LAY MENTAL HEALTH COUNSELING: PROSPECTS AND PROBLEMS

ROBERT R. CARKHUFF
State University of New York at Buffalo

Reviews of training and treatment programs employing lay personnel as "helpers" yield provocative findings. While there now are numerous nonprofessional training programs, only a few have systematically assessed their effects in terms of therapeutic process variables, and fewer still have presented systematic comparisons of the differential effects of lay and professional training (4, 5).

An analysis of the training programs in the few directly comparable studies indicates that following training, lay trainees function at levels as high or higher than professional trainees on dimensions of facilitative interpersonal functioning (empathy, respect, genuineness, concreteness, self-disclosure) that have been found to be related to a variety of constructive client-change indices (6, 17). In addition, lay trainees engage clients in therapuetic process movement (depth of self-exploration, immediacy of experiencing, problem expression) as much or more than do professional trainees (2, 3, 6, 7, 8, 12, 14).

Similarly, although ongoing treatment programs are of necessity much more numerous than the training programs, few have systematically assessed their effects, and fewer still have compared the differential effectiveness of lay and professional treatment. However, in directly comparable studies of treatment, with both inpatients and outpatients, lay persons have patients who demonstrate change as great or greater than the patients of professional practitioners (1, 10, 11, 13, 15, 16, 18).

At a minimum, then, lay personnel are as effective as the products of our traditional training programs. At a maximum, under many circumstances they are more effective than professional practitioners. These findings will be briefly summarized with regard to training and to treatment, and prospects and problems will be presented.

Training

There are numerous potential causes for the favorable findings regarding lay personnel. These include differences between lay and professional trainees and trainers, and their training and treatment procedures. While these causes have been explored extensively elsewhere (5), it may be valuable to summarize some of the conclusions that were reached.

Trainees. The evidence suggests that both the means (socio-educational as well as facilitative interpersonal functioning) and the intentions (in terms of what the trainees seek to find in the helping role) of prospective lay helpers are more humble and honest at the beginning of training than the means and intentions of prospective professional helpers. Specifically, the lay trainees function at lower levels of empathy, regard, and other facilitative dimensions at the beginning of training than professional trainees. On the other hand, the lay person's motivation to help appears more simple and direct, unconfounded by needs to find position, status, prestige, money and perhaps some "handles" on his own psychological difficulties within the helping role. While selection-indices of professionals appear, at best, irrelevant to effective therapeutic functioning, lay trainees ranging from essentially unselected volunteers to carefully selected, "psychologically healthy persons," are apparently able effectively to employ the training experiences which are provided to them. Thus, following the brief training programs of lay personnel and the extensive programs of professionals, the initial discrepancy is reversed in favor of the lay person.

Trainers. Concerning trainers of professional persons, data suggest that they function below minimally facilitating levels of interpersonal functioning, indeed at levels commensurate to or lower than professional trainees at the beginning of graduate training. And there is evidence to suggest further that trainees—as well as clients—tend to converge on the level of functioning of their trainer-therapists (14). Perhaps the type and level of practitioner attracted to conducting and participating in lay training functions more effectively in his respective program.

Programs. Lay training involves simple, rather homogeneous programs pragmatically geared toward producing helpers who can effectively relate to persons in need of help, and can facilitate their positive movement. In training programs ranging from 20 hours to a year of twice-weekly sessions, the focus seems to center around two phenomena: (*a*) sensitivity training or the acquisition of interpersonal skills in discrimination and communication, often employing research scales of those facilitative dimensions which, independent of theoretical orientation, had been related in previous research to constructive therapeutic outcome (empathy, respect, genuineness, concreteness, self-disclosure); (*b*) change in the personality and

attitudes of the trainee himself. Thus, these programs emphasize patient involvement and action and are built around the core conditions of understanding, regard, and genuineness, both in their teaching for helping and the experiential base provided the trainee.

By contrast, in professional training there are highly complex, heterogeneous programs attempting ineffectually to bridge the gap between research and practice. They are generally very cognitively oriented toward developing diagnostic understanding and research skills. The lay programs appear to use the little time they have available to effect as great a change as they can in the personality and attitudinal makeup of the trainee, and in his acquisition of interpersonal and action-oriented skills. Professional programs, on the other hand, appear to utilize the great amount of time they have available to effect changes on indices unrelated to counselee or trainee change.

TREATMENT

Again, lay persons, with or without training and or supervision, have patients who demonstrate change as great or greater than the patients of professional practitioners. This finding is based on assessments by outside experts, the practitioner's supervisors and co-workers, the patient's ward attendants and significant others, as well as reports by the patient himself, and client-outcome criteria such as hospital discharge and recidivism rates, assessments of psychological functioning and total adjustment, social-interpersonal behavior, communication and cooperation, self-care and mobility, reaction time and verbal fluency, and indices of sexual-marital and educational-vocational functioning, as well as the more traditional testing indices. The potential causes of these findings are also multifarious.

The professional helper all too often focuses upon highly elaborate, highly cognitive treatment systems: his efforts are role-dominated. "By contrast, the lay counselor has less expertise; he is more in contact with his uncertainty, less sure and less formulative; he has only himself (and, sometimes, his supervisor) to rely upon, and often tries only to stay with and 'be with' the client. However, the lay counselor is also unencumbered by the professional role conflicts which disallow his full and intense involvement and entry into the life's activities of another person" (5).

In summary, the lay counselor and the treatment he offers appear to have the following distinctive advantages compared to

his professional counterpart: (*a*) increased ability to enter the milieu of the distressed; (*b*) ability to establish peer-like relationships with the needy; (*c*) ability to take an active part in the client's total life situation; (*d*) ability to empathize more effectively with the client's style of life; (*e*) ability to teach the client from within his frame of reference more successful actions; (*f*) ability to provide the client with a more effective transition to more effective levels of functioning within our social system.

PROSPECTS AND PROBLEMS

The one unavoidable conclusion is that whatever allows one individual to help another is not the sole and exclusive province of professional helpers. The lack of significant differences between professionally treated and untreated groups in previous research may perhaps be accounted for by the possibility that some of the "untreated" patients sought out the help of untrained lay persons such as the hospital attendants with whom the patients have most contact.

The logical extension of these findings, then, is to place increased emphasis upon the use of lay personnel in inpatient and outpatient treatment. Indeed, there is reason to believe that lay persons are not simply last resort measures to meet ever-growing mental health needs. In many instances treatment by lay personnel might constitute "a preferred mode of treatment." In this regard, Deane and Ansbacher (9) note that with the hospital attendant, "by reason of his commonality of background and language and his close association in doing things with the patient, . . . his lay approach has been found more effective than the 'deeper' interpretations of the professional."

The demonstrated efficacy of lay programs also has obvious implications for professional training. First, we must overcome our universal reluctance to investigate the effects of professional training. Second, if these effects are "negative" with regard to those conditions which relate to constructive client change or gain, then professional programs have two alternate courses. (*a*) They can emulate the lay programs, choosing a "clinical" emphasis upon what does effect client change and the therapeutic change of the trainee toward higher levels of facilitative functioning. (*b*) They can increase the growing dichotomy between research and practice by abdicating to the internship setting, as many already advocate, the responsibility for clinical functioning, and focusing exclusively upon research and theoretical learnings, independent of skills related

to client change. Unfortunately, in regard to the latter course, some of the "negative results" of investigations of graduate training involved post-interns, thus indicating that neither internship nor academic setting are accomplishing the necessary "human" tasks.

In addition, there are implications for a further downward extension of the lay principle to the "helper therapy" principle wherein personnel from among those being helped are selected and trained to serve in a helping capacity within their communities. Indeed, it may well be that a possible preferred mode of treatment for many patients will involve training programs analagous to those presently being offered lay personnel. At a minimum, there is evidence to suggest that indigenous personnel cast in the helping role will change constructively themselves (5).

Concerning the very difficult problem of selection, several non-academic avenues are being attempted: (*a*) casting prospective helpers (professional and lay, as well as prospective patient helpers) as counselors in the helping role with live or standard patients and assessing the helpers' actual level of functioning on the facilitative dimensions; (*b*) manipulating the interviews to present the prospective helper with client "crises" in order to determine how he responds to these; (*c*) presenting the prospective helper with taped excerpts previously rated at high, moderate and low levels of functioning and gauging the helper's ability to discriminate; (*d*) presenting taped representative client stimulus expressions to assess the prospective helper's repertoire of responses and level of facilitative functioning. These indices, in turn, are being related to therapeutic functioning in clinical interviews as well as to a variety of client outcome criteria. At present, casting the prospective helper in the helping role appears most promising. The best predictor of future functioning on a particular dimension is previous functioning on that dimension.

We are not advocating a lowering of professional standards, as appears to concern so many. Rather, we are suggesting an elevation of the professional's role to the very difficult one involving not only practice but training, supervision, consultation on preferred modes of treatment, and research. Concerning the research aspect, the process of treatment and training cannot be separated from the process of making enlightened and systematic inquiries into treatment and training. It is quite clear that we as professionals have not adequately discharged our responsibilities for investigating the treatment and training which we presently conduct. Additionally, if we

view ourselves as part of a helping hierarchy where each person, in turn, serves not only as agent but also as a model for constructive and productive functioning, then we must assume full responsibility for living effectively ourselves in all aspects of our personal-professional lives.

REFERENCES

1. ANKER, J. M., & WALSH, R. P. Group psychotherapy, a special activity program and group structure in the treatment of chronic schizophrenics. *J. consult. Psychol.*, 1961, 25, 476-481.
2. BERENSON, B. G., CARKHUFF, R. R., & MYRUS, PAMELA. The interpersonal functioning and training of college students. *J. counsel. Psychol.*, 1966, 13, 441-446.
3. BERGIN, A., & SOLOMAN, SANDRA. Personality and performance correlates of empathic understanding in psychotherapy. *Amer. Psychologist*, 1963, 18, 393.
4. CARKHUFF, R. R. The effects of lay counseling: evaluation and implications. In Marceline Jacques (Ed.), *Innovations in rehabilitation counseling*. State University of New York at Buffalo, 1968, in preparation.
5. CARKHUFF, R. R. The differential functioning of lay and professional helpers. *J. counsel. Psychol.*, 1968, in press.
6. CARKHUFF, R. R., & BERENSON, B. G. *Beyond counseling and therapy*. New York: Holt, Rinehart & Winston, 1967.
7. CARKHUFF, R. R., KRATOCHVIL, D., & FRIEL, T. The effects of professional training: communication and discrimination of facilitative conditions. *J. counsel. Psychol.*, 1968, 15, 68-74.
8. CARKHUFF, R. R., & TRUAX, C. B. Training in counseling and psychotherapy: an evaluation of an integrated didactic and experiential approach. *J. consult. Psychol.*, 1965, 29, 333-336.
9. DEANE, W. N., & ANSBACHER, H. L. Attendant-patient commonality as a psychotherapeutic factor. *J. Indiv. Psychol.*, 1962, 19, 157-167.
10. HARVEY, L. V. The use of non-professional auxiliary counselors in staffing a counselling service. *J. counsel. Psychol.*, 1964, 11, 348-351.
11. MAGOON, T. M., & GOLANN, S. E. Nontraditionally trained women as mental health counselors/psychotherapists. *Personnel Guid. J.*, 1966, 44, 788-793.
12. MARTIN, J. C., & CARKHUFF, R. R. The effects of training upon trainee personality and behavior. *J. clin. Psychol.*, 1968, 24, 109-110.
13. MENDEL, W. M., & RAPPORT, S. Outpatient treatment for chronic schizophrenic patients: therapeutic consequences of an existential view. *Arch. gen. Psychiat.*, 1963, 8, 190-196.
14. PIERCE, R., CARKHUFF, R. R., & BERENSON, B. G. The differential effects of the level of counselor functioning upon the level of functioning of outpatients. *J. clin. Psychol.*, 1967, 23, 212-215.
15. POSER, E. G. The effects of therapists' training on group psychotherapeutic outcome. *J. counsel. Psychol.*, 1966, 30, 283-289.
16. RIOCH, MARGARET J., ELKES, E., FLINT, A. A., USDANSKY, B. S., NEWMAN, R. G., & SILBER, E. NIMH pilot study in training mental health counselors. *Amer. J. Orthopsychail.*, 1963, 33, 678-689.
17. TRUAX, C. B., & CARKHUFF, R. R. *Toward effective counseling and psychotherapy*. Chicago, Ill.: Aldine, 1967.
18. ZUNKER, V. G., & BROWN, W. F. Comparative effectiveness of student and professional counselors. *Personnel Guid. J.*, 1966, 44, 738-743.