choreography of defence manoeuvres that were aimed at creating distance between nurse and patient. Of particular note was the splitting of the relationship. This was achieved through restricted contact, inhibiting the development of a full person-to-person relationship, denial of the individual through depersonalisation, emotional detachment and the redistribution of responsibility (Menzies, 2002).

The practice conditions, under which Lifeline's telephone counselling model operates, reflect similar mechanisms that limit the development of the counselling relationship. Menzies (2002) posits that the psychological needs of the members of the organisation leads to the development of socially structured defence mechanisms that are the result of often unconscious, collusive interaction and agreement that influence the culture, structure and mode of functioning. These defence mechanisms tend to become an aspect of external reality, which old and new members accept and come to terms with (Menzies, 2002). By the nature of the counselling endeavour, volunteer telephone counsellors are likely perceived by the organisation as being at considerable risk of being flooded by feelings of anxiety. Conditions of the service may be representative of a social defence system, perhaps developed as a means of protecting telephone counsellors from anxiety. Within this, the splitting and labelling of callers as good and bad can be seen as a defensive manoeuvre, perhaps unconsciously developed over time in concert with telephone counsellors as a means of dealing with threatening emotions.

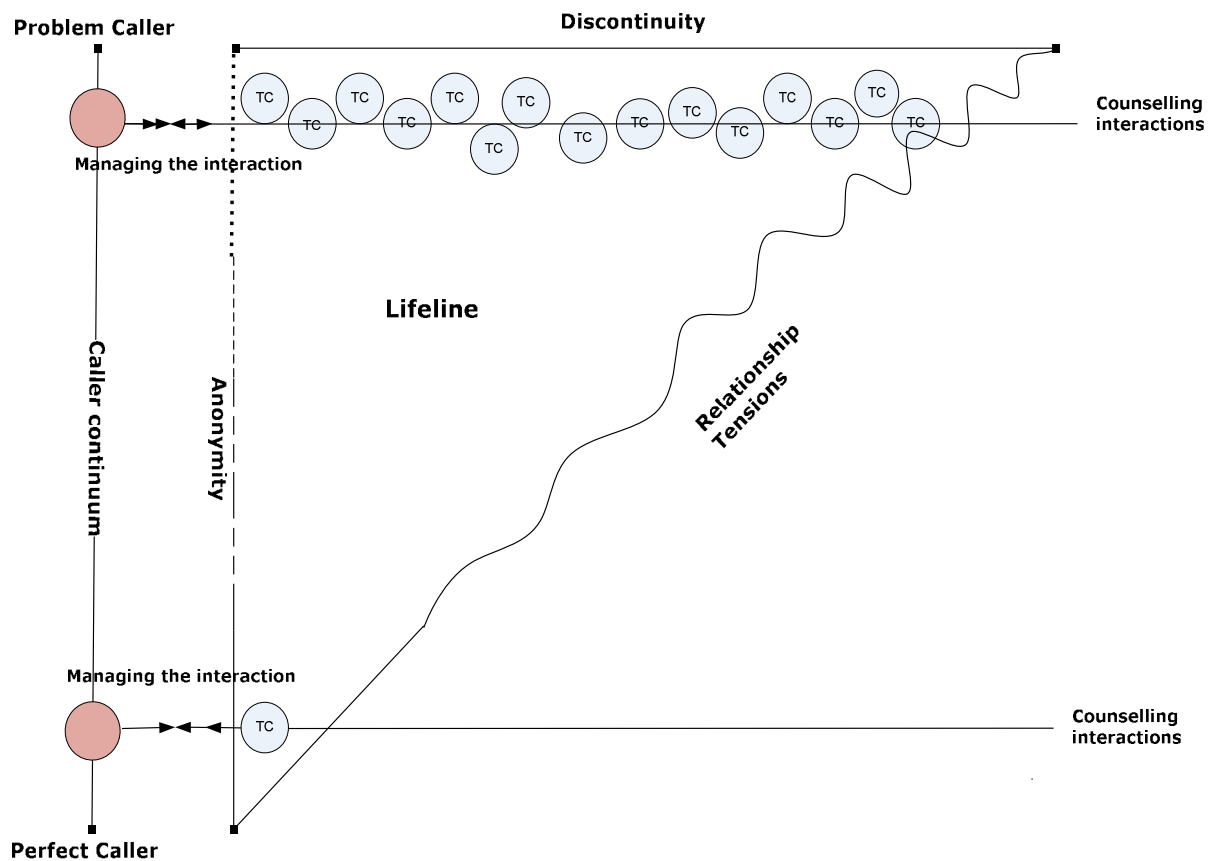
Process dimensions associated with the 'perfect' caller and 'problem' caller

The interdependence of anonymity and discontinuity influences the quality of the counselling interaction and counselling relationship. These conditions also influence caller utilisation of the service, in particular, frequency of calls, as well as reducing the service's ability to effectively address any concerns that may arise in relation to specific callers. Together these attributes may inhibit the capacity of Lifeline to address presenting needs of their callers as well as staff and organisational needs.

The following diagram provides an overview of some of the process dimensions illustrated by the data and portrays the perfect caller and problem caller in relation to their positions on a number of continuums. The model identifies the relationship between anonymity and the associated tensions, with tensions rising as anonymity erodes. With the loss of anonymity, tensions, which are associated with the conflicting needs of the caller and the service, are apparent in both the counselling interaction and service management. The model also depicts the parameters of relationships. In the case of the first time caller, the relationship focus is on the individual telephone counsellor. For the recurrent caller, while they engage in discrete relationships with individual telephone counsellors, a more robust and ongoing relationship develops with the organisation.

The perfect caller, sitting at one end of the vertical caller continuum, and the telephone counsellor establish a connection that is, as yet, largely untainted by past calling experience and knowledge. The caller's anonymity remains intact, the relationship suffers little tension, and the telephone counsellor, for the most part, manages the interaction. The 'perfect' caller relationship can be seen as being largely with the individual telephone counsellor.

Figure 10.1. Diagrammatic representation of process dimensions associated with the 'perfect' caller and 'problem' caller.



The problem caller, sitting at the other end of the vertical caller continuum, and the telephone counsellor establish a connection characterised by both past experience and knowledge. The caller no longer has anonymity within the service and individual interactions reflect the associated tensions. Caller and telephone counsellor struggle to manage the interaction in an effort to achieve their objectives. Recurrent callers' knowledge and experience of service conditions and rules enables them to more actively drive interactions with individual telephone counsellors. Callers' numerous counselling interaction experiences (depicted on the diagram as numerous circles that may or may not fit cleanly along the counselling interaction line) with individual telephone counsellors reflect both helpful and unhelpful connections. Despite occasional indifferent or negative experiences, individual relationships with telephone counsellors are succeeded by a robust relationship with the Organisation. In this way, the recurrent caller relationship can be seen as being with the Organisation. In considering the

Organisation as a 'transitional object' this relationship perhaps symbolises the 'good-enough mother' or the 'good-enough caregiver', in that the Organisation provides a neutral or intermediate area of experience that is not challenged; a comforting representation of the ever available nurturer (Applegate & Bonovitz, 1995; Winnicott, 1953).

Implications for service delivery- telephone counselling

This study was intended to be exploratory and inductive rather than confirmatory or deductive. It attempted to gain new insights and a greater understanding of the complexities involved in providing telephone counselling within the context of Lifeline's generalist crisis counselling service. The telephone counselling model and resulting interaction were explored from the perspective of both telephone counsellors and callers and also in relation to face-to-face counselling practice and theory.

Common themes identified assist in understanding the important aspects of telephone counselling, including the unique dynamics of the counselling relationship in this particular context. This, together with the tensions that emerged in relation to the integration of the Person-centered and crisis intervention counselling models, the application of these in the telephone counselling context in combination with the conditions of the service, and the mismatch between caller needs and service provision, points towards a need for Lifeline's telephone crisis counselling services to consider new theories and/or alternative approaches and practice.

The findings of this study have important implications for telephone counselling service delivery and the conduct of telephone counselling more broadly. They highlight the challenges of applying particular approaches in different contexts and stress the importance and influence of context. In addition, this study underscores the importance of understanding caller needs. Regardless of their presenting problem and despite the parameters and conditions of service delivery that tends to discourage it, the majority of callers who utilise the Lifeline service strive for 'connection' and measure the quality of the telephone

counselling interactions based on their perception of the connection established with the telephone counsellor. For telephone counsellors, this outcome emphasises the importance of maintaining a focus on the counselling relationship rather than on engaging techniques and adhering to particular models of practice. Service providers should take this into account and ensure that the models and conditions they adopt are conducive to and facilitative of telephone counsellors' ability to establish, develop and maintain quality counselling relationships in their practice.

In general, crisis line telephone counselling services need to actively address a number of considerations. These include:

1. The fit of context, conditions and particular practices of telephone counselling with adopted face-to-face counselling theories and practice.

Assumptions are that face-to-face counselling models are easily adapted to the telephone counselling context as well as particular practices that may be employed by the agency. The tensions that emerged from this study illustrate the challenges of integrating different models of face-to-face counselling and of applying these under altered conditions in a different context. Being aware of and exploring stakeholder assumptions may assist in alleviating some of the tensions and their effects.

Although these conditions may be seen as influencing the effectiveness of the telephone counselling session and the quality of individual counselling relationships, an alternate possibility is that they could be used as a powerful tool when combined with more candid interactions. Simple measures would reduce the incidence of many of those interactions that are seen as less helpful. For instance, recognising the parameters of the service and actively engaging with the caller in a cooperative partnership would assist telephone counsellors in their ability to be genuine with the caller; would assist callers in their effort to have their needs met; and would assist the organisation in the more effective functioning of the service.

2. The fit of service provision, the model, conditions and practice, with caller needs and utilisation.

Lifeline assumes that a discrete, time limited intervention will be effective in responding to caller needs. What emerged from the data was that caller needs and use of the service appear to be in conflict with this model. Callers wanted to tell their story and experience a meaningful connection and often repeatedly contacted the service in their attempt to achieve this or because their need was for more than a one off intervention. Services need to recognise that crisis is often not discrete and time limited and that single session interventions may not be sufficient, particularly for those callers struggling with more complex psychological difficulties. Recurrent use of the service seems to point to callers understanding of their needs in this regard. Repeatedly connecting with service, however, means that callers run the risk of being designated as a problem caller. The service is similarly hampered in their efforts to effectively respond to caller needs and to the way in which they utilise the service. The result of this is that the service appears not designed for the largest proportion of their users, or, alternatively, 93% of callers to Lifeline appear not to be a good fit with the service model.

Mismatched expectations of counselling interactions, mismatched needs of telephone counsellors and callers and misunderstandings about caller needs together add extra strain on discrete counselling relationships. Caller expectations of telephone counselling or of their current interaction with a particular telephone counsellor, however, were largely unspoken. Perhaps perceptions of time limitations and assumptions of commonly held expectations relegate these discussions to a secondary position. Exploring these aspects may serve to heighten understandings of both callers and telephone counsellors so that common goals are more achievable and misunderstandings are reduced. Greater understanding of caller needs and expectations may also help to guide the organisation in service delivery. As noted earlier, research points to the therapeutic relationship being one of the key ingredients of counselling and identifies that improvement is associated with a greater number of counselling sessions. Callers desire for 'connection' and recurrent use of the service may be reflective of these same domains.

3. The impact of service conditions on the telephone counselling interaction and relationship

The conditions under which the service operates emerged as an important factor in the telephone counselling endeavour. Effects were apparent in the telephone counselling interaction and counselling relationship and could often be seen as being interactive and recursive. The conditions defined the content and quality of the telephone counselling interaction and how and who, managed the interaction. They also influenced the counselling relationship. In a broader sense, effects were also apparent in callers' engagement with and utilisation of the service and in organisational culture.

Gaining a better understanding of these dynamics and recognising the parameters of the conditions would assist in improving service effectiveness. For instance, it may be helpful in thinking about the case management of recurrent callers to recognise when service conditions are counterproductive to the effective treatment of some individuals and actively address these circumstances with the caller. Other concerns may include cases when service conditions contribute to dependency in the caller and when maintaining the façade of anonymity inhibits genuine dialogue and effective practice.

4. Telephone counselling fit with other mental health care services and practitioners.

Telephone counselling can be seen as playing a significant role in community mental health and indications are that Lifeline fulfils this role via a number of different avenues. One pathway is as an adjunct or support service to other mental health services and practitioners. Although telephone counsellors may be mindful of this circumstance, they remain uncertain about the role they play and what constitutes best practice in regard to the parameters of the interventions they offer. Mental health practitioners similarly may be unaware of the frequency and type of intervention clients are receiving via telephone counselling. This component of the service may well represent an important resource to both the community and other mental health professionals. Networking with, encouraging and developing relationships with other community mental health care services

and mental health practitioners may improve referral processes, treatment and case management. Improved associations would also assist in the development and implementation of clearer protocols and communication about managing demand and type of caller.

5. Telephone counsellor training

Providing volunteer telephone counsellor with a structured approach and specific responses may be seen as helpful, particularly as a tool that serves to alleviate their anxiety, however, shifting the focus of training models away from specific techniques and placing more emphasis on common factors that represent the core of effective counselling practice would be likely to provide a greater degree of comfort and more effective interactions. In learning the importance of providing a supportive counselling relationship that allows the space for callers to tell the stories they need to tell in the way they need to tell them, telephone counsellors need not be anxious about applying specific techniques and can shift their approach and attention from abstract interventions towards caller specific responses. This shift would also highlight the unique contribution provided by individual telephone counsellors, encourage them to draw on their human qualities, and enable them to more effectively connect with the caller.

Limitations of the study

While the study incorporated different methods of data collection and drew upon a number of data sources, one of the challenges was in the difficulties associated with gaining the triad data sets. The intention of the triads was to explore the intersections between counsellor, context and caller.

Although not all data sets were interconnected, telephone counselling sessions and telephone counsellor and caller interviews provided insight into a number of different dimensions. These included the components of the telephone counselling interaction and how these relate to face-to-face counselling practice, the experiences of first time callers versus repeat callers, as well as the perspectives of telephone counsellors and callers and the relationship between

the two. These different perspectives were also important in the provision of the triangulation of the data and assisted in providing a broad perspective and more in-depth understanding as well as highlighting the significant role that telephone counselling plays. The common themes that were present between the first time and repeat callers also act to reduce concerns regarding the validity of the retrospective data. Perhaps the clarity of their recall further serves to illustrate the importance of this experience.

In addition, selection biases exist with regard to telephone counsellors and callers who participated. The telephone counsellors had to be amenable to having their practice observed and prepared to appeal to callers to take part in the study, which for some telephone counsellors was not perceived as being compatible with the Lifeline telephone counselling model. At times participant telephone counsellors engaged in a gate-keeping role. Although this was intended to protect the caller, it may have limited the diversity and number of triad data sets that were able to be included in the study. However, an analysis of all calls, and associated caller characteristics, received by Lifeline Melbourne in 2005 positioned the caller participants in this study as being representative of the broader characteristics of the caller group.

Other, more pragmatic, difficulties also limited the number of telephone counselling sessions recorded. In particular, only one telephone counsellor at a time was able to record their counselling interactions and only those callers they deemed as appropriate for inclusion in the study were invited to take part. Consequently, gaining complete triad data sets was difficult and a decision was made to gain additional caller interviews that were not connected with telephone counselling interactions or telephone counsellor interviews. The advantage of this decision was that it provided a greater number of caller interviews and reduced the incidence of gate keeping, potentially allowing a more representative group of callers to be included. However, the disadvantage was that there were fewer interconnected data points within which comparisons could be made.

Furthermore, the implementation of the research protocol may have influenced the nature of the interaction between the counsellor and the caller. Anecdotal reports from counsellor participants were mixed in that some found it particularly

difficult to invite callers to take part and perceived the process to be somewhat intrusive and a threat to anonymity, while others were more comfortable with the process. Telephone counsellors also reported varying degrees of awareness regarding the recording of telephone counselling sessions, which may have influenced the counselling interaction, although they reported that this usually dissipated during the call. One caller reported that the knowledge that another person would be listening to the telephone counselling session helped her to clarify her problems, enabled her to become more objective and really 'hear' what she was saying, identify improvement and recognise that she needed more formal ongoing and in-depth counselling. This experience also prompted the caller to empathise with what she imagined would be the telephone counsellor's experience of the study and to make a comment about this to the telephone counsellor.

Lifeline is one of the biggest agencies of its type and is widely recognised with representative centres worldwide. Although Lifeline Melbourne is one of the largest in Australia, the fact that the study was exclusively focused on one telephone counselling agency might reflect another limitation. However, this focus enabled an in-depth understanding of telephone counselling in context, allowing a more comprehensive exploration of the processes and dynamics that play an integral part.

Issues in studying telephone counselling in context

McLeod and Machin (1998) point to an absence of research into the contexts of counselling and a lack of acknowledgement of the role that context plays. Research and practice considerations regarding the relevance and importance of context in shaping and informing the counselling endeavour, remains limited.

While context, in relation to the application of face-to-face counselling theories and approaches in the context of a one off time limited telephone counselling interaction, was to be considered, it was not the primary focus of this study. However, context, in the form of the conditions surrounding the telephone counselling interaction, their influence on organisational ideology and subsequent

identification of the ideal caller, emerged as a significant component influencing content, approach, process and the relationship between caller and telephone counsellor.

In the process of studying telephone counselling in context, important information and experiences came to light. One, unanticipated attribute was telephone counsellors' enthusiasm and desire for self-development and professional growth. This meant that they were prepared to place themselves in a position where their interactions and practices could be minutely analysed. Telephone counsellors also expressed an interest in gaining feedback and often actively sought this.

As observations and data collection activities ensued, organisational rules and culture, that created a number of tensions and played a significant role in the research process, were highlighted. Telephone counsellors often struggled with their dual role of telephone counsellor and researcher, at times protecting the caller from what they perceived to be an invasive process or excluding callers they deemed as not a good fit for the study. The emergence of these attitudes and behaviours on the part of the telephone counsellors was an unanticipated consequence of the research and raised the organisation's awareness of the challenges of conducting research in context.

While expectations were that callers would most likely be reticent in allowing interactions and interviews to be recorded, it appeared that callers valued the opportunity to 'give back', provide feedback and talk about their experiences. In some instances callers spontaneously offered to be called back for further interviews. Previously unknown information about callers was discovered and, despite the limitations of some of their telephone counselling interactions, callers acknowledged the value of the organisation and the service they provide.

These outcomes bode well for future research endeavours in the field of telephone counselling. In particular, while it is important to remain sensitive to participant concerns, the knowledge that many telephone counsellors welcome the opportunity to continue their learning through research and that many callers are equally willing to engage with the research process is both reassuring and

encouraging. Organisations and researchers can feel more confident in their approach and more certain about conducting studies in the field.

Future Research

There is a need for further research in telephone counselling given the continuing demand for, and growth of, crisis line services and their potential for doing both harm and good. The major shareholders of these services, the callers, are often vulnerable and in need, yet few research studies have explored their experiences or discovered their needs.

Future investigations may benefit from conducting studies that explore callers' needs in more depth. Gaining a fuller understanding of the needs of the callers would assist professionals in the field to better provide the supports and help required to alleviate some of the distress, stresses and concerns callers experience.

Investigating the different roles that Lifeline plays for both callers and the mental health services may also serve to improve case management and caller outcomes. The current study points to a number of interesting processes that seem to take place within the organisation, the individual and between the caller and the counsellor. These pointed to the importance of exploring the influence of situational factors such as organisational culture, counsellor knowledge about the caller, counsellor mood, the nature of the caller's problem and the caller's knowledge and understanding of the system. Therefore, while continuing to collect data from individuals is important it might also be useful for other studies to consider a system approach, in order to explore these factors and their impact on the interaction, so as to promote a greater understanding of the dynamics involved.

While this study focused on the counselling interaction, future studies might find it helpful to gain additional data about what beliefs and expectations the organisation, health care professionals, telephone counsellors and the general public hold about the role and effectiveness of telephone counselling. This may allow for some cross-referencing and improved quality control. For instance,

examining organisational beliefs, expectations and culture and considering these in light of caller beliefs, expectations and desires may enable a close matching of service provision and caller needs and, henceforth, more effective practice and outcomes.

Commentary

“Lifeline began with a vision for the future. In 1963, its founder imagined a world in which a ‘mantle of care’ would touch the lives of people who might otherwise feel unsupported in times of need” (Lifeline Australia, 2004, p. 2). Consistent with this vision, a review of the literature and the findings of this study confirm and highlight the valuable role that Lifeline’s 24-hour counselling service can play within a contemporary and comprehensive mental health care system. As a 24-hour telephone counselling service, Lifeline offers a number of unique benefits by: (1) providing counselling that is more widely available to the general public than face-to-face counselling, (2) offering rapid response intervention, (3) supporting clients who are waiting to gain access to specialist mental health services, or are currently involved in a service but need additional support and connection.

Caller retention appears to be particularly high. This suggests that, despite occasions when telephone interactions are unsatisfactory or unhelpful, callers are able to maintain a level of resilience that may be going unrecognised. Callers are also resourceful in that they learn the rules and try to manage the system as well as individual interactions. It may be that for many long-term recurrent callers their understanding of the system within which the interaction operates outstrips that of the telephone counsellor, many of whom volunteer for a relatively short period of time in comparison. Callers’ repeated use of the service points not only to an ongoing need for the service but also to the development of a robust relationship with the organisation itself, that is able to withstand a number and variety of challenges, and callers’ need or desire for more than one telephone counselling session.

Much of Lifeline's role and effectiveness may be in the sense of community they provide and the perception of them as the symbolic healer. As volunteers, the telephone counsellors are perceived as caring individuals and the organisation as having a reliable and constant presence. For many callers, particularly those struggling with social isolation and more complex long-term mental health problems, Lifeline may represent one of their longest and most consistent relationships.

Overall, telephone counselling offers an acceptable and practical option for many individuals; however, like other forms of counselling the potential to do harm is always present. In a society where social networks continue to weaken, these services provide an integral human connection without which many would experience additional suffering. As was illustrated in the stories of the callers involved in this study, telephone counselling also offers the possibility of strengthening coping and enhancing personal development. If we continue to broaden our knowledge, improve supports to telephone counselling services and establish some regulatory standards then many of the risks involved would be minimised and the benefits amplified.

The use of the telephone as a counselling medium is rapidly growing and the alternative it provides to face-to-face counselling is likely to result in increased access by more people from a broader spectrum of the community. It is important to note that for many recurrent callers the effects of a telephone counselling call, while seemingly discrete, reflect an ongoing relationship with the organisation that plays an important role in their lives. In our desire to provide an easily accessible and affordable service, it is essential that we do not forget the human element and the ongoing effects that these connections no doubt have on individuals and communities. The interpretive methods employed in the current study provided an opportunity to gather information about the complex and multifaceted nature of telephone counselling as seen by its chief protagonists, the counsellor and the caller.

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Appendix A

Complete Data set for period 27th February – 6th March 2006

27Feb-06Mar Total	Total	%
Victoria University Research Data:	11014	0
Access:	2019	18.33
Called previously:	673	33.33
Yes (Regularly)	96	14.26
Yes (Occasionally)	123	18.28
No (1st time caller)	97	14.41
Unknown	357	53.05
Frequency of calls:	673	33.33
Once a day	18	2.67
More than once a day	9	1.34
Once a week	18	2.67
More than once a week	21	3.12
Once a month	15	2.23
More than once a month	25	3.71
A few times over past year	35	5.2
Never called before	87	12.93
unknown	445	66.12
Time of calls:	673	33.33
Mostly early morning	10	1.49
Mostly during the day	30	4.46
Mostly in the evening	37	5.5
Mostly overnight	4	0.59
Any time	16	2.38
unknown	576	85.59
Demographic Details:	3365	30.55
Gender:	673	20
Male	188	27.93
Female	410	60.92
Not asked	75	11.14
Age:	673	20
15-19	13	1.93
20-24	23	3.42
25-29	47	6.98
30-34	46	6.84
35-39	43	6.39
40-44	46	6.84
45-49	44	6.54
50-54	51	7.58
55-59	28	4.16
60-64	20	2.97
65-69	4	0.59
70-74	10	1.49
75-79	4	0.59
80+	4	0.59
Not asked	290	43.09
Education:	673	20
Secondary Education	25	3.71
Tertiary Education	45	6.69
TAFE	9	1.34
Currently attending	20	2.97
Not asked	574	85.29
Employment:	673	20
Yes	53	7.88

No	123	18.28
Pension	62	9.21
Long-term unemployed	31	4.61
Part-time	24	3.57
Full-time	44	6.54
Casual	15	2.23
Not asked	321	47.7
Relationship:	673	20
Single	208	30.91
Partnered (not living together)	36	5.35
Partnered (living together)	96	14.26
Widowed	22	3.27
Divorced	41	6.09
Separated	39	5.79
Not asked	231	34.32
Mental Health Issues:	5630	51.12
Professionally Diagnosed with a Mental Illness:	673	11.95
Yes	198	29.42
No	132	19.61
Unknown	343	50.97
Diagnosis made by whom:	687	12.2
GP	55	8.01
Counsellor	9	1.31
Psychologist	11	1.6
Psychiatrist	90	13.1
Other	2	0.29
Unknown	290	42.21
No identified professional carer	230	33.48
Diagnosis made when:	673	11.95
less than 1 month	11	1.63
between 1 month and 6 months	3	0.45
between 6 months and 12 months	5	0.74
between 1 year and 2 years	8	1.19
between 2 years and 5 years	21	3.12
over 5 years	67	9.96
unknown	558	82.91
Mental Health Diagnosis:	709	12.59
Anxiety Disorder	35	4.94
Bipolar Disorder	22	3.1
Depression	102	14.39
Eating Disorder	2	0.28
Panic Attack	7	0.99
Phobia	3	0.42
Post-Traumatic Stress Disorder	11	1.55
Personality Disorder	9	1.27
Psychotic Disorder	8	1.13
Schizophrenia	29	4.09
Substance Abuse Disorder	2	0.28
Unknown Diagnosis	242	34.13
No Diagnosis	237	33.43
Receiving Treatment from:	727	12.91
Case Worker	13	1.79
Counsellor	72	9.9
GP	94	12.93
Psychiatrist	89	12.24
Psychologist	31	4.26
Other	12	1.65
Unknown	220	30.26
No identified professional carer	196	26.96

Currently Receiving Treatment for:	695	12.34
Anxiety Disorder	34	4.89
Bipolar Disorder	20	2.88
Depression	84	12.09
Eating Disorder	1	0.14
Panic Attack	7	1.01
Phobia	1	0.14
Post-Traumatic Stress Disorder	11	1.58
Personality Disorder	6	0.86
Psychotic Disorder	4	0.58
Schizophrenia	27	3.88
Sleep Disorder	3	0.43
Substance Abuse Disorder	5	0.72
Unknown Current Treatment	279	40.14
No Current Treatment	213	30.65
Previously Received Treatment for:	693	12.31
Anxiety Disorder	18	2.6
Bipolar Disorder	15	2.16
Depression	71	10.25
Eating Disorder	1	0.14
Panic Attack	4	0.58
Phobia	1	0.14
Post-Traumatic Stress Disorder	5	0.72
Personality Disorder	4	0.58
Psychotic Disorder	4	0.58
Schizophrenia	21	3.03
Sleep Disorder	3	0.43
Substance Abuse Disorder	7	1.01
No Previous Treatment	58	8.37
Unknown Previous Treatment	481	69.41
Social Supports:	773	13.73
Church	21	2.72
Family	226	29.24
Friends	158	20.44
Support Group	42	5.43
No significant support	90	11.64
Unknown	236	30.53

Example of Complete Record

RECORD DETAILS: ID001XXXXX

Date/Time:	27/02/2006 15:14-15:29 (00:15)		
Line Used:	Lifeline Caller	Focus:	Self
Call Type:	Counselling - non-suicide	Suburb:	SXXXXX (3XXX)
Gender:	Male	Age Group:	25-34
Relationship:	Separated	Called Before:	1st time caller
For How Long:		Reviewed:	No

STATISTICS SHEET SUMMARY:

Caller's Issues - Counselling Call

Adjustment and Loss

Relationships breakdown

Behaviour Problems

Anger

Self and Society

Relationships

Caller's current support

No significant support

Caller's mental health issues

Mental health experiences (for at least 2 weeks)

Mood swings

How did you respond to mental health issues?

Assessed suicide risk

Caller receiving treatment/counselling for

No indication of treatment/counselling

Caller under care of

No identified professional carer

Caller called at suggestion of

Family/Friend

Referrals provided to Caller

General Referrals

Counselling (General)

Indigenous/Ethno Specific

Vic Uni Research Data

Access

Called previously

No (1st time caller)

Frequency of calls

Never called before

Time of calls

Mostly during the day

Demographic Details

Gender

Male

Age

30-34

Education

Not asked

Employment

Not asked

Relationship

Separated

Mental Health Issues

Professionally Diagnosed with a Mental Illness

No

Diagnosis made by whom

No identified professional carer

Diagnosis made when

unknown

Mental Health Diagnosis

No Diagnosis

Receiving Treatment from

No identified professional carer

Currently Receiving Treatment for

No Current Treatment

Previously Received Treatment for

Unknown Previous Treatment

Social Supports

No significant support

COMMENTS:

Referrals provided to Caller:

General Referrals:

Referral to mens referral service and also to Fxxxxxx community centre

About the Caller - Comments:

Caller's Situation/Concerns/Background:

Male caller with koori background, has just had his partner leave him and go to Txxxxxx, he is devastated that she may not come back, she's taken his 1 1/2 year old with her and he is very angry. He doesn't want to harm anyone and is feeling his anger getting out of control, he is hitting walls and is fearful it will escalate. He called lifeline to get some help.

Caller's Emotional/Mental State:

There was sadness in his voice and a genuine call out for help.

Your Counselling - Comments:

Help provided:

Discussed his issues and the background to what happened, This is the 3rd time this has happened, and he wants help with his emotions before he explodes. He said 5that he gets angry when he is not being listened to or gets cut off while he is talking.

Challenges:

This was a good call, I felt in control and the caller was content with the help/referrals he got.

Appendix B

Telephone counsellor plain language statement: Record session and Interview

2nd February, 2006

My name is Heather Young and I am studying for my Doctor of Philosophy at Victoria University. I am working under the supervision of Dr Jenny Sharples and Dr Bernadette Hood on a research project about telephone counselling, in particular the Lifeline telephone crisis counselling service.

We are hoping to gain an understanding about how both callers and counsellors experience a telephone counselling call and what they perceive to be the most helpful or unhelpful aspects of the interaction. Whilst some research has been conducted into telephone counselling, very little is known about crisis line counselling.

I would like to invite you to take part in this study. It will involve the tape-recording of telephone counselling calls and will also require that you take part in a brief interview. The interview(s) will be conducted within a couple of days of a specific telephone counselling call. Initially I will only be considering a small sample of counselling calls and so it is unlikely that you will be involved in more than one call and, therefore, one interview. The interview should only take about 10-15 minutes of your time and will ask a few questions about your perceptions of that particular counselling call. It would also be useful for you to share anything else that you believe plays an important part. The interview will also be tape-recorded to ensure that we have an accurate record of the information you provide. In order to protect your identity there will be no identifying names on the tape.

The results of this part of the study will be used to inform the development of a questionnaire and may also be published as part of my PhD thesis. The results of the study may also be published in a psychological or medical journal. If so then this information will be available to organizations, counsellors and other health care professionals working in this field, enabling them to gain a greater understanding and improve the practices of telephone counselling services. I am obliged when conducting this research to ensure that your identity is protected, therefore, no names or any other identifying information will be included in the thesis or any other publications.

Participation in the study is entirely voluntary and you may withdraw at any time. Your decision to participate, or not, will not influence your work at Lifeline. This project has been approved by the Victoria University Human Research Ethics Committee.

I hope that this information is useful in helping you decide whether you are willing to take part in this study. Should you have any queries or wish to discuss it further before committing yourself, please feel free to contact either myself (9365-2824) or Prof Jill Astbury (9919 2335).

Your time and assistance are greatly appreciated.

Heather Young

Appendix C

Telephone counsellor consent form: Record session and interview

Victoria University of Technology

Consent Form for Counsellor Participants Involved in Research

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into Lifeline’s (Melbourne) telephone crisis counselling service. The study will require the tape recording of telephone counselling calls and an interview, which should only take about 15-30 minutes of your time. The results may be used to inform the development of a questionnaire and will later be published as part of a PhD thesis and in other relevant health related journals.

CERTIFICATION BY SUBJECT

I,
of

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study entitled

Components of effectiveness for the Lifeline crisis telephone counselling service: Stakeholder perspectives.

being conducted at Victoria University of Technology by: Dr Jill Astbury, Dr Bernadette Hood, and Heather Young.

I understand the information that has been provided and I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way. I understand that the information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project.

Signed:

Date:

Witness (other than the researcher):

Appendix D

Preparation notes for telephone counsellor

Victoria University of Technology

Plain Language Statement and Consent Form for Participant Callers Involved in Research

NOTES FOR COUNSELLORS

Victoria University and Lifeline have linked together to conduct a study into Lifelines telephone counselling service. As part of Lifeline's participation in the study, a researcher from Victoria University will be conducting interviews with callers and counsellors at Lifeline (Melbourne) in mid-late February over a period of several weeks.

The name of the researcher is Heather Young.

BEFORE YOU START TAKING CALLS

- 1. Ensure that you have everything you need in place to tape-record the counselling call.*
- 2. Check that you have sufficient contact sheets. You will also need to record your details on the contact sheet so that the researcher can contact you within the next few days.*
- 3. Familiarise yourself with the contact sheet.*
- 4. Clarify any issues or questions you might have before you begin.*

DURING THE CALL

- 1. Make sure that the caller fully understands what is involved in taking part in the research before you begin to record the session.*
- 2. Make sure that the caller gives verbal consent for the call to be tape-recorded and for the interview to take place and that you capture this on tape.*

AT THE END OF THE CALL

- 1. Attach the contact sheet to the information sheet that contains the information you normally collect.*
- 2. If you have successfully recorded a call make sure you have recorded your contact details on the contact sheet so the researcher can contact you to arrange an interview within the next few days.*

Thank you.

Appendix E: Decision Tree: Caller recruitment and consent

Caller record # _____ Computer record# _____ Date/Time of call _____ Duration _____

**At the beginning of each call consider
Is it appropriate to ask the caller to participate? (i.e., No - if caller is in acute crisis)**

œ **NO** – **do not** mention the study and make a note of why while proceeding with the call

œ **YES** à **GO TO 1.**

1. Say 'Before we start, we are currently conducting a study into the sorts of things that people feel are either helpful or unhelpful during their telephone counselling session. Your **participation in the study is voluntary**. Whatever you decide to do it will not affect our work together. If you agree to participate this **call will be tape-recorded**. Also, sometime in the next few days, you may be contacted by a researcher and asked to take part in a **telephone interview**, which should only take about fifteen minutes of your time. Your call will remain **confidential and anonymous**. Would you be willing to take part in this study?'

œ **NO** – **Make a note in the space below and proceed with the call**

œ **YES** à **GO TO 2.**

Say: 'We've been doing this research for some time now – have you been interviewed before?'

œ **YES** – **Say:** 'Thanks, but we only need one response from each person', and proceed with the call.

œ **NO** à **GO TO 3.**

3. Turn on tape-recorder and Say: 'just to make sure that we understand each other correctly. You are willing to take part in this study and understand that this session will be tape-recorded and that you may be contacted in the next few days and asked to take part in an interview'.

œ **NO** – **STOP RECORDING - Make a note in the space below.**

œ **Clarify any misunderstandings with the caller** à **RETURN TO 3**

Or, reassure the caller and reiterate that participation is voluntary and **proceed with the call.**

œ **YES** à **OBTAIN CALLER DETAILS**

Name

Ph. #

Best times to call:

Say: 'the researcher should call you within the next few days. But they are not interviewing everyone so don't be concerned if you don't hear back' **proceed with the call.**

COUNSELLOR CONTACT DETAILS

Name:

Phone #:

Best time to contact for interview:

Thank you

œ **ANY COMMENTS**

Appendix F

PHASE I: Data collection period April – September 2006

Telephone counsellor calls fielded: Calls recorded and reasons calls not recorded

TC	TC decision Not appropriate	Hang-ups Sexual- harassment	3rd party issue	Suicide	Suicide – other	Already asked	Caller declined Reasons given	No reason recorded	TC Difficulty asking	Call recorded	Info call	TOTALS calls
TC1	1 regular/edgy 1 ID 3 crying	5	3	2		1	3 c/sensitive 1 1 uncontainable			4	1	26
TC2	1 short call 1 difficult speech 3 case-managed 6 crying 1 anxious 1 not ready to talk	4	2	4	1	1	1 1 privacy 1 too busy 1 not paid 2 c/sensitive 1 too difficult	1	1	2	2	38
TC4	1 young 2 schizophrenic 1 unable to hear caller 1 panic attack 2 intoxicated 1 upset	3		1 1 self harm			1	1	3	1		19
TC5	1 language 2 crying 1 young 1 angry 1 bipolar					1	1		1	2	1	12
TC3	1 TC not ready	1		1			1 privacy 1 c/sensitive 1 inhibiting	1		1	1	9
TC6	1 ID 1 case-managed 1 TC not ready 1 case-managed 1 young	1		1	1				3			11
TC7	2 distressed	1		1			1 c/sensitive				1	6
TOTAL	39	15	5	11	2	3	19	3	8	10	6	121

Appendix G
Interview questions: CALLER

How would you describe your experience of the telephone counselling session?

CALLER

How did they know about LL?

Did someone suggest LL/were they referred by a professional?

Why now?

Why telephone service?

Why LL?

History with LL

Is this the first time they've called LL?

If repeat caller:

How often do they call

When do they tend to call

What is it that makes them keep calling LL?

How did they feel making the call?

How many times did they try?

Have they called LL since this call?

Location in system

Are they supported in any way by other professionals? If so,

How does LL fit in with other services

How have they coped in the past? What other coping mechanisms?

If LL not available – what alternatives

Do/have they call/ed other services

History of distress

How long experiencing distress before calling?

Needs

What needs does LL fulfil?

What is the most important thing that LL offers them?

How does the service work for them?

What role does LL play for them

How important is the LL service

What else would they like LL to do?

Intent and Expectations:
<p>What made them call LL (not another service – telephone or otherwise)?</p> <p>What were their expectations of the call? What were they hoping for when they called? Did they get what they wanted? How did they think the counsellor could help them?</p>
Specification of problem:
<p>Did they call about a specific problem? Was it addressed during the call? Were they satisfied with the outcome?</p> <p>What was the most important issue for them? Would they say that that they talked about and worked on what they wanted?</p>

Facilitative Conditions & Perceptions of the therapeutic bond: (empathy, warmth, genuineness)
<p>What expectations did they have of the telephone counsellor?</p> <p>What are the most important qualities in a telephone counsellor? Kind/caring/reassuring vs. knowledge/techniques/expertise</p> <p>How confident were they in the counsellor’s ability to help them?</p> <p>Did they feel they made a good connection with the counsellor? i.e., heard, understood and respected How important was the relationship in achieving positive outcomes for them?</p> <p>Description of the relationship that developed between them and the counsellor? Did they make a connection/feel comfortable? How would they rate the quality of the relationship?</p> <p>How would they describe the level of communication established? Did you find it easy talking to the counsellor?</p>

What approach did the counsellor take?

Was this approach a good fit for them?

What else might have worked?

Was there something in particular that they liked?

Were there things they didn't like?

How did this approach help?

What else might have helped?

Was there anything that didn't help/made things worse?

Change:

Effectiveness of call

How did the call help?

Any immediate change (in their emotions)?

Did they feel better/worse/same immediately after the call?

Enhancement of coping

Problem solving

Has the call helped you to deal more effectively with your problem?

Were they happy with the amount of time spent on the telephone with the counsellor?

How much would be enough?

What impact has the call had?

How have things changed since making the call?

How satisfied were they with amount of help they received?

What made the difference?

What constitutes change?

What was the most significant/important aspect of the call?

Is there anything else that we haven't covered that I should have asked you?

Is there anything you would like to ask me?

Offer call back from LL supervisor

Appendix H

Interview questions: TELEPHONE COUNSELLOR

How would you describe your experience of the telephone counselling session?

TELEPHONE COUNSELLOR

What made them volunteer with LL?
What were/are their expectations?
How do they perceive what they do?
Do they respond differently to different callers (male/female, repeat callers/first time, types of issues etc

General Perceptions, Intent and Expectations:

Their perceptions of why people call LL?
Their expectations of how they can help callers/have these been met?
Their perceptions of how LL fits with other supports the caller might have?
Their perceptions of the role LL plays for the caller?
Their perceptions of the most important things that LL offers the caller?
Relationship/qualities of counsellor/content-problem solving aspects
Accessibility, availability, affordability
anonymity

Perceptions of Call: - Specification of problem:

Would you say the caller had a specific problem?
What was it?
Was it addressed during the call
Were you satisfied with the outcome?

What was the most important issue for you?
Would you say that you talked about and worked on the most important issue/s?

Facilitative Conditions: (empathy, warmth, genuineness)
<p>Their perceptions of the most important qualities in a telephone counsellor? How confident did they feel in their ability to help the caller? Perceptions of the caller? Did they feel they made a good connection with the caller? What made them think this?</p>
Perceptions of the therapeutic bond:
<p>Their perceptions of the relationship that developed between themselves and the caller? Their perceptions of the quality of their communication? Perceptions of the importance of the relationship in achieving positive outcomes for the caller?</p>
Approach or Method
<p>Describe of the approach utilised with this caller? Strategies/techniques/support etc Enhancement of coping Reduce distress Challenge Friendly chat etc</p> <p>Their perceptions of the quality of fit between the approach and the caller? Was there something in particular that worked? What made the difference? What else might have helped? Was there anything that didn't help/made things worse? Their overall perception of the effectiveness of the call for the caller? How much is enough</p> <p style="padding-left: 40px;">Were they happy with the amount of time spent with the caller? How much would be enough?</p> <p>Were you satisfied with the amount of help they provided?</p>

Client change:

In this context, what are their aims/goals with the caller? What constitutes change?

What was the most significant/important aspect of the call?

Their overall perception of the effectiveness of the call for achieving change for the caller?

Appendix I

Case summary: Caller interview

Caller/call profile

This male caller, aged 47 years and widowed, called into LL at 605am and spoke with a female TC for 15 minutes.

TC record:

This call was recorded as 'counselling-non-suicide' and 'self focused'. The TC recorded the caller's issues as 'Self and Society', subcategorised as 'relationships'. 'Bipolar and schizophrenia' were recorded under 'mental health experiences' (for at least 2 weeks) and it was noted that he was 'under the care of GP' and receiving treatment for 'bipolar and schizophrenia'. The caller's emotional state was reported as 'fine got a bit stressed in his communication at times but pulled it back himself'. The TC reported under 'help provided' 'I was sus (sic) at first when I pressed him to explain what prompted his call and he stated he was a "30" year long caller...I felt this call was more about alleviating his boredom.... I respectfully challenged him on this and avoided being drawn into more gibberish'. The TC commented under 'challenges' that the caller was 'at times quite rude when challenged about his use of the LL service...'. The TC reported that they checked caller profiles but the caller 'masked his profile very well'. After the caller provided his name for the VU study the TC identified him as a caller 'who has no access to LL Melbourne', Upon further consideration this later turned out not to be the case (mistaken identity).

Review of interview with researcher

The caller reported that he has been calling LL for about 32 years and the first time he called he was about 15 years old.

In his experience LL had undergone a significant change in the way the TC's related to callers. When he first started calling in the TC's were 'really friendly and open' and would often share their own experiences. His sense now is that 'it's all done by a book' as a 'learning period... for them' and he doesn't find this very helpful or 'attractive'. He doesn't find them very 'sensitive' anymore 'there's no human contact, there's no human element' they've 'lost the human touch, the feeling and warmth and the emotion, knowledge, ability, talent,...' instead they 'always come up with the same saying' and he 'find it very difficult to handle'. He reports that he 'would like them to talk to me at my problem level, But now a days you don't get that, you say your piece and they say...What are you going to do when we finish the call?... [then]...They just throw it back in your face... they're like tiny miniature robots' 'it's all so dry' 'I know exactly what they're going to say...'. He says 'I've got to keep in the mix of things so they don't just get sick of you and hang up'. His sense is that he has control of the conversation in as much as he can hang up at any time but otherwise he feels that 'they want to take control'.

He often feels that they want to push him away now 'a tendency to push [ing] the call through now, to get somebody else' and he asks 'what advantage is it to open up to somebody? when I open up to them and they say, times up now we've got to go and they leave you in the lurch, they don't give you any feedback, or summary or anything'

For this caller his greatest need is someone he can talk to 'Just so long as you know that somebody else is alive out there' he 'wants active interaction'. But his sense is that 'we [the caller] are the problem' and 'there's a lack of love, understanding and trust' 'you can't hear the heart beat...only their head working'

'When you ring up Lifeline ...you have to explain the whole situation, the whole story over and over again.. .which really, really, really peeves me off' 'a very few are really really good, they are really hardy'

As a result he has reduced the number of times he calls LL to perhaps once a month. He now prefers to call Grief line.

Interestingly the caller states that he believes that LL is '...the pulse of the country...' and on the whole he thinks they're 'pretty good....we need them, they've got to stick around, we've got to have them...'

He generally finds it easier to talk about his problems on the phone, in that way he's not so concerned about what the counsellor thinks of him, for instance if they like him.

Researcher's comments:

Although this caller seemed have significant mental health issues (he identified himself as suffering both schizophrenia and bipolar) his contact with LL now is only as a last resort when he's feeling extremely lonely. However, even this appears to be frustrating for him as he rarely gets what he wants out of the call and reports that at times 'they deliberately hang up on me'.

This caller interprets what sounds to me like the usual suicide risk assessment as a lack of caring and has developed a perception that LL wants him to commit suicide.

It's interesting that the TC felt the need to police the use of the LL service to such a degree. Perhaps this caller is frequently misidentified as the other caller who 'has no access to LL'. This might explain some of his more negative experiences.