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NOTE TO CONTRIBUTORS

Volunteer Administration serves as a primary publication for disseminating theoretical, research, and professional activities related to the utilization of citizen volunteers in a wide variety of institutional and community settings. The journal is designed to be of interest to directors of volunteer services, social scientists, colleges and universities, and public and private agencies.

Manuscripts are encouraged and welcomed. Contributors are asked to limit their papers to approximately 2000 words. Research reports, theoretical papers, discussions of issues, and description of practices are acceptable. Two double-spaced typed copies of your paper are requested. Five free copies will be sent to the author or senior author of an article. Duplication of an article is permitted if publication in Volunteer Administration is noted.

INTERDISCIPLINARY WORK AND TRAINING IN THE MENTAL HEALTH FIELD

An Approach to the Problem of Manpower

Jacob Christ *

The general need for manpower, both trained and untrained, in the field of mental health has been recognized for some time. While greatly enlarged funds have been allocated to a good many mental health settings in the last few years, the cry of "not enough" is still heard widely, and even in places where funds are available. At times there are no takers. The common picture of the overworked and understaffed clinic or hospital is still very much with us and in spite of considerable progress the problem of manpower is a day-to-day reality for most professionals, and for many patients. The "helpers" have to restrict intake of patients and most painfully patients find themselves denied treatment, because "there is no one available right now". So-called waiting lists are frequently established even when there is no reasonable expectation that something will be forthcoming soon. The challenge is there to meet, at least partially, the mental health needs of a community or an area. I would like to focus on two particular avenues with which I am familiar from experience in an outpatient clinic setting. They are (1) ability to work in an interdisciplinary setting and (2) wide application of in-service training of semi-trained or untrained people.

Beginning with the first issue, the interdisciplinary nature of mental health work, we may wonder why this particular field, mental health, has not done as most other scientific endeavors have, namely specialized into numerous smaller fields. In other disciplines of medicine and in engineering, for example, a refined division of labor has taken place. Yet in the mental health field a clear-cut definition of boundary lines is missing and therefore confusion as to "who does what" is rather common. While it is perhaps not desirable to have concise boundaries in the field of mental health, interdisciplinary tasks have their problems precisely because people cannot stay only within their own areas of competence. It is, colloquially speaking, impossible for people to "mind their own business", and they must in some way or another, overstep the boundary lines of their professional skills, if not by action, at least by understanding of what the other person is about to do.

But how did mental health work come to be an interdisciplinary task? Does it perhaps lie in the nature of the work that mental health work is different from medicine? If I have a bellyache and a physician decides that my appendix has to come out, the matter is a fairly clear-cut one. I'll go to a hospital and sooner or later a well-qualified doctor or a surgeon will remove my appendix and that will be that. The lines are clearly drawn and the referral process is a simple and by and large, non-controversial one. It may be added that most patients will make allowances for the "master" surgeon to have trainees who will eventually follow the master. Provided the doctor and the hospital inspire confidence, the trust that people put into the professional person or institution can be spread from the expert to a number of staff persons who work under his guidance. It has been accepted for a long time that in teaching institutions, one gets cared for by interns, residents or junior members of the staff and there is

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relatively little objection to extend the necessary trust from the "master" to a large number of people in a teaching or training situation. Manpower in this way is extended, simply along lines of authority by the process of teaching and training.

In psychiatric hospitals and most particularly in psychiatric outpatient facilities, the situation has been somewhat different and seems to become increasingly more different from this relatively simple medical-surgical model. It became repeatedly observable, particularly in institutions where psychotherapy came to take an important place in the treatment of the mentally ill, that very often a young and relatively untrained member of the staff would accomplish great things with a patient where the seniors looked on and felt that they could very likely not have accomplished anything comparable. Continuing in this line of thinking, much research in modern social psychiatry has pointed to the importance precisely of relatively low-status but stable people in an institution, i.e., some of the attendants, the kitchen personnel etc. in the course of certain types of mental illness. Particularly where milieu treatment is intended, it is important to pay attention to many more relationships than the one between doctor and patient which is so important in physical medicine and in office practice. This humiliating fact, that the expert often does not accomplish more than the novice and that sometimes the relationships with low-status personnel is more important than what the doctor may do, calls for an explanation. Why is it that in the mental health field the well trained and recognized expert is not necessarily the one who accomplishes the most?

There must be something else in mental health work which comes into play besides the technical skill or expertise. An example, perhaps, will prove the point. At one point, a 33-year old single lady came to the clinic with complaints of depression. She spoke hardly a word and it was indeed difficult both to assess where her problem was and what could possibly be done to help her. We knew from relatives that she was the youngest of a numerous family, had always lived at home and taken care of the children of her older brothers and sisters. Somehow, something had happened that made her feel worse in the last two or three months. A student was assigned to deal with the case, under supervision. The problems that ensued were considerable. The student was intensely curious and had an obvious commitment to find out what might be the matter; the patient, on the other hand, reacted to him in just as solemn, obtuse and frustrating a manner as she had done before to the clinic social worker, and before that, to her family. Clearly, these two people, the intensely curious student and the solemn, depressed patient, were on a collision course. The collision happened in the third interview and while the student barely contained his anger and frustration, the patient for the first time, was able to shed a few tears and then let the student know what really had been the matter. The story that unfolded in the remaining two or three interviews had to do with a fleeting interest that this female patient had taken in a man who worked in the same factory where she had worked for a while, and this influx of strong feelings on her had not permitted her to keep up her performance, so that she had to leave her job and was once again exposed to being exploited by her numerous family for baby-sitting. After the initial collision with the student had taken place, the patient became more open, and in subsequent interviews with someone else, was able to work out something about her feelings and more importantly, a program of rehabilitation which permitted her to go back to work. I believe in retrospect that it was necessary for this woman to be able to feel the intense interest and curiosity that a young person could bring to her problem and that she, moreover, needed to frustrate someone in retaliation for her frustrations at home before she could accept help. Clearly, something had

happened in this unsatisfactory but useful first encounter, and very likely the intensity of the young professional's involvement had something to do with the ultimate opening up and success of this person's treatment, which at first was considered to have a less than optimal chance.

Experiences such as the one described are not infrequent in teaching programs of clinics and on a rough impression, it is possible to say that easily two thirds of the patients that we have assigned to students for a relatively short period have benefited from that contact and that in very few cases, have there been undue difficulties due to the fact that an untrained person dealt with patients. We were, of course, careful in selecting those problems that would lend themselves for the kind of brief encounter that we were able to provide for the teaching situation, and we were fortunate in the consistently high caliber of trainees. Obviously, such experiences must be closely supervised by a professional, for such encounters as the one described bring about a great deal of anxiety, and anxiety requires understanding. Follow-up treatment with personnel who could be available for a longer time, had to be arranged in many instances. But as the experience with students was by and large encouraging, it became possible not only to use contacts with young professionals, but also to have lay volunteers take a part in the outpatient clinic treatment program.* If indeed it was true that people without training in any of the mental health professions could be worked in to a role in mental health, this was an opportunity to prove it, and to prove it by a proper way of building the untrained worker into the patient's functioning. Clearly, the beginning mental health worker could not fit into the role of the psychotherapist or psychoanalyst; very likely also, she could not replace a caseworker, not having had the necessary training. Therefore, we had to find a new role which an untrained worker could fill and which would lead him or her to further growth and possibly fitting in to other more demanding roles. The first such role we devised was that of the family aide where the most conspicuous function was that of visiting the family of a patient who had applied for help in the clinic. It is perhaps a commonplace to say that in listening to people's many complaints, one finds that a relatively large number are in some ways related to people's interpersonal relations. Many people express their troubles in terms of aching backs, headaches, heart beatings or a multiplicity of other physical symptoms, yet if one listens carefully, the pain most often lies somewhere in a relationship with a spouse, a child or a parent, and clarification of the disturbed relationship often helps. Our volunteer aides were in an outstanding position to look at relationships as they showed themselves in the daily lives of our patients, and by visiting them, they were able to see much more sometimes than a trained psychiatrist or caseworker might in an office setting. We had the gratifying experience that many of our patients told the volunteers that came to visit them at home, more of their secrets than they had been able to tell us in the clinic. In the case of a rather seriously sick woman who was visited by a volunteer, it became apparent just where the husband's rather casual attitude about his wife's needs fitted in and where a rather domineering, although disabled mother came to frustrate the young wife's attempts at asserting herself even more. The volunteer was able to get her into hospital care for a short time and while no great improvement could be made at the time, at least a beginning and a clarification of circumstances had taken place.

We came to see two specific issues very clearly that are related to expansion

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of manpower by way of volunteers; one was that a volunteer, like a professional, needs something of an education. It is not appropriate to have a volunteer simply carry out certain tasks, but we owe him or her an opportunity for learning. We found that a small group discussion is probably the most valuable tool in this regard. It permits not only supervision by a professional, but perhaps more importantly, exchange of views among peers. We as professionals are members of a graduating class, or in some other way relate our experiences to one another and support one another. We furthermore need to discuss particularly the emotional aspects of our professional growth with each other and do the necessary reality testing. The medical people may well remember how as students, they were affected by fears of having heart disease when heart diseases were being lectured about. I am sure in other helping professions, the prospective helper will identify himself at one time or another during his training with the patient or client he is supposed to help and will fear that he may be beset with precisely the kind of illness that he is called upon to remedy. Reality testing during professional education will show the prospective professional the difference between the client's problems and his own, and so of course, it has to be with the volunteer. Our family aides were housewives with families of their own, and they had to learn to see the differences between the problem of the families they visited and the way they themselves ran their own families. This work was done primarily in group discussions with an experienced caseworker. A similar program, of course, would be feasible with college students who might be working primarily with adolescents in the clinic and who in the process will learn to compare what they see in their clients with what they have gone through themselves in their recently past adolescence.

A second and perhaps more obvious issue that came to our attention, is that of the volunteers being included into the work of the clinic. A feeling of belonging to the setting is, I believe, a must and can be attained by attending of staff conferences or similar occasions. From the role of family aide, a volunteer may graduate after a while into a more prolonged contact with clients, participating in group functions perhaps, or undertaking the reporting of a case history, i.e. noting down the patient's complaints and bringing into focus the pertinent problems and eventually become a counsellor.

Perhaps it is possible now to reach some general conclusions about the matter of manpower and training in the mental health field. (1) The relatively simple medical model where the recognized expert is the one who by implication guides or directs all the treatment, is I believe, no longer applicable to the mental health field. It is not correct any more to consider psychologists, caseworkers, educators or counsellors as members of ancillary professions to psychiatry. They have arrived on their own and have their specific contributions to make. Psychiatrists will have to live with that. Vice-versa, the so-called psychiatric outpatient clinic need not limit itself to what seem like purely psychiatric diseases, but may do well to consider problems of disturbed human relations in one form or another, such as marital problems or problems between parents and adolescents as legitimately within their province. More comprehensive outpatient services will be the result. (2) The effectiveness of a given setting is not necessarily commensurate with the technical ability of the staff, but in many instances has to do with the possibility of providing a meaningful and pertinent human relationship, short or long, which will in some way "make a difference" for the patient. It becomes important then, not only to have technical skills, but also to provide a number of possibilities where something significant may happen. The meaningful contact may indeed be with the psychiatrist, it may be in a therapeutic group, it may be in a family setting, on a visit at home, or in

any other contact which may come about through the clinic. A main focus of work in the mental hygiene clinic will then become the correct assessment of the patient's personal or interpersonal needs in the intake situation. (3) Ongoing training, perhaps in-service training of all staff and volunteers, become something of a way of life in a mental health facility. A supportable and livable milieu is created where there is openness to continued adaptation and new learning on the part of the staff who is daily confronted with new and different problems. (4) A common focus appears for the disciplines sharing in mental health work, a focus sometimes evident, sometimes elusive, but available to experts and novices alike given the opportunity: the meaningful human relationship. It is a task for community mental health workers to organize settings where such relationships can come about and where increasing understanding for their meaning can be aimed for.

RESEARCH NEEDS IN VOLUNTEER ACTIVITY

John Tringo*

This country has a long history of volunteer activity. Initially, of course, there was no choice. Banding together for a common cause or volunteering to help others was more of a cooperative necessity than an altruistic gesture. Each volunteer could foresee the possibility, or even probability, that he might require the same services he was providing to others. As the country grew and diversified, this reciprocal and simple relationship ceased to exist. Many of the functions that were handled by volunteers were turned over to employees of local and state governments. The federal government at that time provided little in the way of social services and volunteer activity was generally directed at helping people who were "less fortunate". Volunteer groups were organized and directed by crusaders who became aroused by social conditions or the neglect and mistreatment of specific groups of people. Many of these groups prospered from public support, hired employees, developed as a profession, and lost many of their characteristics as a volunteer organization. At the same time, the federal government began to take an increasing role in the prevention and treatment of social problems - at least in part due to the pressure brought by volunteer organizations. The result today is a proliferation of funds and profes sional services by both government and private agencies. Unfortunately, it is still not enough. More money is needed, but more important, more people are needed to do the work. There are not enough trained professionals to do the job alone; it may be that there will never be enough. The use of volunteers to fill the gap appears to be an ideal solution. However, we can no longer afford a haphazard and poorly organized approach to volunteer activity. There is an almost complete lack of research in this area. Without an adequate background of research, it is extremely difficult to select and utilize volunteers for the maximum benefit of the client, the professional worker, and the volunteer himself

The disciplines of psychology, sociology, and social psychology can be most fruitfully applied to research in volunteer activity. Sociology would be concerned with volunteers as a group, their characteristic structure and role in society, and their impact on the organizations with which they interact. Psychological research is more concerned with the individual characteristics and behavior of the members of a group. Social psychology, of course, has some attributes of both psychology and sociology. This paper describes some of the research that has been done and discusses areas where research is needed on volunteers. The approach is primarily psychological and social psychological. The sociological approach would suggest a different set of problems and methods and will not be dealt with in this paper.

The research needs are divided into eight categories, or problem areas. The categories are listed below and will be discussed separately in the following sections of this paper.

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1. Survey of need for volunteers - A survey must be made to estimate the number of volunteers that could be used, the rate at which they could be trained and absorbed, and the types of jobs they could do.

2. Usefulness of volunteers - People now serving as volunteers can be studied to determine how much they contribute to the organization they are serving. Possible detrimental effects of volunteers should also be investigated.

3. Characteristics of volunteers - Descriptive studies on volunteers and comparative studies with non-volunteers should provide data on intelligence, aptitude, and personality of volunteers.

4. Utilization of volunteers - Studies should be made to determine how volunteers are now being used. Experiments could be devised to investigate the optimal use of volunteers and program assessment techniques developed.

5. Motivation of volunteers - An intensive study of why people volunteer and how they became involved in volunteer activity should suggest where to look for volunteers and methods to increase the number of volunteers.

6. Role of the Volunteer - The status of the volunteer in the community and in the organization he serves should be studied together with the factors that influence this relationship.

7. Qualifications of volunteers - An analysis of jobs available as well as those filled by volunteers should be undertaken to determine job levels and qualifications required of volunteers for each level.

8. Prediction - The background data gathered in the seven areas listed above can be combined to make predictions that can be experimentally verified. When this stage is reached, selection and utilization of volunteers can be made on a scientific basis.

Survey of Need for Volunteers

The most basic research step is to determine the nature and extent of the problem. There is no question that a need for services exists; the question is whether this need can be met by volunteers. Volunteer activity can be divided into two distinct types: direct and indirect. Direct volunteer activity is concerned with a service performed for the patient or client and usually requires close interaction between the volunteer, the professional, and the patient. Examples of the direct type of volunteer are Gray Ladies and Candy-stripers. The indirect type of volunteer may never even see the people he is serving. This type of volunteer may be raising money or performing a service such as typing reports at home for a charitable organization. These two types of volunteer activity should be kept separate. The need for volunteers and the characteristics of volunteers required for direct activity differ greatly from those required for indirect activity. This last statement should be verified by comparisons of volunteers now engaged in each type of activity.

The general feeling that an overall need exists must be translated into specific needs for specific groups. A survey could be made of a number of representative organizations and their volunteer needs categorized. This survey could be used as a basis for extrapolating the number and types of volunteers

needed across the country. A second step would be to determine the amount of training required for the various types of volunteers and the rate at which the organizations could train and absorb these volunteers.

Another aspect of this problem is the number of potential volunteers available in society. Just as no one can say what the total need for volunteers is, no one can predict the nature and number of available volunteers. The comparison of the demand for volunteers with the supply has many practical consequences. If the potential supply is plentiful, standards for volunteers could be high and organizations selective. If the demand exceeded the supply, organizations would tend to compete for volunteers and many volunteer jobs would have to be re-structured to permit the use of volunteers with marginal qualifications. If a survey showed a high demand and a low supply of volunteers at a specific level, research could describe the volunteer that has performed best at that level and indicate where that individual would most likely be found and the type of recruiting program likely to motivate him to volunteer. Three factors would suggest, however, that there is a plentiful supply of potential volunteers. The factors are automation, increased leisure time, and early retirement. Automation has resulted in less job satisfaction and frustrated personal needs for achievement which could be directed towards volunteer work. Increased leisure time and early retirement provide an opportunity to do useful and meaningful work that is therapeutic to the volunteer as well as to the patien As Stein (1967) states, the volunteers are "overcoming feelings of emptiness and depression experienced in everyday living." This topic will be discussed further under motivation of volunteers.

Usefulness of Volunteers

The usefulness of volunteers, at least in some situations, is still an open question. Often there is some hostility expressed by members of the professional staff (Stein, 1967) towards volunteers. The professional or paid employee may feel that the volunteer is "interfering" in the treatment of the patient. At least part of this hostility may be traced to the ambiguous role of the volunteer in a highly structured setting such as a hospital. The employee knows where he and every other employee stands in the pecking order and he may resent the presence of the volunteer outside this structure. This is more a matter of communication and utilization of volunteers than their actual usefulnes but it can influence our evaluation of their usefulness if we rely entirely on assessments of volunteers by staff members. A more direct measure of usefulness would be the accomplishments of similar organizations with and without the aid of volunteers. The same organization could also be evaluated before and after the introduction of volunteers.

Three criteria that may be used to assess usefulness are:

1. Benefit to the patient or client - The patient's progress, recovery, and outlook may be compared with and without the direct aid of volunteers.

2. Benefit to the organization - The value of the volunteer to the organization may be measured in savings of time, money; or an increase in production.

3. Benefit to the volunteer - The physical and mental condition of the volunteer before, during, and after his volunteer service may be compared.

It is also necessary to determine the relative usefulness of volunteers in different types of organizations. The two primary types of volunteer activity were mentioned earlier - direct and indirect. In addition, a distinction should be made between organizations that function independently and are completely made up of volunteers; and organizations that utilize volunteers in certain jobs within a regular structure of employees.

Characteristics of Volunteers

Probably the most straight-forward studies can be done in the area of descriptive and comparative characteristics of volunteers and non-volunteers. There are literally hundreds of standardized psychological tests available that may be used for this purpose. It is surprising that so very few studies have been made in this area. There are several possible reasons for this. It may be that volunteers are considered to be no different than non-volunteers and merely represent a random sample of the population. This, in itself, would be an interesting and valuable finding, if true. However, available research seems to indicate that it is not true. L'Abate, (1967) in a study of volunteer housewives and candy-stripers, found a greater degree of intelligence, emotional stability, and cooperative functioning in these volunteers. MMPI results indicated "a lower degree of submissiveness and a higher degree of activity in volunteers than the controls." Several psychological studies concerned with people who volunteer for experiments seem to substantiate this finding of a difference between volunteers and non-volunteers. Maslow and Sakoda (1952) in a study on volunteer-error in the Kinsey study found that volunteers for a sex study were high in levels of self-esteem. Riggs and Kaess (1955) found that students who volunteered for an experiment as subjects showed more introversive thinking and tended toward a moody cycloid emotionality. On projective tests, the volunteers scored higher on intrapunitive measures and lower on extrapunitive measures. These findings may not be applicable to all types of volunteer activity, but they seem quite consistent with one another. The finding of high ability and self-esteem coupled with low-submissiveness indicate that volunteers may not be used to the full level of their ability and may also be a reason for some of the friction between volunteers and employees. A low extra-punitive score would be an asset for volunteers who deal directly with patients. These findings, however, may not hold up when we start tapping a larger segment of potential volunteers. There is a strong self-selection factor since there is little external pressure to volunteer and most volunteers are thus self-motivated. This will be discussed further in the section on motivation of volunteers. A finding of general superiority is not an unmixed blessing. There are many menial but necessary jobs that could be done better by volunteers with less ability. There are also many volunteer activities where empathy or interest is far more important than ability.

Utilization of Volunteers

Volunteers have been used for everything from guinea pigs to professional workers. At either extreme, the utilization of the volunteer is not a problem. The volunteer for a short-term experiment is simply an anonymous, random, and interchangeable sample and is useable in whatever form he comes. The professionally -trained volunteer is used in his professional capacity. The problem lies in the great majority of volunteers who lie between these two extremes and

come armed with only a willingness to work and a varied history of employment. These volunteers must be utilized effectively so they can make a maximum contribution to the organization and achieve a measure of self-satisfaction that will motivate them to stay on the job.

A study should first be made to determine how volunteers are now being used and to categorize the types of jobs they fill. This can be compared with the survey of the need for volunteers that was mentioned earlier. The characteristics of these volunteers can be compared with the requirements for the job they are filling to determine if they are being fully utilized. Experiments could then be devised to determine the optimal volunteer characteristics for each job type.

The study of volunteer utilization should include program assessment and the evaluation of the volunteer training program. Program assessment is very difficult if the program is not composed entirely of volunteers since it amounts to an evaluation of the entire program and its professional staff. This portion of the study is not concerned with how well the volunteers are performing, but with how well they are being utilized in the overall program. The volunteer training program is probably a critical indicator in the utilization of volunteers. If a volunteer training program exists, then the job of the volunteer must be somewhat defined and some thought given to the skills and orientation required by the volunteer. Beyond this, the program may vary from a half-hour lecture to a condensed professional training course.

Motivation of Volunteers

Volunteers, by definition, are motivated; but they are not all motivated alike. Indeed, motivation is so complex that a single volunteer has many motives - not all of them conscious and recognizable by himself or others. Nevertheless, there may be common motivational factors among volunteers. If these could be identified, the question of why people volunteer would be answered and could be used to influence more people to volunteer. Both depth psychology and surveys should be used to investigate the motives of volunteers. The depth psychology study may be used to identify the unconscious motivation of volunteers while the survey will identify the verbalized motivation of the volunteers. The survey should also note the conditions under which the person volunteered. Only a person with extreme motivation or some need for self-actualization will volunteer on his own initiative. Most volunteers are probably recruited or respond to an appeal for volunteers. If this is true, more people would volunteer if more people were simply asked. While it may be true that the unconscious motives are stronger, they are also more difficult to reach and control. The law of parsimony would suggest that volunteers be reached through their claimed motivations unless that proves inadequate.

Bair and Gallagher (1960), in a study on volunteering for extra-hazardous duty by cadets, found that they could influence the amount of volunteering by manipulating conditions. Subjects were requested to volunteer under both public and private conditions. Blake et al (1956) also requested subjects to volunteer under public or private conditions and found a difference in favor of public conditions where the alternative to volunteering was less attractive than the requested action. Studies by Rosenbaum and Blake (1955) and Rosenbaum (1956) substantiate this effect of background factors which Rosenbaum relates to Helson's theory of adaptation level. In both experiments, more subjects volunteered after

seeing other subjects accept an invitation to volunteer than did the control group. Less subjects volunteered after seeing others refuse an invitation. These studies seem to suggest that either a marginal motivation level can be raised above threshold by external conditions; or that external conditions in itself can provide a force to motivate people to volunteer.

These studies were done under conditions where the subject was asked to volunteer for a short-term experiment. The results have not been confirmed for volunteers that are being asked to provide considerably more of their time and effort. Even if these people could be induced to volunteer, there is still a question of whether their motivation would be strong enough to carry them through a complete volunteer program. It doesn't do much good to just increase the number of drop-outs.

Roles of Volunteers

Volunteers have a unique role, both in society and in the organizations they serve. They may be considered as unselfish and public-spirited by their neighbors and be accorded special status. The patient may see the volunteer as a friend, the nurse may see him as a pest, and the administrator may see him as an unpaid employee. The volunteer is an ambiguous figure - he does not have the means by which we usually assign status: salary, position, or power. He does have an amount of independence that the employee does not have and this increases the difficulty of assigning the volunteer a role by our ordinary standards. It may be this lack of a consistent role that generates some antagonism from other employees and discomfort for the volunteer. This problem is intensified since volunteers are most frequently found in rigid, hierarchical organizations such as a hospital. Research should undertake to determine what role is appropriate for volunteers in different situations and attempt to communicate an understanding of that role to other employees and the volunteer. Stein (1967) found that suggestions for improvements by both hospital personnel and volunteers centered on a clearer understanding of what was expected of volunteers and a clearer role-definition. In addition to improving communication and work-relationships in the organization, a clearer role-definition may motivate more people to volunteer.

Qualifications of Volunteers

Hassol (1967) describes a situation where six hundred applications were received, the volunteers were interviewed and tested, and twelve were selected and trained to take intake case histories. After one year on the job, these volunteers left to become fully trained as professionals. This is a perfect example of the misuse of volunteers. The qualifications of volunteers can be readily determined and screening should be intense only when the demands of the job are great. All jobs should be analyzed and, if necessary, broken down into components that can be handled by the majority of volunteers available. Whenever possible, jobs should be available at several levels of difficulty requiring different abilities and personality traits so the qualifications of available volunteers can be matched to the job requirements.

Prediction of Volunteer Success

The ultimate goal of the seven areas listed and discussed above is to provide a scientific basis for further research and development in the field of volunteer activity. The division of research into the above areas is arbitrary sometimes overlapping and sometimes contradictory. None of these areas provides an answer in itself, but gathering basic background data in a number of areas is a necessary start to more precise theories and experimentation on volunteer activity. When this stage is reached, accurate predictions can be made on any aspect of volunteer activity that will aid planning and assure steady and orderly growth.

Conclusion

This paper has presented an overview of research needs in volunteer activity with some examples of preliminary studies that are related to this area Research on volunteers from a psychological frame of reference is practically non-existent. Research needs have been categorized into problem areas that are amenable to solution by standard psychological techniques. Sociological techniques could also be directed to the study of volunteer activity from a different frame of reference. It is suggested that a background of research is essential if volunteer activity is to increase and if volunteers are to be effectively utilized.

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THE VOLUNTEER'S CONTRIBUTION TO THE MENTAL HEALTH OF THE GERIATRIC PATIENT *

Irene Mackintosh Hulicka **

Volunteer workers perform invaluable and deeply appreciated services in hospital wards designed for the long-term care of severely disabled elderly patients. Volunteers visit with the patients, shop for them, write their letters, read to them, play cards with them, bring them news of the outside world, and in general, contribute appreciably to adding meaning to their present existence. If the volunteers did not know that they make a significant contribution, they would not give of their time so freely. If the hospital staff did not value the work of the volunteers, their services would not be solicited. And if the patients did not benefit from their associations with the volunteers, they would find ways to terminate the relationship. Since all concerned are well aware of the importance of the volunteers' contributions it is unnecessary to enumerate reasons for valuing their services so highly.

However, excellent as the work of the volunteers with geriatric patients is, both the staff members and the volunteers themselves realize that, in some cases, the effectiveness of the work could be improved. Volunteers point out that they are handicapped by lack of knowledge about the psychologic problems of being old and disabled. They ask for information and guidance about techniques to increase effectiveness of their work. Among questions asked by volunteers about elderly patients are the following: What are their special emotional needs? What do they like to talk about? What topics should be avoided? How does one go about initiating a relationship? What are the goals that one should be attempting to achieve? This paper is an attempt to provide some background information to guide volunteers in their work with elderly and severely disabled patients.

Patients' Problems

The majority of geriatric patients are facing problems of great magnitude which they are ill equipped to handle. Perhaps unfortunately, basic emotional needs do not disappear with age, physical disabilities and hospitalization. Elderly people, like all other human beings, have the need or desire for affection, belonging, achievement, recognition, independence, hope and particularly for self-esteem. Although the needs do not disappear the opportunities for their gratification do diminish considerably. Almost all of the disabled and hospitalized aged are confronted with new barriers in their attempts to satisfy their

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emotional needs, although the type of barrier and its flexibility may vary from person to person. Consider the lot of the geriatric patient. The majority of them are severely ill or chronically disabled. Many realistically assume that they will have to spend the rest of their days in an institution. Hospitalization is usually precipitated by severe physical insult, and is often accompanied by real or perceived rejection by the family or perhaps by the death or illness of the spouse or family member who has been caring for the patient. Thus, institutionalization is usually accompanied by a strong sense of loss--loss of physical prowess, family, associates, familiar routines, and not infrequently loss of hope. Often it is extremely difficult for the patient who has passed the acute phase of his illness, but definitely requires long term care, to adjust to institutional living. Even hospital uniforms and the minimization of personal belongings deprive the individual of status symbols, remove him from potential sources of activity and comfort, and contribute to a sense of depersonalization. Some patients find it very difficult to adjust to ward life and the consequent lack of privacy. Habits of long duration have to be modified and oldsters are not noted for their flexibility. There are schedules for appointments, meals, baths, and sometimes even toileting. Sometimes an elderly person who functioned adequately in his previous environment, where long established habits served him well, has difficulty in learning what is expected of him in a new environment, and consequently acts in a confused manner. The radical changes and the difficulty which he has in adjusting to the changes may have a detrimental effect on the patient's self-esteem.

Few of the elderly patients do not have major barriers which drastically limit their available activities. Many of them are in severe pain. A goodly percentage spend all or almost all of their working hours sitting in a wheel chair (how often one hears the complaint, "It isn't easy to sit in a wheel chair for 14 hours at a stretch!") Most of them are unable to indulge in activities which they might enjoy because of physical weakness, paralysis, aphasia, impaired vision or hearing, or for other physical reasons. They might like to visit with others, but they cannot hear or perhaps cannot talk. They might like to read, or watch television, but they cannot see. They might like to make things but do not have the use of their hands. They might like to go outside to enjoy the fresh air, the fragrance of the flowers, and the sound of the birds, but they are dependent on someone to wheel their chair. One patient said with wry humor combined with pathos, "I even have to get some one else to scratch my nose."

Many of the elderly patients are so preoccupied with their own problems that they are unable to take the initiative to socialize with fellow patients. Sometimes when they are transferred to a geriatric ward they are so overwhelmed by the superficial impression of deterioration that they withdraw into themselves, and pass up the opportunity to learn that among their co-patients are many people whose companionship they could enjoy. Sometimes they do make friendly overtures but feel rebuffed because the recipient of the overture happens to be deaf, or speechless, or in a vile mood.

These are people who have lived, loved, dreamed, planned, worked, grieved, sacrificed, succeeded and failed. They are sons, husbands, and fathers (or daughters, wives and mothers), many of whom have gradually lost most of their loved ones. Some, it is true, have regular visits from their families, and at most, a person who was once the head of the household, the breadwinner or homemaker, a wanted member of a family group, may enjoy in a diluted form the pleasures of family life. Many of the elderly patients are not so fortunate. Their loved ones may be dead, or far away, or worse still, may not care. Some

of them live in pain and face death with the realization that there is not one person who loves them or who wants their affection. An unhappy, disillusioned, apathetic, poorly motivated patient, resigned to his present fate because he perceives neither reason for nor hope of improving is ill equipped to surmount or circumvent the combination of physical, emotional, social and economic barriers which limit his opportunities for leading a meaningful and purposeful life. Some of the elderly marshal their energy to make valiant and constructive attempts to gratify their personal needs. Of these, some achieve partial success. For others, repeated efforts are met with failure and gradually they cease to try. Instead they may grudgingly accept the status quo, complain bitterly, withdraw, indulge in socially non-acceptable behavior, or act in a variety of ways which tend to further limit their opportunities for the gratification of emotional needs.

Many of the disabled and hospitalized elderly are in desperate need of help to break the barriers which limit their every attempt to find meaning and comfort in their present existence. Hospital staffs, fully cognizant of the magnitude of the problems of the chronically disabled elderly patient, make concentrated efforts to help them meet not only their physical, but also their emotional and social needs. Volumes could be written about the programs, the unique techniques, and the individualized care provided for the geriatric patients by dedicated staffs. However, ingenious, diligent and well meaning as staff members may be, they realize that they cannot, and never will be able to render all of the assistance necessary to help all of the elderly patients achieve even minimum gratification of the most pervasive emotional needs. Volunteers can and do make significant contributions to the mental health of elderly patients by adding to and supplementing the efforts of the staff. Moreover, volunteers may by virtue of their different positions and orientations accomplish what staff members cannot.

Hospital Problems

Hospitals have traditionally been designed to provide physical care. It is natural that in a hospital setting, the activities of the patients should be centered around bodily functioning. Although each staff member does much more than to provide services and therapy designed to improve or preserve functions most staff members are so busy performing the necessary services of diagnosing, treating, bandaging, exercising, feeding, and bathing, that it is easy to forget that the ulcerated stomach, paralyzed arm, broken hip, cancerous throat or untrained bowels belong to a whole person who has all the needs common to humanity. The biologic segmental orientation makes it more difficult to regard the person as a living, thinking, feeling human being. Because a patient's perception of himself is influenced by his perception of the reactions of others to him, a biologic orientation on the part of those who care for him, may reinforce his concept of himself as an aching and infirm body rather than as an individual with personal goals. Hence the exclamation by a patient, "I feel like an object--like a piece of furniture!" When this happens the patient's own aspirations cease to function adequately as the crucial fuel for the rehabilitation process. Volunteers can provide an excellent antidote for the patient's biologic perception of himself. By perceiving and dealing with the patient as a whole person, albeit a person with aches and pains, but also as a person who thinks, feels, and dislikes, a person with a past, present and future, a person with strengths and weaknesses, joys and sorrows, a person with unique capabilities and interests,

the volunteer may appreciably affect the patient's attitude toward himself.

Many patients have no social life apart from the hospital and within the patient group some are relatively isolated because of their inability to initiate relationships, behavior which other patients find objectionable, of physical limitations such as deafness or being unable to speak. To many a visit from a volunteer is a major event because the patient is able to feel that the volunteer comes because he or she will enjoy the visit rather than because professional duties require the contact. Patients appreciate someone who will take time to share their thoughts, feelings and experiences, and who does not terminate the visit after a perfunctory "Hello. How are you?" Moreover, volunteers serve as "Windows to the outside world" for the patients.

When measured by the standard of the young and healthy, the accomplishments of most disabled elderly patients appear to be rather insignificant. Physical and intellectual impairment, combined in many cases with lack of motivation, stringently limit their accomplishments. Moreover, what they do achieve, such as being able to assume more responsibility for feeding or dressing themselves, or being able to walk a little farther, is likely to be judged by them in terms of their pre-disability standards of performance. Hence, an outstanding accomplishment in terms of present limitations may be judged by the patient to be substandard. Because of his limited accomplishments, he may receive relatively little recognition and praise from others. Too often, the commendable efforts which the patient makes, perhaps with no small effort on his part, are overlooked, while negative features of his behavior are brought to his attention. Volunteers make a major contribution to the well-being of the elderly patient by seizing every opportunity to notice and praise him for accomplishments, his efforts, his kindness to others, his knowledge about some specific topic, his good grooming, his persistence in spite of overwhelming obstacles, his smile in spite of pain, and the many other praise worthy characteristics which might otherwise receive no comment.

Many of the disabled aged make statements such as "I wish they would give me shot of something--then no pain, no worries, no suffering". Why do so many of the elderly patients express a longing for death? Perhaps the question should be phrased differently. What do they have to live for? If a group of young and healthy individuals were asked to tell what makes life meaningful for them some of the following responses would be frequent: a good marriage, pleasure from children, family and friends, a challenging job, a nice home, books, music, and other cultural features, the acquisition of property, the right to govern one's own life to a certain extent, and particularly, the hope for better things to come. How many of these are available to most elderly and chronically disabled patients? Human beings have a marvelous capacity for enduring hardships in the present, if they can hope for improvement in the future. The present life of the majority of the disabled aged is besought with hardships some of which the young and the healthy cannot even realize. Worse still, many of them when they are awakened in the morning, realize that today they have nothing to look forward to--that today can be expected to be as bleak, painful, long and lonesome as yesterday and the day before, and that tomorrow and all the tomorrows can be expected to bring, instead of relief and pleasure, only progressive impairment.

However, many elderly patients who would otherwise indulge in little happy anticipation, do, because of the volunteers, have something which they await with pleasure. Patients look forward to a visit with a favorite volunteer, to playing rummy with her, or teaching her to play cribbage, to the unusual stamp she might bring, or the postcard she might send, to sitting in the sunshine when she takes him to the patio, to showing her a picture of his grandchild, to her pleasure when he demonstrates that he can light his own cigarette, or her delight when he gives her the bookends which he made with so much effort. These are little things--trivial perhaps from our more fortunate positions. But a crust of bread to a starving man is highly appreciated. Moreover, the ingredients of pleasure, happiness and contentment are usually a number of small events rather than one major item.

A major need of all human beings is for self-esteem. Elderly patients who are rejected, useless, unloved and unwanted are often sadly lacking in this important source of contentment. Volunteers add to the self-esteem of patients by accepting them and liking them as they are, by commenting on their good qualities and overlooking their faults, by treating them as interesting and interested individuals, fully worthy of the respect of others, and hence of their own self respect.

The importance of stressing the positive and overlooking the negative can be illustrated by an actual case. As a result of taking a corner too fast a 50-year old man was severely crippled for the rest of his life. Eight years later, he still lay in a virtually helpless state in a hospital. His wife, who was much younger than he, was not strong enough to stand by him in adversity, and deprived him of her love, his child, and his faith in the goodness of others. He had been brought up in an orphanage, and had had no close ties with people other than his immediate family. Acquaintances who visited him occasionally at first soon forgot about him. No matter how competent the staff were, they could not always attend to all of his physical needs instantaneously. When he had to wait for a few minutes to be turned over, it seemed to him like hours. When his food was put in his mouth at a rate different from what he wanted it, he became angry. Periodically, an accumulation of such unavoidable irritations resulted in a furious temper tantrum. Was a temper tantrum unreasonable under the circumstances? He had no one who loved him or who would accept his affection but staff members. There was no group of which he was a wanted member. Because he could achieve little that was obvious to others, he got little recognition and praise. He had virtually no independence because of his physical debilitation. He had no hopes for improvement of his physical or personal status. Because his other emotional needs were being gratified so poorly, he had little self-esteem. It is small wonder that his temper got the better of him at times. The hospital staff, well aware of the magnitude of problems, arranged for him to be visited regularly by a volunteer companionship therapist.

The volunteer had the best intentions in the world, but unfortunately, good intentions alone did not help the patient's emotional wellbeing. She tried to shame him out of his tempers. She told him that he was a worthless sinner, that he ought to be overcome with gratitude for the care he was receiving, and that if he didn't like it in the hospital he ought to leave, though she knew he had no money to pay for services elsewhere. In short, she beat the

patient down and added to his problems. Finally the patient requested that he no longer be subjected to her lectures. What could she have done differently? She could have accepted the fact that he had reason to feel despondent and annoyed at times. Rather than blaming him she could have helped him to develop techniques to avoid having tantrums. She could have stressed his many admirable qualities--for example, he was always able to see and present fairly both sides of a story; he seldom complained about his difficulties; he was genuinely concerned about the welfare of others; most of the time, he attempted to be considerate of the staff and after a tantrum he always apologized. She could have let him feel that she was privileged to know a person who was facing up to such adversity with equanimity and courage. Instead of building him up, and accepting him as he was, she downgraded him, humiliated him, and added to his problems.

Examples of Excellent Work

Fortunately examples of the excellent work volunteers do with patients are much more common. A 65-year-old patient had become a quadraplegic 10 years previously. He had apparently never been a warm loving individual and had almost no company. His wife was in a mental hospital, and his three sons who lived in the vicinity were completely disinterested in him. He had, however, one daughter who visited him briefly about once a month. Then she married, and although she lived close to the hospital, stopped visiting her father. After her visits ceased, it was noticed that the patient became increasingly withdrawn and hostile. He spoke to staff members only to make rude demands for services. Most of the time he lay motionless as a corpse with a sheet drawn over his face. He was obviously unhappy and lonesome, but he literally drove away staff members who tried to approach him with personal kindness.

A volunteer was asked to help. He was warned that a warm or interested reception was unlikely. One lead was given to him about how he might establish a relationship. Prior to the patient's severe withdrawal, one of the few things in which he had demonstrated a positive interest was stamp collecting. At the appointed time, the volunteer arrived armed with a few stamps and a magnifying glass. He used the stamps as a legitimate reason for the visit and had a conversation about stamps underway before the patient had an opportunity to say "Go away and leave me alone". From the stamps, the conversation moved naturally to the patient's daughter who used to help her father with the collection, and from there to a discussion of what the city was like thirty years ago. The charge nurse was incredulous when she realized that the volunteer had not only spent an hour in comfortable discussion with the patient, but that he had also been invited to come again.

What did this volunteer do that was so different from the volunteer in the previous example? Most important, he accepted the patient, just as he was, as an individual worthy of his respect, attention and interest. Rather than lecturing the patient about his withdrawal and rudeness, he treated him in such a manner that rudeness and withdrawal were unlikely to occur. He arranged for a legitimate reason to visit the patient, and hence did not appear to be snooping or invading his privacy. He let the conversation center around topics of interest to the patient so that he could contribute his knowledge and experience. From the volunteer's point of view, the needs of the patient were primary.

What the second volunteer did touches on one of the problems which volunteers may face with reference to their initial contacts with patients. How does one start? How does one ordinarily initiate social relationships? If one were to walk up to a man on the street and gush "How do you do? I am Mrs. B. Where do you come from? How many children do you have? What kind of work do you do?", the victim would probably consider the interrogator either down right nosy or somewhat peculiar. But what about patients in the hospitals? Are they so different from the man in the street apart from the fact that they are ill or physically debilitated? Sometimes it might be well to think back to the days of one's youth when it seemed important to meet some "fascinating" individual. How did one go about it? Probably one used a combination of techniques such as finding out what interested the other person, manufacturing a plausible excuse to contact him, arranging for an introduction, etc. And eventually, once one met the sought after person, one tried to hold his interest, to make him feel good so that he would want to continue the relationship. Volunteers might be advised to use some of their time tested techniques in initiating relationships with patients.

Use the Right Approach!

Sometimes people seem to talk at or about rather than with patients. Instead of using the natural voice which is used in other situations, some people in talking to patients and small children adopt a sugary, cooing voice. There is not much that a small child can reply to the shrill "coochy coochy coo" approach inflicted on it by some adults. The same applies to elderly patients. But patients can respond to questions which show awareness that they are unique individuals, topics of mutual interest, awareness of problems, etc. Some people apparently consider it therapeutic to disregard a patient's remarks about how badly he feels. An 84-year old patient commented. "There is a lady who comes around every morning and says 'Good morning, Mr. R., how are you today' and I say, 'Well I'm as good as can be expected but my hip aches and my left shoulder is awful sore and I've got a bad cough' and then she says 'Oh, now, that's all in your imagination. You are looking fine. Come on now, let's think about something bright and cheery'. It's all very well for her to say it's in my imagination" he said, "But that doesn't make the pain go away." Not only did her dismissing remark not make the pain go away; it also gave the impression that she didn't think the patient was capable of knowing how he felt, or that how he felt was completely unimportant to her, in which case she should not have asked. The life of the patient is not easy. Each patient is suffering either physically or emotionally, or both. Whereas no one would recommend that the patient be subjected to unsolicited gushing sympathy, on the other hand it does not seem kind when he brings up his problems to dismiss them as imaginary or unimportant.

One rather frequently hears the comment that elderly patients are just like a bunch of children. Certainly, some of the patients do sometimes indulge in childlike behavior--tempers, weeping, bragging, demanding, withdrawal, etc. The important point is to consider why this kind of behavior occurs and what can be done to make it unnecessary. When a patient manifests behavior similar to some of the behavior of kindergarten children, we can be sure that he has some emotional needs which are not being met. He may have tried more acceptable approaches to meet his needs without success. The regressive behavior of a misbehaving child is merely an attempt on his part to meet his needs. To content ourselves with the comment "They are just like a bunch of children" does nothing construc-

tive to remedy the situation. On the other hand, concentrated efforts to help the patient meet his emotional needs will probably result in a considerable reduction in the manifestations of regressive behavior.

Moreover, if we treat a patient like a child, we may be thwarting his attempts to satisfy his needs, lowering his self-esteem and encouraging the regressive type of behavior which is considered undesirable. Elderly patients are not children. Unlike children, they do not have a glorious future to anticipate. They are not surrounded by the love and tenderness which is accorded to most children in our culture. They are formerly independent persons who until a physical disability struck them down were handling their own affairs with a reasonable degree of competency.

How much is taken away from them when they are treated like children? They have already lost much because of their physical dependence. A child can accept being fed, clothed, dressed and toileted because he has never done these things for himself. For adult patients who have formerly been independent and who have taken responsibility for others, physical dependence may be a bitter pill. Need we add to their problems by treating them as somewhat wayward children instead of as mature and respected adults? Incidentally, one wonders whether addressing elderly patients by their first names on the basis of casual contacts might not be reinforcing their inferior and dependency status.

Some people in a commendable attempt to identify with the patient tend to use the word "we" as it is sometimes used in addressing toddlers. "We have been trying so hard to walk", said a volunteer of a patient whom she was wheeling back to the ward, "and we've really been working on our temper. Nurse tells me we haven't had an outburst for over a week," she added. Subsequently the patient confided that he would like to correct the volunteer's statement: it was he who had been practicing walking so diligently; as far as he knew she was able to walk without much effort. A very attractive volunteer bent cosily over an elderly gentleman and confided, "We've had a good shave, and a wonderful time in O.T., and now we are going to bed"! Either she didn't mean to keep her word, or she intended to violate the mores of the hospital.

Volunteers can and do make significant contributions to the emotional well being of disabled elderly patients. By treating the elderly patient as an unique individual fully worthy of the respect of others and hence of his own self-respect, and by seizing every opportunity to help him satisfy his need for affection, belonging, achievement, recognition, independence, hope and self-esteem, the volunteer may be able to add immeasurably to the emotional comfort of people who sorely need such help.

A CONCEPT OF MANAGEMENT DEVELOPMENT

Part 1: General Statement*

It is a common mistake in organizations and institutions to assume that after a plan has been developed, a procedure determined upon and people selected to carry it out, a satisfactory result automatically follows. With this goes the idea that the process, having produced a satisfactory result, will continue to do so. Like everything else this is subject to constant change. There are always better plans, improved methods, more modern equipment and more adaptable materials to be used. Outside of this there are the constantly changing political factors and public reactions.

The people in the organization change. Some develop and show unexpected capacity and others the reverse. People, equipment and ideas depreciate and become obsolete and must be replaced or brought up-to-date. The public, on whom the organization depends for its support, changes. Whatever the problem and the situations that exist today, they will be different tomorrow or will change over any given period of time. The serious problem has an unexpected answer or circumstances alter it so it becomes a minor one. The minor problem suddenly becomes serious.

Nothing is fixed. Any tabulation of these influences shows very pointedly the necessity for flexibility in executive and management work.

It is common practice to set up schedules and rules, make charts, detail and fix methods and to determine and set procedures. This is one of the first steps in good management because it records the best practice, contributes to standardization at a high level and eliminates scrambling around for answers to routine matters. The great danger is a belief in their finality and permanence and the resulting feeling of accomplishment and security.

However, none of this is the final answer. It is only the answer today to a temporary group of conditions. Its value depends upon how easily and rapidly it is adjusted to changed conditions and necessary improvements.

This is just as true but not so readily recognized with respect to the human side of the organization. The specific abilities of people change because of their inherent qualities of adaptability and development, through the process of experience and also because of their health, age and other conditions.

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* First of a series in three parts. The remaining parts will appear in the next two issues of Volunteer Administration. Reprinted from "Effecting Excellence in Management Practice in Vocational Rehabilitation," a project of the Management Center, College of St. Thomas, St. Paul, Minnesota supported by a grant from the Vocational Rehabilitation Administration, Washington, D. C. Howard P. Mold: Project Director. January, 1966.

Not only does the ability of the human unit change but also its relationship to every other human unit in the organization because of the change. So, the individual is variable not only within himself but in his relations to every other individual. These changes take place faster and more markedly than most people realize and alter the combinations of abilities as they have been set up for meeting the requirements of the organization. As a result, the organizing of an institution or organization is a continuous process and the human structure must be rearranged and adjusted to meet the changing interrelationship of relative abilities and their application to the various functions of the operation.

LETTERS TO THE EDITOR

Just a note of congratulations on the publication of your new Journal.... I look forward to future issues of the Journal.

Lawrence B. Feinberg, Ph.D.
Assistant Professor, Rehabilitation
Counselor Training Program
Syracuse University
Syracuse, New York

* *

Thank you so much for Volume I, Number I, of Volunteer Administration--and congratulations!....It is a much needed addition to our family of journals, and is the best way I can think of giving real recognition to the valuable contributions of volunteer workers.

Robert L. Masson, Ed.D.
Associate Professor and Coordinator
Rehabilitation Counseling
West Virginia University
Morgantown, West Virginia

* *

I just received your publication, Volunteer Administration, which will be published quarterly by the Center for Continuing Education. I am delighted with it - but - will you please tell the printing department to print the next issue in larger type? This one is almost unreadable, if one wishes to read very long, and certainly looks overwhelming when seen in such a style. If there is another printing run on this one, and they consider making it larger, may I be on the list to receive one? Thank you.

Mary Frances Young
Fort Logan Mental Health Center
Denver, Colorado

* *

Volunteer Administration has been well received here, however, I pass on these comments for your consideration. Our staff has commented that the print of Volunteer Administration is too small. We refer you to Canada Mental Health, a monthly publication, also offset, for a more desirable size print. Secondly, although you indicate the titles or affiliations of your editors and contributors, the omission of their specific credentials has been critically questioned.....We look forward to future issues for stimulating ideas and approaches to a subject matter too long neglected.

Mrs. Anne U. Vargus, ACSW
Director of Volunteers
Greater Lawrence Guidance Center, Inc
Lawrence, Massachusetts

* *

Directors of Volunteers who work with younger Student Volunteers find that some who are eager to help the Hospital are unable to manage themselves. These are the ones who get lost on errands, who collect in giggling groups and who amuse themselves in non-hospital ways. They are not necessarily bad; they are too immature to cope with what is expected of them....Instead of condemning them or firing them it is kinder to ask them to wait for a period of time for more maturity. Teenagers, whose confidence in themselves is vulnerable anyway, can accept this without feeling rejected. An invitation to try again at a later date keeps the door open for another effort....To handle the situation this way allows the Hospital to be thought of as a friendly place instead of being the scene of a young person's defeat. Young people need to grow in power and not to feel inadequate.

Unsigned

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Those of us in the volunteer field owe you a debt of gratitude for the new publication Volunteer Administration. I found your first issue to be very worthwhile and interesting....One question - could the print possibly be enlarged? Even if it meant an increase in cost, I believe your readers would appreciate it.

Mrs. Marian Schori
Director, Office of Volunteers
The American National Red Cross
Baltimore, Maryland

KEEPING UP TO DATE

Selected Annotations of Current Literature

Clark, Julian W. Volunteers in a new land. Hospitals, 1966, 40 (10), 72-74.

"A Volunteer program was developed at Central Wisconsin Colony and Training School in an attempt to give MR children more than custodial care. Following orientation, actual training was the reponsibility of the department to which the volunteers were assigned. No attempt was made to overemphasize their being successful. It was found that assigning 2 volunteers to work together as a team created self-consciousness, so this practice was discontinued. Volunteers were used successfully in physical therapy, activities, nursing, and as teachers' aides. Both mature women and adolescent girls participated. Recruitment was broadened to include church and civic groups and public service announcements on television and radio." (Mental Retardation Abstract, vol. 4, no. 1)

Cooper, CeCilia R. A comparison of work perceptions and derived satisfactions of hospital volunteers and paid employees. Dissertation Abstract, vol. 27, no. 5-B, 1618.

"In this study two groups of female volunteers and two groups of female paid employees within a general medical hospital setting were compared with one another with respect to their perceptions of the setting and the satisfactions which they derived from working in it. It was found that volunteers and paid employees differed in their perceptions of the work situation. In general, there was more similarity among volunteers than among paid employees in terms of the major satisfactions which they derive from participation in the work situation. The perceptions which the individual has of the work situation appear to be closely related to the satisfactions which she derives or wishes to derive from her work."

Cowen, Emory L., Zax, Melvin and Laird, James D. A college student volunteer program in the elementary school setting. Community Mental Health Journal, 1966, 2 (4), 319-328.

"A college student, after school, day-care volunteer program for primary grade children with manifest or incipient emotional problems is reported. Attitudes differentiating volunteers from nonvolunteers and changes in volunteer attitudes following participation in the program are identified. A description of the program itself, including objective process data and evaluation of outcome indices is presented. Interrelations among and between process and outcome measures are summarized." (Journal Abstract).

Davis, William J. Students who help people. California Youth Authority Quarterly. 1965, 18 (2), 30-37.

"Student services to the underprivileged youths in the community, at the University of California's YMCA, Stiles Hall, began in the 1950's with the Big Brother Project. Successful extensions of this volunteer activity have included informal companion relationships set up between University male students and troubled 5th and 6th grade boys. Recommendations for the operation of programs similar to this Interpersonal Relations Project will be based on a report of its progress. Successful student work with pre-adolescents and institutionalized delinquents led to recommendations for continuation of pre-release and aftercare relationships. Students have tutored a variety of academic and vocational subjects and have been active in School Resource Volunteer work, low-cost housing fund raising, and developing better interracial relations. Research into the use of non-professionals as mental health counselors in programs similar to the Interpersonal Relation Project is recommended." (Crime and Delinquency Abstracts, vol. 4, no. 1)

Jones, Betty Lacy. Nonprofessional workers in professional foster family agencies. Dissertation Abstract, 1966, vol. 27 (5-A), 1451.

"Evaluations of case illustrations showed nonprofessionals working helpfully with fearful, withdrawn children and children in need of a warm, supporting relationship, but less well with aggressive, acting out children. Most foster mothers received some help from nonprofessionals in using agency and community resources but they also needed assistance from professional social workers. There were few differences in agency policies and supervisory controls relating to nonprofessional and professional workers. A significant difference was the evolution of methods of sharing case responsibility; professional and nonprofessional workers were sometimes assigned to the same case, and all supervisors assumed responsibility for direction and decisions in each case assigned to nonprofessionals. It was concluded that caseloads could be assigned to teams composed of a professional caseworker and several nonprofessionals."

Schmitthausler, Carl Marvin. Analysis of programs using nonprofessional teacher helpers in public elementary school classrooms. Dissertation Abstracts, 1966, vol. 27.

"The purpose of the study was to describe and compare four elementary school programs in which noncertificated classroom helpers assisted certificated teachers with classroom tasks.

In three of the school districts studied, classroom helpers were employed. In the fourth district, volunteers were used.

Where teachers participated in the selection of their classroom helpers, satisfaction reports from both teachers and helpers were higher than in cases where helpers were simply assigned to teachers.

Other conclusions reached were: 1) teachers who describe themselves as leaders or who indicate that they have qualifications for and interest in administrative work tend to enjoy directing the work of other adults. 2) Teachers are not conscious of social or economic status differences between themselves and their helpers. 3) Most teachers state a preference

for lower pupil-teacher ratios to classroom helpers as a means of improving classroom productivity. 4) Exchange relationships between teachers and paid classroom helpers and teachers with volunteer classroom helpers are different. Although paid helpers receive some non-monetary benefits of importance to them (prestige, opportunity for self-improvement, etc.), the contractual relationship between employer and employee is understood. Volunteers sought a variety of benefits and expected a reciprocal relationship with the teachers whom they helped. Teachers seemed unaware of the expectations of volunteers, and satisfaction levels were lower than with paid helpers. 5) Teachers revealed a high degree of agreement about classroom functions which should properly be retained by the professional. Teachers felt that they could not delegate to nonprofessional helpers the functions of managing the class, reporting to parents, diagnosing learners' needs, planning to meet learners' needs, and assigning learning tasks to learners. Some teachers indicated a willingness to share or delegate the function of presenting information and concepts to learners. Many felt that helpers could assist with guiding learners' behavior, and with discussing learners' work with them. Most agreed that they could delegate the functions of supplying, clerking, and housekeeping to helpers."

aver, Phillip R. and Scheibe, Karl E. Transformation of social identity: A udy of chronic mental patients and college volunteers in a summer camp setting. e Journal of Psychology, 1967, 66, 19-37.

"Drawing upon present controversies regarding the utility of the 'mental illness' concept, a view is presented that mental patients might be regarded as individuals with degraded social identities. A camping program for chronic mental patients is described as an application of this conception. Camper-patients become highly involved in real, functional roles and at the same time become disinvolved from subordinate and dehumanizing positions within the mental hospital. In terms of immediate effects on patients and students, the program was highly successful." The authors further contend "that a means might be devised, perhaps as an extension of present volunteer programs, for the more permanent social rebuilding and promotion of those who are presently called mentally ill." (Author's summary)

yler, Ralph W. The role of the volunteer. California Youth Authority Quarterly, 965, 18 (4), 15-23.

"There are five basic reasons for involving volunteers in youth development organizations: (1) to help maintain a friendly climate in the agency; (2) to learn from their experience in the organization, ways that help them to be better family and community members; (3) to obtain public understanding and support for their organization's work; (4) to complement the professional staff; and (5) to increase the agency's services in spite of a limited budget. Similarly, there are a number of roles that the volunteer can fulfill. Some of these are: encouragement and reassurance to youth; furnishing examples of behavior and character; serving as a medium of communication between staff and clients; and performing non-specialized tasks." (Crime and Delinquency Abstracts, vol. 4, no. 1)

Peters, Thomas H. United Community Services. Pilot Youth Project. "VIA Clubs": a guide for working with groups of troubled youth. Lorain, Ohio, 1965, 105 p. $1

"This booklet is intended as a guide for volunteers working as advisors to clubs of problem youth. It is designed to suit the approach used in the Pilot Youth Project of the Lorain, Ohio, United Community Services. VIA clubs constitute a program in which volunteers spend one hour a week in small club meetings with delinquent and pre-delinquent children, ranging in age from six to 21, in the children's own neighborhood. They come into the clubs or are formed into clubs because of problems recognized by their teachers, parents, the police, or the youths themselves. Many are without normal families and most have problems getting along with others in school, in their homes, and in their communities. The volunteer helps the members of VIA clubs look at their own problems and work out their own solutions. They use a technique of confronting each member with the behavior that is causing his problem. Each member in the group is helped to look at his own behavior and to comment on the behavior of others. They look at past behavior as well as behavior exhibited in the meeting itself. The group brings pressure on the individual to face the facts of his conduct, to try a specific change of behavior, to become aware of the gratification and reward resulting from different behavior, and to then make continued change until a new character begins to emerge.

Available from: Pilot Youth Project, United Community Services, P. O. Box 255, Lorain, Ohio, 44052 (Crime and Delinquency Abstracts, vol. 4 no. 1)

Welles, Judy. Denver's young offenders offered another chance. VISTA Volunteer, 1966, 2 (1), 13-15.

"VISTA volunteers assigned to the Denver Juvenile Court were given the Court's toughest cases: the families that probation officers and social workers had nearly given up. These families are known as "hard core" or "multi-problem" and their children are among the worst juvenile offenders. Each volunteer is assigned to work with about nine families whose youngsters are counseled by the Court's probation officers. The volunteers work in many ways to give meaning to the lives of these families, to encourage stability, and to build an atmosphere in which children can find a sense of security they may never have known. Through frequent informal visits, the volunteers are developing a two-way communication with needy families the existing Court services could not reach. They hope that their work will prove to be an example to other juvenile courts seeking new ways to curb delinquency." (Crime and Delinquency Abstracts, vol. 4, no. 2)

CURRENT PROJECTS

Evaluating the impact of volunteer workers in the prevention, control and treatment of juvenile delinquency.

CORRESPONDENT: Ivan H. Scheier, Ph. D., Boulder District Court, Boulder, Colorado, 80301.

"The project aims to demonstrate and evaluate the potential and effectiveness of the use of volunteer personnel in action programs designed for the prevention, control and treatment of juvenile delinquency. This project, which will operate within the structure of the Boulder, Colorado Juvenile Court Probation Department, has broad implications for similar agencies in other parts of the country and especially in small and medium sized cities and the rapidly developing suburban areas. The project will evaluate such areas as volunteer recruitment, participation in group discussion programs and tale-playback discussion sessions held between adolescents and adults, parent groups, police, teachers and other significant forces within the lives of the adolescents. There will be an evaluation of the net effect of volunteer participation in accomplishing program goals as compared with the amount of professional staff time required to support volunteer activities. The project will also evaluate the use of college youth (upperclassmen) as assistant probation officers and the effect which such a program has on the probationers within the program as well as the effect which such a program has on the college youth in orienting them toward a career in the corrections field. The maximum number of channels for effective volunteer contribution to a juvenile court effort, will be developed and evaluated." (Crime and Delinquency Abstracts, vol. 4, no. 1)

Tutoring probationers.

CORRESPONDENT: Mrs. Robert Weiner, Adirondack Community College, Hudson Falls, New York, 12839.

The Adirondack Community College - Warren County Tutoring Project has been in operation for two periods of time: the school year 1963-1964 and the school year 1965-1966. During these periods, Big Brothers and Big Sisters have worked with probationers with the specific goal of helping the probationer pass his school work and break the cycle of failure in which so many of them are trapped. The benefit of a close one-to-one relationship for the probationer and the volunteer has been an additional facet of the project.

The probation department screened the probationers, looking for boys and girls who had the ability to form a relationship and would accept this form of assistance. The college screened the volunteer group looking for young men and women who were educationally and emotionally sound. The tutor agreed to see the probationer at least once a week. In many cases they performed services such as giving music lessons, haircuts, advising girls on

dress, etc. They intervened in the school situation, particularly in cases where parents felt unable to deal with the school authorities.

While it is too soon to make any definite appraisal, the program has been helpful to both groups. Two of the tutors involved are going on to Social Work School and this project provided basic work experience for them. Several of the probationers who would have been dropouts are now continuing in school and have a better sense of their own identity as well as better general adjustment." (Crime and Delinqueney Abstracts, vol. 4, no. 1)

Additional Readings

Ewalt, Patricia (Ed.) Mental Health Volunteers. Springfield, Illinois: Charles C. Thomas, 1967.

Janowitz, Gayle. Helping Hands: Volunteer Work in Education. Chicago: The University of Chicago Press, 1965.

ERRATUM - Volume 1 Number 1

(Additions are underlined)

L'Abate, Luciano, "The Personality of Volunteer Housewives and Candy-Stripers," Page 30, Paragraph 2, following line 2 should read: - Schultz's (D + W, p. 455), Hy 5, inhibition of aggression by Harris & Lingoes (D + W, p. 456), IM, impulsivity by Gough (D + W, p. 457); Jh, judged manifest hostility.....

Editor's Note:

Space is available for listings of relevant job openings or any other items concerned with the employment market for Directors of Volunteer Services. Send any items to The Editor.

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