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We cannot pick up a newspaper, journal or magazine without reading of new and exciting programs utilizing volunteers; for today the volunteer movement is gaining tremendous momentum and sophistication, reflecting and paralleling the society which has mobilized it. It is a complex movement motivated by human needs which are being frustrated by accelerating social change, automation, mobility, national and international crises.

We see volunteers in the Peace Corps working with people in foreign lands who lack the basic necessities for healthy living; we see volunteers in the Vista Program working with people in overwhelming despair, poverty and deprivation; we see volunteers in the Massachusetts Commonwealth Service Corps helping people with various handicaps or problems which deprive them of a full, meaningful or even comfortable life; we see volunteers throughout the country demonstrating their disapproval of the status quo; we see youth volunteers attracted by the Red Cross Program for the elderly and we see volunteers in clinics, hospitals and facilities for the retarded or mentally ill expressing their desire to participate in programs designed to help others. Indeed, today's vol-

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*An amended version of a paper presented at the Massachusetts Association for Mental Health Volunteer Conference, October 27, 1965, Boston State Hospital, Boston, Massachusetts

unteer movement is comprised not only of those from the upper and middle classes, rather it encourages the participation of people from all socio-economic levels. As part of the total movement, local and federal governmental installations are promoting and supporting these programs. Churches, schools, colleges and private agencies are encouraging these activities; and in this pandemonium, if you will, the professional is hopefully becoming less threatened by, and more positive about, the value and worth of these volunteer resolutions.

The current volunteer resolves, an extension of our historical tradition, stem from the very roots of our communities and reflect the inherent beliefs of a democratic society. These resolves should be channeled rather than inhibited, they should be guided not left undirected; they should be integrated into the mainstream rather than isolated, for there is much that can be accomplished by this groundswell of enthusiasm. At the Greater Lawrence Guidance Center (1) we have met the groundswell of volunteer interest with the resolve to guide, channel and integrate this valuable resevoir of talent from our community into the total clinic service program.

The Guidance Center, founded in 1954, serves the area of Andover, Lawrence, North Andover and Methuen. These municipalities encompass a population of 135,000 people. The Center is supported by the Commonwealth of Massachusetts,

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[1]The author wishes to acknowledge the invaluable assistance of Mary D. Bain, M.D., Psychiatric Director of the Greater Lawrence Guidance Center, Inc., in the writing of this paper.

the United Fund of Greater Lawrence, the City of Lawrence, the towns of Andover, Methuen and North Andover, as well as by modest fees and generous donations. The Founders and Board of Directors of the Clinic represent various levels, economic and cultural, of the total community and of the different structures within it. This group of citizens is committed to the improvement of their community, and their involvement in the Guidance Center is a reflection of this committment. The Clinic is rather unique in that a large percentage of its staff are residents of the Greater Lawrence area. This high percentage, which at varying intervals has ranged from 40% to 100% of staff residing in the area served by the Clinic, has numerous implications relative to the whole concept of a community clinic. The multiple dimensions of this factor will not be discussed in this paper.

The Center is an outpatient psychiatric facility with services for both children and adults; its children's service is one of the few full and active members of the American Association of Psychiatric Clinics for Children. The Clinic has been recognized as a training center by the Harvard School of Public Health, by four graduate schools of social work in Massachusetts and by the United States Public Health Service. Plans for a graduate training program in psychiatric nursing at the master's level are currently underway. Clinic research is supported by NIMH, the United States Public Health Service.

The Greater Lawrence Guidance Center provides direct clinic services which includes crisis-focused treatment. It provides consultation to medical and non-medical professionals

in the community whose daily work is concerned with the health and welfare of children, adults and their families. It also provides mental health education for the local professional community, with courses for graduate and student nurses, social workers, teachers, general practitioners, as well as for the lay public, to promote broader community understanding of the clinic philosophy and services and its relationship to the total mental health needs of the area. The community also relates to the Center as a resource for mental health education through the Lilly Siskind Library, named in honor of the Founder and first President of the Board. This library, housed within the Center, has an excellent collection of books, periodicals and journals in the field of mental health and the behavioral sciences. The collection includes 600 bound volumes, 45 journal subscriptions and nearly 1000 pamphlets, reprints, and monographs.

The Clinic philosophy is based on the concept that a community psychiatric facility is by definition part of the community. This basic concept provides the philosophical foundation for the development of the Volunteer Department. In every community people desire the self-fulfillment found in the personal interaction with their neighbors. Mental health is achieved in an environment which provides opportunity for social usefulness and the attainment of human satisfaction. Programming for and with volunteers is based on these premises.

Prior to the establishment of the formal Volunteer Department, occasional volunteers

were recruited to assist staff on various time-limited programs. The services of these volunteers were given further impetus with the formation of the Friends, the Center's auxiliary. Chartered on January 2, 1962, the Friends organized to further the aims of the Center, to create community understanding of its programs and services and to assist with the Clinic's extra-budgetary needs. In retrospect, it appears that this group reflected the community's acknowledgement, understanding, response and acceptance of the Clinic's philosophy vis a vis the role and responsibility of the public it serves.

Within two years the Chairman of the Volunteer Committee of the Friends, despite the obvious progress of her various programs, had begun to state with conviction that the future of volunteer activities could only be assured if professional staff were made available for direction. Because the Chairman of Volunteers was not a staff person, she could not possibly be aware of total clinic needs and had recruited more volunteers than anticipated. Also, it was quite evident that she had neither the time nor the professional training to provide supervision. The volunteers felt neither part of the staff nor of the clinic program. These observations were acknowledged by the administrators of the Center who began active recruiting for a full-time, professional Director of Volunteers. In the process of recruiting a person for this position, it became clear that for the sound development of the volunteer program, a mental health specialist was necessary.

Our description of the Greater Lawrence Guidanc

Center and the community has been offered to provide the perspective needed to understand the structure, services and philosophy within which our Volunteer Department has been integrated. It is on this frame of reference that the Director of Volunteers relied as the actual Volunteer Department was further conceptualized and developed.

In November 1964, a full-time Director of Volunteers was appointed. A certified social worker, she had five years of psychiatric casework experience, group therapy, supervision of graduate social work students, placement and supervision of volunteers in a Veterans' Neuropsychiatric Hospital and experience in community organization. She brought to this position a strong conviction that volunteers have a vital role in a community clinic and, when properly deployed, make a valuable contribution in the provision of psychiatric services to patients. This conviction was obviously shared by the Psychiatric Director and Board as shown by their initial investment and continued interest in the development of the Volunteer Department. This support was of critical importance, for no program can function to full potential without the interwoven support of the Board, Administration and Staff.

Inventory, evaluation and development are three major and continuous dimensions of the role of any chief of service. Of key importance during the initial planning stages were the meetings between the newly-appointed Director of Volunteers and the Chairman of the Volunteer Committee of the Friends. These meetings were scheduled to take inventory of previous volunteer activities, their present

plans and future expectations; to appraise problems encountered or anticipated; to exchange ideas; to explore avenues for recruiting future volunteers. Meetings were frequent at first, but were held less often as the Director of Volunteers gathered and incorporated the Committee's ideas and expectations into the total developmental planning. In the course of these meetings, as the Friends' Chairman shared her judgement regarding the volunteers and her knowledge of the community of which she had been a long-time resident, it became obvious that the Chairman of this committee was a most valuable and resourceful person.

During this period, the Chairman also acted as liaison between her committee and the Volunteer Department. Four years later, she continues to function as the barometer of community reaction to the programs and services of the Volunteer Department.

The Director of Volunteers, again, as with any chief of service, has continuing responsibilities as innovator, communicator, leader within his Department, as well as a role of influence in the total organization. During the initial stages, weekly conferences were held with the Psychiatric Director and Director of Volunteers in which total clinic services, potential growth of clinic programs, and ideas and plans for the volunteers, present and future, were reviewed and appraised. Following these preliminary steps, the operational development of the Volunteer Department began with a REQUEST FOR VOLUNTEER FORM, designed as a referral and face sheet to be used by the staff for the VOLUNTEER CASE RECORD; and outline of the VOLUNTEER ORIENTATION COURSE; a

VOLUNTEER APPLICATION FORM; and a TIME CARD for statistical purposes.

Also during these initial stages, a preliminary report was requested by the President of the Board of Directors. We determined this request to be significant and directly related to their interest in the program. The Board was impressed with our prefatory efforts and clearly saw the program's potential for growth. They communicated their desire to be of help and through the years, have proven to be a resource for recruitment.

Clarification of function and program should be effected vertically from the Director of Volunteers and those to whom he is responsible. Therefore, it is deemed essential that integration and coordination of the program relate to the abstract super-structure and persons within it before it is worked out on a tangible service level. Thus, the exchanges between the Director of Volunteers and the Community, Administration and Board were essential steps in the integration of the formalized department.

Clarification of program function and responsibility should also be effected horizontally between the Director of Volunteers and his associates for obviously, staff will only relate constructively to what they know and understand. As the personal and professional relationships with the Director of Volunteers and the staff began to solidify, conferences with each Department head as well as with individual staff members were arranged to exchange ideas about the potential areas of volunteer service, interpretation of the volunteer's function relevant to service for patients and the administrative

structure of the Volunteer Department. Despite the staff's manifest expressions of acceptance, their initial latent resistance was obvious by the nature of their requests. Social workers tended to request service for children rather than for adults who were seen as "their patients"; requests from the psychologists were slow in coming. The response of the psychiatrists varied: one was enthused and quickly and regularly requested volunteer service; another was also enthused initially, but referrals gradually diminished; a third referred only cases with learning problems. The clerical department was the first to request volunteers. The volunteer turnover rate within this department, although high at the outset, decreased as the volunteers proved their worth. We were aware of these natural resistances and accepted them as an inevitable phenomenon in a total process. In general, resistance has been handled on a building-block basis. It was anticipated that in time, with demonstrated success of volunteer performance, staff confidence would develop, thereby lowering the defensive patterns. This approach has been somewhat successful, for we have not evidenced gross, chronic or insurmountable resistance to the use of volunteers.

Our preliminary study of the services to be performed by volunteers, a compilation of suggestions by staff, administration, and former volunteers, was by no means conclusive. We felt that increased use of volunteers would parallel not only the expansion of the clinic services with the concomitant increase in senior staff available for supervision, but the increasing skill and creativity in utilizing volunteers. The first listing of areas of need to be serviced by volunteers included:

(1) Indirect services, such as writing for our newsletter, typing, filing, stenographing, addressographing and bookkeeping in the library and the administrative offices; and (2) Direct service which included automobile escorts, individual or group sessions with children, adolescents, and adults who needed basic tutoring or cultural enrichment; and the formation of relationships with those emotionally deprived patients manifesting a need for support and ego-building. Waiting room assistants were also needed. Request for this service was based on a determination of the need for the provision of a healthy relationship via an activity program for siblings who regularly accompanied parents or other siblings to their appointments. It was felt that intervention through relationship activities with family members, part of the constellation currently in crisis, could be a preventive measure. This preliminary survey served to delineate areas for volunteer service in the Clinic. It further helped clarify the relationships between the volunteer and the professional staff and the volunteer and patient.

Once vertical and horizontal understanding of this program was clarified and a genuine need for volunteers was established, we began recruiting volunteers from a mailing list of 600 members of the Friends. The Chairman of the Volunteer Committee sent a letter to all the Friends introducing the Director of Volunteers. Following this introductory letter, a second letter briefly outlining the program with an enclosed return postcard to indicate degree of interest and availability was mailed by the Director of Volunteers. Out of 600, approximately 60 women responded, 25 of whom indicated

availability at that particular time. Others stated interest but requested that we contact them the following year. With the escalation of staff requests for volunteer service, we broadened our recruitment channels for adult and youth volunteers to include local high-schools, private academies, colleges and secretarial associations. Simultaneously, as the community became more aware of our volunteer department, churches, P.T.A.'s, social groups and individuals expressed interest. In addition, we applied to the Commonwealth Service Corps for ten full-time, paid, youth volunteers to staff a special therapeutic summer program. In essence, these volunteers were the basic staff of this Clinic project. The success of the program and the ramifications of the experience for these youth volunteers are so complex and extensive that we find ourselves unable to incorporate them into this paper. Because it has served a community need, this special summer program has been continued for the past four years.

There are many untapped resources in a community for volunteer activity. One very unusual and exciting program at the Center was provided by a local actors' group. A staff psychologist suggested that a group of volunteers might present a well-known mental health play in his teachers' seminar. This, he felt, would be a unique method of conveying psychiatric theory to this group, who had grown weary of the traditional lectures, films and discussions. The Director of Volunteers talked with a local theatrical group about volunteering their time in this new venture. The spokesman for the actors' group was delighted with the request, for this actors' guild, interestingly enough, see themselves as a community service. The even-

ing was such a tremendous success that a neighboring clinic requested a repeat performance as the highlight of their annual evening Board meeting.

Through the use of volunteers, a very active and successful program for the child with Perceptual Disability has been initiated at the Guidance Center. It is staffed by carefully selected female volunteers who are trained and supervised by a language training consultant. The program provides special tutorial services for children with Perceptual Disability who are seen one, two or three times per week. In this way, the community has been provided with a service heretofore almost unavailable, demonstrating how volunteers can backbone services not feasible within regular operating resources. (2)

The potential use of volunteers in an outpatient facility is unlimited. We have chosen to highlight a few of our specific and unprecedented projects here for the purpose of illustration. It is suggested that these illustrations serve as guides or models. Variations are contingent upon the creativity of the Director and the sophistication of staff in a particular setting.

Despite the various community groups expressing interest in our volunteer department, all screening has been individualized. The advantage of the individualized screening method

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[2]A current and more detailed description of the Clinic's program for the child with Perceptual Disability was discussed in a panel presentation, "A Language Training Program in a Child Guidance Center", at the Fifth International ACLD Conference, February 1968.

is that it permits careful selection essential to building a program around the interest and natural abilities of the volunteer rather than around the designation of function. Secondly, it allows more careful matching of volunteers for the potential assignments and thirdly, it allows the time to outline clinic needs and services, to explain the function of the Volunteer Department, the role of the volunteer, the rules and regulations, standards of performance, and the methods to be used. These three steps are of critical importance in that they establish the climate of the department to which the volunteer will relate and sets the tone of the volunteer's future relationship with the Center. As the Volunteer Department developed, recruiting has been done only to fill specific requests from the staff so as to discourage a waiting list of interested, but unusable volunteers, which would have a negative influence in the community.

The selection of volunteers is the responsibility of the Director of Volunteer Services. The application interview, conducted in an informal manner, is scheduled with adequate time to enable the applicant to pursue any doubts or questions. In the selection of volunteers, the interviewer must sensitively explore motivation, attitudes, interests, qualifications or training, ability and willingness to dedicate time, willingness to adapt skills and capabilities to a particular job and flexibility to adjust them to the program, and willingness to accept training and supervision.

Volunteers interested in direct services must manifest warmth, understanding, sound judgment and an ability to relate to others with ease. These are prerequisites; for the fundamental contribution of the direct service vol-

unteer is warmth, spontaneity, and ability to relate. In addition to the volunteer's role and responsibility, the interviewer must allow adequate time for the discussion of the Center's role and responsibility to the volunteer. Despite these rather specific, theoretical guides for the screening interview, we have also found intuitive judgment to be a valid criterion for selection. This intuitive perception, however, remains only one of the many selection factors involved in the final analysis.

Often times, the interviewer's initial impression of the applicant in the waiting room is revealing. A volunteer applicant, who arrived a few minutes early for her appointment and began reading to a little child in the waiting room, presented a dramatically warm picture. Needless to say, this applicant was selected, and has proven to be an excellent volunteer. On the other hand, an applicant in her thirties who sat rigidly in the corner of the waiting room, who complained of the stairs to climb and noise of the children in the waiting room, did not seem a likely choice. Her firm request to work with children, yet her total inability to commit time confirmed our initial impression. While exploring her motivation, she was greatly relieved and indicated some self-awareness when she stated that she applied partly in response to social pressure which dictates that the wife of a doctor should do some volunteer work. We eased her guilt by supporting her many family and social committments which obviously allowed little time at that point for service at the Center.

The volunteer who has been accepted by the clinic needs orientation to the new under-

taking. Staff, too, may need review regarding the volunteer services. Unless staff know how best to use volunteers' services, relate to the volunteers' need to be accepted and given a place of dignity within the Center, the program will be severely handicapped. Orientation is a continuing process based on the turnover of volunteers and staff, professional resistance to changing roles, increased services and the introduction of volunteers into new areas.

Our Orientation Course for Volunteers is two hours a week for eight weeks. Open to all applicants and non-applicants, the Course is publicized by press releases in local newspapers and special mailings. Many are interested in taking the course for their own knowledge and this is welcomed; others attend in order to satisfy a pressing social need for companionship; others because of intellectual curiosity. We feel those who attend are potential community missionaries regarding the philosophy and function of the Clinic. Some who begin the course drop out after the first few sessions. This process of attrition is interpreted as a healthy self-screening mechanism, for volunteers who are not interested in the orientation course would probably drop out later. Many express ambivalence by spasmodic attendance, which is noted, and utilized in the screening interview. The primary purpose of the orientation course is to enhance the volunteers' identification with the goals and objectives of the clinic, thereby instilling a feeling of belonging so necessary for good esprit de corps. It also provides an opportunity for the Director, who attends each session, to observe sensitivities and quality of interactions as he begins evaluation of potential individual volunteers. These observations provide valuable insights which can be

utilized in the screening interviews.

The subject matter of the orientation course focuses on the philosophy, departmental structure, and staffing patterns of the Center; the roles of the various professional disciplines in the total treatment process; the functions of other available community agencies and resources; the meaning of illness, its inter-relationship with the past, present, future, and its effect on the person, family constellation and community; current mental health issues; the use of the relationship in the treatment process; and the role of the volunteer within the Center. Each session is led by an appropriate member of the Guidance Center Staff. This serves the two-fold purpose of giving potential volunteers an opportunity to relate to staff and vice versa, which hopefully results in correcting stereotypes and diminishing respective anxieties which reflect mutual insecurities. In addition to the Orientation Course, a series of eight to ten field trips to other community agencies are scheduled. These field trips are designed to widen the volunteers' frame of reference as they begin to place the clinic in perspective vis a vis the gestalt of community caretakers. Field trips include visits to the Welfare Department, Society for the Prevention of Cruelty to Children, Regional Psychiatric Hospital, Family Service Association, Probation Office, Young Women's Christian Association, Division of Child Guardianship, Boys' Club, State School, et al.

It seems timely at this point to state our definition of "volunteer". At the Greater Lawrence Guidance Center, we have defined volunteers as professional or non-professional unpaid staff members. This distinction is

important to note as so often we find in researching the literature, the term volunteer used interchangeably and synonomously with the terms non-professional, sub-professional, and indigenous worker. It would not be unusual for a professionally trained teacher, social worker, speech therapist, dietician as well as housewife, student, etc., to volunteer at the Guidance Center. When volunteers are screened, their respective backgrounds are of vital significance. We deploy, for example, a trained social worker to the social service department, a speech therapist to the special therapeutic education department, a dietician to work with a group of obese adolescents, a math teacher to a patient experiencing difficulty in that particular subject. On occasion, by request of the volunteer or by design of a specific request, assignments are not related to background; but this would be the exception rather than the rule. For example, a dental hygienist, whose professional training would not find a place within the Center, but who states in the screening interview that she has always found the greatest pleasure in teaching children good dental care, may, with training, prove to be an excellent remedial tutor. A very feminine mother states that rearing four boys has been most difficult as she had no brothers and little previous knowledge about the management and growth process of boys. When we talk with her about working with a culturally deprived five year old girl, her eyes sparkle. It is noteworthy to add that, since her experience here, she adopted a three year old girl.

Placement or assignment of the volunteer is a matching process, a utilization of all knowledge gathered about the emotional needs and qualifications of the volunteer with the

prerequisites for a particular service. Placement actually begins in the screening interview. During the placement interview, the Director of Volunteers should make clear the purpose and importance of the particular assignment, reassure the volunteer of her competence for this undertaking and make clear the resources arranged or available to her for supervision.

If the volunteer is assigned to an area of indirect service, she is introduced to her supervisor, the office manager, within the placement interview. If the volunteer is to participate in direct service, she is introduced to the professional staff person who has requested the volunteer service; this initiates the relationship with the supervisory and/or collateral staff which will continue during the course of the volunteer's tour of duty. All volunteers assigned to direct service are supervised by the Director of Volunteers or another member of the professional staff. Supervision conferences with direct service volunteers are scheduled weekly and range from a half hour to an hour depending on the material to be covered and the number of cases to be discussed.

Supervision of volunteers is a prime concern, and one would be truly remiss to underestimate its worth in the total process. It is here that a volunteer service distinguishes itself, for supervision represents the focal investment of the agency sponsoring the program. A volunteer responds, internalizes, and translates this investment into quality performance. Volunteers are no different than others in their need to feel that their work is meaningful and the investment of supervision may serve as a barometer for their measurement. They need

support and reassurance in their performance; they need an opportunity to explore, discuss and question. They need encouragement to go forward with confidence.

In addition to the regular supervisory sessions, conferences are arranged as needed, with the volunteer, therapist and Director of Volunteers to discuss case assignments. Here again, volunteers need, especially initially, to be supported, for they often feel inadequate and insecure with the professional. These conferences which can be initiated by either volunteer, staff, or Director of Volunteers not only serve as a method of communication but anchor the relationship between volunteers and staff.

In this paper we have reported the historical planning and development of our volunteer program, with a description of our method of formulation, integration, and coordination. We are cognizant that this description and appraisal is largely subjective and look forward to objective research which would reveal weak spots and highlight strengths. We would like to say in closing that in our experience the Volunteer Department has proven to be a most worthwhile pioneering venture. That the Volunteer Department has provided service to patients, has engaged and involved the community and has met the needs of the Volunteers is now a matter of history.

Now our questions must be, how far can we go and in what direction. Volunteers provide service at many diverse levels and it is important to underscore that they serve to bring the community into the clinic in a way that no other method has yet been able. As we contemplate the projected plans for the delivery of mental health

services to patients, it becomes apparent that volunteers must be an integral part of our planning and programs, for the community is being asked by planners and legislation to deepen its awareness of mental health needs and to take a role of leadership and partnership in the planning of services.

Our clinic's use of volunteers in the delivery of services to patients is indeed a milestone in community mental health programming.

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COLLEGE STUDENTS AND MENTAL HEALTH PROGRAMS FOR CHILDREN

Earl C. Brennen, M.S.W.

THE manpower shortage in the helping professions is an old story by now, but people in high places keep reminding us of the problem. Earlier this year the Surgeon General, Dr. William Stewart, announced that 500,000 additional persons were required today in the health professions. Stewart suggested, as have others in the past several years, that the need far exceeds the national training capacity, and therefore "we must give greatly increased effort . . . to the development of meaningful technician and assistant groups. . . ."[1]

While our concern here will be with *assistant* groups, the emergence of new *technician* groups invites brief attention. The Department of the Army presently has twice as many social work specialists as it has professionally trained social workers, and the Veterans Administration plans to use one social work technician for every four social workers in its hospitals and clinics.[2] In 1954, the state of Florida introduced a new position—the Mental Health Worker. Selected college graduates give services ranging from community consultation to individual counseling. One reported value is that the mental health worker is less likely to see certain needed services as beneath his dignity. He is ready to take on unglamorous tasks such as arranging for transportation or making sympathetic visits; thus he has been able to supplement the work of others without encroaching.[3]

In contrast to the slowly developing technician categories, programs using nonprofessional assistants are rapidly proliferating. The antipoverty programs in particular have demonstrated how imaginative use can be made of persons, often regarded as "unequipped," in performing tasks previously assumed by professionals alone.[4] In the mental health field, a sizable number of college students have been working with hospitalized mental patients,[5] and even mental patients themselves have been systematically used in one state hospital as therapists for fellow inmates.[6] Mention should also be made of the colorful self-help groups which have cropped up throughout the country. These have ranged from leaderless self-exploration groups to "need" groups such as Synanon for drug addicts.[7] Nonprofessionals have also

been employed experimentally as public health aides, and recent reports are favorable. In following up x-ray call-ins for tuberculosis, these aides made odd-hour visits to bars, flophouses, and other places deemed inappropriate for public health nurses to visit.[8]

Use of the Nonprofessional Worker

Some program directors have found it easy to become enchanted with the real or imagined ability and potential of the nonprofessional helper. Frequently, indigenous aides have been able to reach out to their impoverished neighbors more effectively than have their professionally trained social work colleagues. Among the poor, nonprofessionals are often used not as aides but as direct service workers, in preference to agency personnel with full credentials. Within the public health field a report of one extreme situation, where professionals are not available, reveals that nonprofessionals can perform some rather sophisticated tasks. Minimally trained village health aides in the Kotzebue area of Alaska listen to complaints and offer medical advice, give injections, report symptoms to a physician via short wave radio and carry out the treatment plan, provide nursing care, order drugs, and otherwise serve as "medical centers." They have treated a variety of conditions including trauma and pneumonia, and when radio reception is poor, which is often, they use their own judgment. Most of these aides have not progressed beyond elementary school.[9]

I do not wish to argue that given the opportunity, nonprofessionals can do almost anything; some activities require knowledge which is not easily obtained or shared with others. My point is that nonpros can make a sizable dent in the manpower problem because they are clearly able to perform some significant tasks now handled by professionals. When assigning responsibilities to nonprofessionals, we should take care not to close too many doors too soon. Fifty years ago some nursing spokesmen argued against the training of attendants to carry out limited tasks in order to ease the nursing shortage in hospitals. Their *stated* fear was that women from an inferior class would subject patients to second-rate care.[10] Now the job hierarchy in nursing is accepted and seen as necessary if the registered nurse is to deploy her skills where they are most needed. Today in social work, the "elite" voluntary family agencies are against using nonprofessionals for fear of "watering down good professional standards."[11] Yet a recent study of several foster family agencies in New York City divulges that of the 53 nonprofessionals employed, 86 per cent were assigned the same kinds of jobs as the professional caseworkers.[12]

Thus far I have touched on the manpower problem in the health and welfare fields, and have indicated how varied types of nonprofessionals have been used with some effectiveness in alleviating the shortages. While continued attention will no doubt be given to tapping additional sources of manpower, some thought might also be given to how various "groups" of nonprofessionals can best be assigned. On a *global* level, for example, it would appear that low-income persons —keeping their heterogeneity in mind— are better suited for some programs or services than are, say, educated mature housewives with grown children. (The latter, in turn, may invite the kind of therapist training offered by Margaret Rioch, which requires verbal facility and manipulation of ideas.)[13] And, on a more *refined* level, it may be that talent and task can be matched with some specificity. I have heard that 12-year-old girls perform splendidly when given charge of nursery school children. While old enough to assume some responsibil-

ity, they still find it easy to enter into the fantasy life of toddlers, to the delight of the children.

Manpower on the College Campus

One source of manpower which deserves increased attention can be found on the ubiquitous college campus. An incomplete survey conducted about five years ago showed that 87 colleges in this country had programs involving students in mental hospitals[14]; the number may well have increased since then. College students have also been used in a few extramural mental health programs, such as working with emotionally troubled children.[15] Our own experience at the Interpersonal Relations Project[16] in pairing students with troubled boys has shown that this type of program is feasible and gives promise of becoming part of a longer-term community mental health effort.

What has been the experience of those who have used college students in mental health programs? Some advantages can be claimed.

The first advantage relates to administrative matters. Recruitment is fairly simple, for the campus offers a large pool of recruits within a small, contained geographical area. And if a student likes the program, he tells others—word spreads fast on campus. Another aspect of recruitment hinges on the general availability of college students; since most do not have family responsibilities, they can usually spare the time. Furthermore, once a student is in the program he is likely to stay with it. He will probably not leave town for "greener pastures" during enrollment, and experience has shown that he honors his commitment. The Harvard-Radcliffe program has had a drop-out rate of less than 3 per cent over a period of several years.[17] As a final administrative concern, students tend to regard the work as a learning experience and therefore welcome training sessions and supervision. They are highly motivated for such work, and frequently the program affords an opportunity for them to supplement relevant courses.

The second advantage concerns college students as therapeutic agents. Their youth, with its accompanying energy and optimism, can be therapeutic in itself; and with children, students may serve as suitable models for socialization and identification. While this last point may introduce a class bias where low-income children are involved, it should be remembered that a sizable number of college students today—particularly in the community or junior colleges—are from low-income backgrounds. And as one reviewer of a recent work on the poor in human services has astutely observed, indigenous helpers are frequently not indigent.[18] That is, one can be *of* the poor without being poor at the moment or aspiring to maintain such status.

There is some beginning evidence that college students are effective therapeutic agents with hospitalized mental patients, though it can hardly be claimed that nonstudents would have done less well. In the Harvard-Radcliffe program (which was originated by an undergraduate student), a controlled study of two comparable wards showed that in the ward with the volunteers, patients showed advances on several criteria of improvement (e.g., less conceptual disorganization).[19] A follow-up study of 120 chronic patients seen by these students revealed that 31 per cent left the hospital while working with the students. This was ten times the expected discharge rate for chronic patients. Over half of these discharged patients were considered greatly improved.[20]

Finally, since some students actually decide upon a mental health career through participation in such programs, what better group to use in helping to ease the professional manpower shortage? One study indicates that such ca-

reer choices have occurred,[21] and our own experience bears this out.

These inducements suggest our courting the wider use of college students. In particular it may be that students, with their youth and inclination toward activity, are especially suited for programs addressed to children. And it is precisely here where services are needed. In their position paper (psychology) Smith and Hobbs hold that the major emphasis in the new community health centers should go to services for children.[22] They point out that current mental health programs tend to neglect children, largely because the favored method in such programs, individual psychotherapy, is best suited to adults. Further, these spokesmen note that new patterns for the development of manpower will be required.

Some of the traditional services for children might also benefit from supplemental programs involving nonprofessional helpers. Child guidance clinics, for example, draw heavily upon professional personnel and apparently the effort often comes to naught. In the largest study of its kind to date (N=1,548 children), the over-all attrition rate in the sample clinics was found to be 59 per cent![23] Many parents and children, it seems, do not regard such conventional services as an appropriate resource. Further evidence that the conventional service model for children and youth needs to be supplemented can be inferred from a study of preventive services experimentally offered potential problem girls at "Vocational High."[24] Not only did the individual therapy (casework) program fail to have a positive effect, but until the service was modified along group work-recreation lines about half of the girls dropped out. The "individual therapy" approach also did nothing to allay the girls' fears that they were singled out for being "bad, crazy, or not studying enough."

In contrast, the attrition rate for troubled preadolescent boys in our project is about 12 per cent for a continuous school year. While a helping companionship may not replace certain diagnostic and treatment services for many children, it can represent a service they will *use*. Children seem to enjoy the company of an interested nondemanding adult who will *do* things with them and provide an atmosphere wherein feelings can be shared and new responses can be risked without penalty.

While children and their college student companions may relate to each other, the question remains, of course, as to whether these children actually experience therapeutic gains. No claim can yet be made. The problem of evaluating the effectiveness of students is fraught with the same methodological difficulties inherent in all evaluation studies. Our own study (using a relatively large sample with matched-pair controls and multiple instruments and observers) will be analyzed shortly, and we hope to produce findings which others will find useful for similar programs. Reinherz[25] has reported improvement in a small sample of disturbed children assigned to college student volunteers; the results from other studies known to us are not clear-cut.

Summary

The shortage of professional personnel has led to novel and effective uses of nonprofessional helpers, and college students have shown themselves to be an attractive source of such manpower, particularly for children. On the program side, some observers have urged that the major emphasis of community mental health programs should be on services to children. Thus it appears that the desirability of using college students as helpers and the requisites of expanded services for children can be joined in a felicitous union.

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AN EXPERIMENT WITH COMPANIONSHIP THERAPY: COLLEGE STUDENTS AND TROUBLED BOYS— ASSUMPTIONS, SELECTION, AND DESIGN

Gerald Goodman, Ph.D.

NONTRADITIONAL programs for helping troubled people are cropping up all over the country. They can be a cause of concern to nearby professionals and the community at large. They are also subject to polemical evaluation by those sure of their values or dangers. Few serious researchers seem attracted by these programs. Thus, we know little about how to study them and less about their effectiveness and most about their adventures in getting off the ground. I would like to skip over the adventure story of how we started and what the implications of our work might be in favor of an outline of our project's structure, selection procedure, and research design. I also do not have enough time to detail our primary assumptions, except to say that client-centered theory and research have been a major influence. We think people can help themselves with other people's honesty and courage. The baby-steps of honesty and courage in the helping relationship are self-disclosure and emotional risk-taking. For us, these are the critical interpersonal modes that in combination produce qualities that are helping. The relationship of these qualities to age, training, and theoretical orientation are still a mystery. Therefore, we are quite confused except for our unhappy lack of confidence in most traditional orientations toward psychotherapy—especially their tendency to cling to a medical model of the helping relationship using professional distance and patient management. To me, professional distance and patient management seem to foster the type of therapist role-taking that generates concealment, expedient manipulation, and an ineffective type of responsibility toward troubled people. In short, our project is—in part—a reaction to the one-way intimacy that shapes most current professional therapy environments. We try not to let our bias and attendant assumptions compromise the rigor of our research or the freedom of our questions.

Selection of Participants

Our nontraditional helpers are male college students. Their clients are troubled boys. They are brought together with instructions to meet twice a week over the school year and do what they please. We do not ask them to talk about problems. Half of the students (we call them counselors) attend weekly training sessions. All of the counselors attend an initial workshop based on client-centered principles and take a short two-person teaching machine course on interpersonal relations. We study the entire program—boys, counselors, and training—using systematic observations from our participants' peers, from participants themselves, and from the boys' parents and teachers. We try not to let the research interfere with the program itself. The major research questions point at the process of the relationship, boy and counselor change, counselor training, and the matching of

counselor and boy. For example, we want to know if positive change in the boy is related to his counselor's personality type, or the topics of conversation and activities pursued during the relationship, or the training of counselors. Unfortunately, questions such as these require large quantities of data, especially since we use a multiobserver, multi-instrument design. Good answers for most of the questions will not be ready until 1968.

This is the procedure we use for selecting our clients—the boys. A neater job seemed possible by concentrating on preadolescent boys. Each year the program starts by collecting systematic observations on all 1,500 of Berkeley's fifth and sixth grade public school boys. Children describe their classmates on Wiggins' and Winder's "Peer Nominations Inventory" and teachers describe their pupils on a parallel form generating dimensions such as hostility, isolation, and likeability.

Next, we send an announcement to all parents and their boys openly describing the project and inviting application for boys who are having distinct problems getting along with people. When the combined systematic descriptions of parents, teachers, and classmates indicate that a boy is having real problems, we place him in a pool of potential participants. The pool is carefully searched for 50 highly matched pairs of boys. Twenty-five of the matched pairs have problems with isolation, withdrawal, depression, and the like. For simplicity we call these boys "Quiets." The remaining 25 are designated "Outgoings" and evidence problems with aggression, hostility, and so forth. One of each pair is randomly selected to participate and the other to serve in a nonparticipating control group. In this way we end up with 50 participating boys and their 50 individually matched controls — both groups evenly divided as evidencing "quiet" and "outgoing" problems. A group of 200 random stratified boys were also selected for study.

Now to the counselors. We invite applications from students through campus-wide advertisement at the University of California at Berkeley. The job offers $1.40 an hour, including report-writing and training sessions. Applicants describe themselves on the "Adjective Check List," Wrightsman's "Philosophy of Human Nature" questionnaire, Jourard's "Self-Disclosure Questionnaire"; and they take Chapin's "Social Insight Test." After that, students are scheduled to attend our group assessment sessions. Each session is attended by eight applicants and three staff members. These sessions provide the major source of our selection information. As a warm-up, the group is asked to do the following task: one applicant asks the group a personal question without knowing who will answer it. Anyone feeling comfortable with the question is encouraged to respond briefly (a minute or less) and directly. When the first two-person exchange is complete, the procedure rather automatically begins again as another person throws out a question. Anyone who has not answered a question can respond. The procedure continues around the group until everyone has both asked and answered one question.

At that point the group receives new instructions. Each member is given a card and asked to fill it out with a description of one of his interpersonal concerns that can eventually be read to the group. These descriptions are most often about problems with a girl friend, parents, roommates, and involve concerns about guilt, giving and taking, control, concealment, esteem, and general problems of relating to people. An applicant, chosen at random, is asked to read his card to the group. We call him the "discloser." Any other applicant can make an effort to understand how the discloser feels about the problem read to the group by engaging him in a five-minute

dialogue. We call the second person the "understander." Understanders are instructed not to give advice or interpret and to avoid asking many questions. Thus, one person is attempting to solve the problem of how to disclose or to be genuine in a manufactured group situation, while the other is attempting to solve the problem of how to listen—how to understand spontaneously. Of course, the task is made more difficult because of the observers, but students have a go at it with great spirit. They often complain that we cut off the dialogues too quickly. At any rate, we assume that the conditions are roughly equal for all applicants, and that the procedure may offer some index of an applicant's potential to understand and disclose in a dyad.

The procedure continues around the group, as in the warm-up round, and everyone tries each task once. At the end, all applicants rate each other, and the three staff members rate the applicants. Ratings are done on a sociometric type instrument, with items such as "He really seemed to understand what the other person meant" with six-point scales ranging from "much like him" to "not like him." Items cover the areas of warmth, self-disclosure, empathy, rigidity, surgency, and so on. We have discovered a tendency for strong rating agreements between individuals. Correlations between the ratings of applicants and staff were generally strong, with the exception of the disclosure item. It seems our professionals have special standards for the act of emotional self-disclosure. Applicants and staff produced very similar ratings on items describing mildness, dominance, depression, tension, and good potential for working with troubled boys. Moderate agreement was observed for rigidity, understanding, and warmth items.

Various patterns of group assessment scores were developed as criteria for accepting applicants into the program. For example, any applicant not seen as warm, self-disclosing, and understanding by a majority of the combined student and staff raters, was rejected. Thus far, we have been accepting about 65 per cent of the applicants who get as far as our group assessment procedure. Many applicants screen themselves out before getting to that point, so an estimate would be that we hire fewer than 50 per cent of those students asking for an application. I am becoming convinced that this group assessment selection procedure yields a high percentage of students with therapeutic potential. It certainly appears superior to our old method of using judgments and ratings from two individual interviews with professionals, combined with self-ratings and test scores. We began using the group assessment method during our third year of operation. All three of our group trainers were individually impressed by the change in the quality of counselors for that year. Our office staff noticed the difference too. It is too early to tell if these counselors are better able to help troubled boys because we are in the midst of analyzing third-year outcome data. Just one more thing about this assessment technic—it seems to generate descriptions that can be externally validated. Certain self-description scales correlate with the group scores in a meaningful way—especially in the quiet-outgoing areas. It was also surprising to find that a student's performance on the old Chapin "Social Insight Test" was strongly correlated with the group assessment item on understanding. Several counselors who were accepted as borderline on the group assessment criteria turned out to be poor counselors, in our estimation, as the year progressed. We have not completed refining and studying this method, but it is reasonable to guess that it can be useful in detecting good mental health counselors in wide applications utilizing little professional manpower.

After counselors are selected, they are reliably divided into a "Quiet" group and an "Outgoing" group on the basis of the group assessment ratings and several self-description sources. Counselors are then matched to boys in the following way: half of the quiet counselors are paired with boys evidencing quiet problems, and the other half of the quiet counselors are paired with boys having outgoing problems. The same procedure is followed for the group of outgoing counselors. This matching system gave us four dyad types: quiet counselors with outgoing problem boys, outgoings with quiets, and so on. Boys and counselors were matched on social class. A balanced half of counselors from each of the four dyad types were then selected for group training. This type of balancing allows us to assess the effects of training with a more rigorous design.

Counselor Training

Thus far our selection procedures for boys, and their counselors, and their matching into dyads have been outlined. Now I shall briefly sketch out the training of counselors. Before the actual companion relationships begin, all of the counselors attend two half-day experimental workshops on helping relationships. The workshops include lectures, structured small group interaction, listening to bits of therapy tapes, and some procedural orientation. Counselors must have also taken at least three lessons of programed instruction on interpersonal relations. The ten-lesson course we use was developed by Berlin and Wykoff, and contains many role-playing experiments. Counselors take the course in pairs.

Half of the counselors received additional inservice training by meeting weekly in discussion groups of eight all through the year. The training is essentially self-exploration, with professional leaders functioning primarily as facilitators of communication. Often a counselor's behavior in the group is related to his behavior with his boy. I suppose the most common thing discussed and demonstrated in the groups is emotional self-disclosure. At the end of each group session, counselors describe each other on warmth, understanding, and disclosure scales. Mean ratings for each counselor are placed on a flow chart that is returned to the group before the next session. Counselors attend about 25 two-hour sessions over the academic year.

This past program year has been the first capable of yielding meaningful findings. Since it has just been completed, there are only a few scattered results available. Our research design and variables are geared to study the various subgroups such as "quiet" or "outgoing" subjects, "trained" or "untrained" counselors, and so on. It appears that the measured gains of quiet and outgoing boys tend to cancel each other out when combined. Therefore, we do not expect any dramatic differences in gain between participating boys—grouped as a whole—and their nonparticipating controls. Tentative findings from our second year suggest that boys with quiet problems gain the most from participating, and that boys with group-trained counselors gain more than boys with untrained counselors. So far, the raw third-year data look as though they will produce the same pattern—even though some of the research methods have changed. However, it is still too early to say what type of boy gains most with what type of counselor. It is certainly possible that our final results might suggest that group-trained college students can be of significant help when paired with isolated, depressed, or withdrawn boys. It may be that hostile acting-out boys only gain significantly when paired with group-trained counselors. A quick look at the third-year data suggests that possibility. A clearer picture of how effective

student counselors are in helping troubled boys should emerge in several months.

We are also studying changes that may occur in the student counselors as a result of participating. A group of non-participating matched students are assessed at the beginning and end of the school year on most of the same instruments. The early results fit our expectations, based on investigations of programs using college students as companions to mental hospital patients (Holzberg and Cambridge-Radcliffe Program). So far, our counselors show dramatically heightened interest in the behavior of children, in working with troubled people, and in the way they interact with friends. Differences between counselors and controls are very significant. Group-trained counselors gain a bit more than untrained counselors. An item concerned with interest change in political issues was inserted to test acquiescence set. It showed no difference between counselors and controls.

Counselors feel they relate to friends better as a result of participating. This finding generates one of the strongest differences between the counselors and controls. Without going into detail, I can say that we have evidence suggesting that counselors do not tend to offer spurious claims to change. Experience over the past three years has convinced us that counselors find it easy to be self-critical and conservative in their appraisal of their effectiveness. Some additional miscellaneous second-order findings follow. Counselors tend to feel that psychotherapy helps people much of the time. This may be a reflection of their faith in the psychologically helping relationship. Most of the group-trained counselors were positively impressed with the groups. Many gave convincing details on how the training created important changes in their lives. The two-person teaching machine received negative comments from about half of the counselors. However, they claimed it taught them something despite its redundancy and condescending flavor. We are planning to change it. It also seems our counselors tend to be higher self-disclosers than the average student and, at the project's end, they tended to disclose significantly more personal feeling concerning their personalities and school work than did the controls. Counselors also reported that they disclosed much more to their male friends at the end of the program than did controls. Outgoing counselors tend to disclose a bit more than quiet counselors. Untrained counselors showed more discrepancy between what they "would tell" their boys and what they "did tell" their boys during the project. Perhaps group training helped counselors discuss things that they wanted to disclose with their boys. These odds and ends of information suggest that we may eventually find working with troubled boys changes students in important ways.

Some other questions about counselors that we hope to answer soon follow. Does the group assessment method produce patterns of scores that predict effective counselors? More specifically, will ratings of counselors' self-disclosure, warmth, ability to understand, depression, rigidity, and surgency predict measures of change in boys from observations of parents, peers, and teachers? Are quiet or outgoing counselors more effective with quiet or outgoing boys? Are variables such as age, vocational goal, quality of school work, and attitude toward human nature related to effectiveness? Is the counselor's measured effectiveness predicted by his previous experience working with children? His training in the project? His having received psychotherapy? His expressed motive for joining the project? His perception of the boy during visits? The types of things he tells his boy? And so on. Finally, can patterns or clusters of these variables help us locate students

who can help troubled boys the most?

We will ask this set of questions separately of counselors with several different types of boys. As we have indicated, we are trying to find out which students work best with which boys under what conditions. A few small but solid answers should make us happy. We also want to know how many boys get worse, and whether enough get better to make the entire enterprise worth while. If the research eventually shows that the program fails, we will advertise our errors so that others will not repeat them. If it succeeds, we will prepare a cookbook for distribution to the many communities throughout the country who want to start their own programs.

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