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

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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.

How the Volunteer Can Be of Help

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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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.