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The role of the volunteer in the mental hospital.

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Dissertation

THE ROLE OF THE VOLUNTEER IN THE MENTAL HOSPITAL

by

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CHAPTER I
INTRODUCTION

A. The Problem

The present study deals with an investigation of two major problems dealing with the person who joins an organization in which professionally trained people are employed. The first problem raised is, to what extent can the non-professional volunteer supplement the professional roles within the organization without creating a situation of strain? Or, can a person who is institutionally not expected to be a professional perform a professional function in the technical organization? The second problem asks the question, what is the relationship between the person's role in the organization, or subsystem of the society, with his role outside the subsystem in the total society?

Service to others of one's own free choice, a "helping out" in time of stress to relieve financial or personnel pressures, has in one form or another been a regular phenomenon of human behavior in all societies and in all ages. In the American social structure especially, the
spirit of volunteering has a distinct place in the historical heritage. To give willingly of one's time and energy for some cause vital to the common welfare - that is, to be called a volunteer - means that the person himself perceives a need for his action in the social system. Furthermore, from all outward appearances, he is altruistically motivated: his act is going to be of some benefit to someone else. The society respects him.

The term "volunteer" has several connotations. However, in this study it will refer to the person who is not already a part of the technical organization or the task group but who enters the organization to join the task group in performing some of the functions which the organization specifies need to be done. The volunteer may or may not possess any technical competence for the task at hand; furthermore, he may or may not be required to possess such competence. The main consideration is that he is to work in a supplementary fashion to the regular paid workers, or task group, and he himself is to receive no monetary consideration.

In this capacity as volunteer, the individual assumes certain task functions toward the achievement of the common positive goals of the organization to which he is volunteering while, at the same time, helping to relieve the attendant
pressures. As such, the volunteer works side by side with the professionally trained worker. He may work in a completely supplementary capacity to the professional worker, performing none of the requisites of the professional role. Or, he may assume in part or in whole the functions of the professional role, depending on the needs of the organization, his own technical competence, and the support tendered him by the organization in his role.  

Insofar as the volunteer is performing any aspect of the professional roles within the organization, the problem is that of marginal professionalization. The volunteer stands on the periphery of the social organization because he has not fully accepted or adopted the full norms of the professional task group.

In the present study the marginal person is defined in terms of his position both in the group where his chief

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1. In this respect it is necessary to distinguish between the volunteer who becomes part of a task group which consists entirely of volunteers, such as the local town fireman's group in which no one need possess any technical competence and in which there is no salary paid. However, the present study would even include an organization whose main objective is to offer humanitarian service to people in need of that service and relies mainly on a body of volunteers to accomplish that objective. This would apply to any organization in which professionally trained members are employed to perform certain functions as a task group in which there are also volunteers.
source of status lies and whose norms he has fully adopted (i.e., the group in which he is in the center) and in the subgroup to which he is identifying himself and whose norms he has not fully adopted (i.e., the group to which he is peripheral or marginal). The extent to which he adopts the group norms of this subgroup determines his marginality to the group. The important consideration is that his chief source of status does not lie within this subsystem but elsewhere in the social system. It is also possible, as will be brought out in the present study, that a person can

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1. A distinction must be made between various types of marginal roles and the different meanings attached to the concept of marginality. The marginal role first gained recognition in Robert E. Park, "Human Migration and the Marginal Man," American Journal of Sociology, vol. 55, May, 1928, pp. 881-893, followed by E. V. Stonequist, The Marginal Man, Charles Scribner's Sons, 1937, in which marginality refers to a person's being marginal to two distinct cultural groups and whose chief source of status is thus to be found in neither group. The term also stressed a psychological maladjustment which was the result of the incompatible position in which the marginal person found himself. The nature of the relationship between status and personality characteristics presented a methodological problem which was a major factor in the rejection of this first use of the concept of marginality and the marginal man. Cf. Alan C. Kerakheff and Thomas C. McCormick, "Marginal Status and Marginal Personality," Social Forces, vol. 34, October, 1955, pp. 48-55, for a discussion of the difficulties encountered.
be marginal to both groups.

The problem of marginal professionalisation does not always occur where the marginal people are volunteers. A case in point is the reserve commissioned officer in the army or navy who assumes in his new role the functions of the commissioned officer of the regular army or navy who is the graduate of the training school of West Point or Annapolis. The new officer may or may not have volunteered to serve in the military service. Again, an example from

---

1. This would serve to substantiate the earlier theory of the marginal man mentioned in the previous footnote. However, the psychological factors do not enter into the marginal concept used here, since they are the result of the person's marginal position: the person is still marginal to the system if he does not accept or adopt the full norms of that group. A strict sociological meaning of the term marginality thus makes it possible to describe the many different forms which marginality takes in the society, not merely occurring between cultural or racial groups. For example, one recent use of the term has been made by Walter J. Wardwell, Social Strain and Social Adjustment in the Marginal Role of the Chiropractor, Ph.D. thesis, Harvard University, 1951, in which the chiropractor is marginal to the field of professional medicine and thus to the role of the M.D. In this respect the chiropractor is not a non-professional as is the volunteer but rather a part-professional. The group norms which he adopts are not completely those of professionalization. Thus, although his role is marginal to the full professional norms of the M.D., he is able to compete with the doctor on a professional basis. Another example is the role of the psychiatrist who himself is an M.D. but who is considered marginal to the rest of the medical field. This occurs because of the deviation from the other medical roles which is taken by his own role in psychotherapy. Cf. text and fn. on pp. 187-188.
the present study consists of the student who is sent to
the hospital by his college or university as a learning
experience to assist in the care of patients and assume
some of the functions of the professional hospital per-
sonnel.\footnote{These students are not volunteers in the real sense of
the word since they have been sent to the hospital and
are meeting college requirements to receive credits.
However, they are referred to as student volunteers by
the hospital administration and personnel.} At this point the voluntariness drops out: it
does not matter whether or not the individual is a volun-
teer. The problem is still one of marginal professionali-
sation. The important consideration is that both the
reserve officer and the student do not adopt all the group
norms of the regular army or navy man or the hospital staff
person and are thus marginal to these professional roles.

This raises two fundamental questions which bear direct-
ly on the first problem indicated for investigation in this
study and which also have relevance for a generalized body
of sociological theory. Why do we have volunteers or mar-
ginal people in our society? What is the function of the
marginal person in a technically specialized organization?

These questions relating to marginal professionaliza-
tion point to the second major problem, the institution-
alization of the marginal role, or the extent to which the
marginal role is accepted by both the person who is in that role and by the rest of the society (ego and alters). The problem of institutionalization raises further questions concerning the relationship between the individual's role in the total system to his marginal role in the organizational subsystem. How does the marginal role become institutionalized? Can it become institutionalized in the organizational subsystem but not in the total society; or, vice versa, can it become institutionalized in the total society but not in the subsystem of that society; finally, can it become institutionalized in both systems?

These are some of the questions that the present study will attempt to answer. The scope of the study will be guided by the following three general propositions:

(1) that a close relationship exists between a person's role in the total society and his marginal role in a subsystem of the society.

(a) A person may be in an institutionalized role either within the subsystem or outside it; he may be in an institutionalized role neither within the subsystem nor outside it; finally, he may be in an institutionalized role in both the subsystem and outside it.

(b) What happens to institutionalization outside the subsystem may have some effect on institutionalization inside; and, vice versa, what happens to institutionalization inside the subsystem may have some effect on institutionalization outside.
(2) that in the process of becoming institutionalized, the marginal role affects the institutionalization of the other roles in the subsystem.

(3) where a marginal person must perform a function which is similar to that of the task group and deals with human relationships, the strains can be minimized only insofar as the members of the task group re-define their roles within the organizational subsystem.

The data for the problems to be investigated is the role of the volunteer in the state mental hospital where the non-professional, non-trained, non-paid volunteer is accepted within the organizational setting to serve functions similar to those of the professional staff members and work toward the same common goals of the hospital.

Because the role of the volunteer in the mental hospital is a relatively new one in the society, it will be possible to observe the role in some of its developmental aspects.

The idea of a sociological study of the volunteer in the mental hospital was first suggested by Dr. Milton Greenblatt, Director of Research and Laboratories at the Boston Psychopathic Hospital. The need for studies on every possible interrelationship between mental patients and hospital personnel is also emphasized by the United States Department of Health, Education, and Welfare because of the implications which such relationships might have for therapeutic purposes; and several studies have already been
completed or are now in process which are aimed toward the investigation of these relationships.¹ No sociological study on volunteers in mental hospitals has been attempted previous to the present project. However, all studies which relate to role behavior and interpersonal and group relationships have relevance for the study under hand, including not only those which are strictly sociologically oriented but also these which are usually classified as the subject matter of social psychology. More specifically from the medical point of view, numerous studies on hospital social structure and role behavior within the particular institutional framework have been recently attempted and also serve as a background for the study of the volunteer role.²


Besides contributing to a general body of theory in social organization, a study in marginal professionalization can more specifically contribute to the following areas of sociology: (a) role theory, specifically, the different roles which a person assumes in the total society and in the various subsystems of the society; (b) the sociology of the professions, particularly to the roles of both the professional and non-professional members of the task group, i.e., intra-group role behavior; and (c) the sociology of industry, specifically the relationship between an individual's actions on the job and his actions off the job.

The present study also has several practical implications. First, a study of the volunteer deals with a great potential source of labor to all organizations whose economic resources are inadequate to carry on the organizational functions with paid personnel alone. This includes not only the economics of medical care but also the economics of all welfare organizations. This implication becomes more significant with the increasing amount of leisure time available to citizens of the community. Secondly, a study centered on the layman's participation in a mental hospital with mental patients can contribute to a more receptive understanding of mental illness among the community's citizens and change the present erroneous and stereotyped
attitudes held by the general public. Finally, this more receptive attitude may further enhance the participation of citizens not only in the mental hospital itself but also in the community by assisting non-institutionalized mentally disturbed people with their problems and by helping former mental patients to make satisfactory adjustments to community life.

B. Sources of Data and Methods

The empirical setting for this study is the Boston Psychopathic Hospital located at 74 Fenwood Road in Boston, Massachusetts. Since no sociological study of volunteers has been attempted in the past, the Boston Psychopathic Hospital comprises the entire source of information included here, except for some exploratory research at two other state mental hospitals and at various conferences on volunteers in both general and mental hospitals.

There are several implications in the background for the scope of this study and the validity of the findings presented here. First, the research has been conducted in a small mental hospital, the size of which is not typical of most state mental hospitals. Secondly, the hospital in question is also unique in its specific goals and in several other aspects of its institutional framework (see Chapter II).
Third, comparison with volunteer programs in other mental hospitals which are not state controlled (i.e., private and veterans' psychiatric hospitals) must be made with some reservation because of certain variables which present themselves in connection with the different types of hospitals. However, the central problems and significance of volunteer utilization presented in this study are relevant to all types of mental hospitals.

The method chosen for collecting information for this study consisted principally of observation and interviews. The first step was a preliminary investigation for the purpose of defining the problem, formulating tentative hypotheses, and establishing a set of objectives for further research. In carrying out this step, a great deal of time was spent in informal talks, both individually and in groups, with the hospital administration, staff members, volunteers, and patients. Much of the preliminary work was directed toward compiling a bibliography and broadening the background in the general field of mental health and in hospital social structure. The second step consisted of informal depth interviews for the purpose of soliciting information relating to the central problems of the study. This informal interviewing proved to be an effective method of collecting data, since it allowed for free responses on the part of the subjects. All interviews were
recorded verbatim, which eliminated unnecessary interruptions in the respondents' thinking.

A selection of respondents was made of twenty volunteers who were interviewed for periods ranging from one to three hours at a time. In most cases these respondents were interviewed more than once. The selection of volunteers was made on the basis of a number of criteria: age, sex, period of volunteer service, student or non-student volunteer, auxiliary or non-auxiliary volunteer, and occupation of husband or father.

The remainder of the interviews were conducted with four administrators holding key positions in the hospital, three of whom were also doctors; three staff members of the occupational therapy department, one of whom was the head of the department and the other the recreational director; four doctors, including a first-, second-, third-, and fourth-year resident (in addition to those doctors mentioned above); the five head nurses of the wards, plus the director of nurses, a nurse in shock treatment, and a nurse therapist; four social workers, including the head social worker; five attendants, one of whom was female and the other four male; and the chaplain. In all, staff members comprised twenty-nine of the interviews. Most of the interviews with patients were conducted in informal group
meetings in the occupational therapy department. Approximately twenty patients participated in these discussions.

During the entire five months in which the field work was conducted, February through June, 1955, observation of as many activities as possible was carried on in every part of the hospital such as staff meetings, lectures, psychodrama sessions, and coffee shop meetings of volunteers. At this particular period certain aspects of the volunteer program were in a formative stage and must be mentioned as possible limitations of this study. First, the coffee shop was in its early period of organization, and the problems which were thus precipitated may have received undue stress in the research. Secondly, the First Institute of Volunteers was held in Massachusetts for volunteers from the various state mental hospitals, and certain antagonistic attitudes evolving from this conference may have received sufficient exaggeration to present a slight bias in the relationships between certain individuals in the hospital, notably volunteers and occupational therapists.

G. Theoretical Orientation

The orientation of this research is sociological within

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1. The theoretical schema presented here has been set down as it was discussed at several meetings with Professor Luke M. Smith to whom full credit is attributed.
the framework of the theory of action. All action is viewed as behavior belonging to a system of communication.


2. The concept of the communication system as the basis for analysis of social behavior has been both implied and explicitly designated in recent writings, receiving its first impetus in J. L. Moreno, Who Shall Survive?, Beacon House, Beacon, New York, 1935, followed by G. Lundberg and M. Lawsing, "The Sociography of Some Community Relations," American Sociological Review, June, 1937, pp. 318-338, in which it is suggested that the next logical step to the contributions of the ecological school was to develop techniques explaining social groupings in terms of the structure of the field in which they operate such as "channels of communication" and "networks" and "community nuclei." In The Human Use of Human Beings, Houghton Mifflin Co., Boston, 1950, Norbert Wiener views social behavior as dealing with the sending and receiving of messages in a communication system parallel to that of the newer communication machines. The idea is further developed in a somewhat broader sense by J. Ruesch and G. Bateson, Communication, the Social Matrix of Psychiatry, W. W. Norton and Co., New York, 1951, who emphasize its relevance for psychiatry. Finally, but perhaps most prominently, must be mentioned the contribution of Robert F. Bales in his idea of an interaction system as a key theoretical starting point which would embody the concept of the social communication system as a system of acts proceeding from a beginning toward an end in which each act of the inter-communication process is recorded through the use of a set of categories. Cf. Interaction Process Analysis, rev. ed., Addison-Wesley Press, Cambridge, 1951; also Bales, Strodtbeck, and Mills, "Channels of Communication in Small Groups," American Sociological Review, vol. 16, August, 1951, pp. 461-468.

Although implied in most of the writings cited above, however, there is no explicit statement on culture as the content of the message or personality as the sending-receiving mechanism (see p. 17).
Within such a framework the central concept used in this study will be that of role.

All social behavior is by definition communication behavior. When two or more individuals interact, they are in communication with each other. They are sending and receiving messages. Their expectations of each other's behavior are met or defined in terms of these messages, whether in overt action or in symbolic terms. Their further actions are oriented in terms of these messages and the meanings attached to them.

Social behavior, or communication behavior, consists of the sending and receiving of messages between individuals and groups of individuals; it is not behavior caused by physical or environmental factors. All aspects of human behavior, such as the group, culture, personality, role, status, etc., now become part of the communication system and can be defined operationally in terms of the sending and receiving of messages.

A social group may be defined as a system of communication in which action is viewed in terms of the individuals who send and receive the messages, the content of these messages, and the channels through which these messages are sent.

The three analytical parts of the group as a system of communication may be viewed sociologically as follows:
1. The social organization - the channels through which messages are sent.

2. The culture - the content of the messages. This content consists of three types:
   a. The cognitive content. Messages having a cognitive content refer to objects or events in the situation which are relevant to the interests of the individual sending or receiving the message. The cognitive content constitutes a blueprint of these objects and events.
   b. The moral or effort content. Messages having a moral or effort content refer to objects or events in the situation which are relevant to the individual's gratification needs.
   c. The expressive-symbolic content. Messages having an expressive-symbolic content relate to the meanings attached to social objects or events which "express" the attitudes of the individual. The expressive-symbolic content has the particular function of creating the channels through which the cognitive and moral messages can flow, keeping people predisposed to receive the cognitive messages when they come. An example of this would be ritual.

3. The personality - the sending-receiving set. As a sending-receiving set the personality sends and receives
messages but is never able to send and receive all the messages which reach it. The same personalities can be organized in different communication systems or, put differently, the same personalities can be taken out of one communication system and put into another communication system. Personalities themselves can thus become changed or themselves change the communication system. The structure of the personality is only partially dependent on the social structure.

The use of the communication system as a theoretical framework makes it possible to separate psychological and other factors from those which are purely sociological. "Why" factors and "how" factors are all viewed in terms of the sending and receiving of messages. Secondly, the communication system becomes a common denominator for all kinds of social groups, regardless of the content of the messages or the culture. This makes it possible to compare one kind of social group with any other kind of social group by simply asking the questions, who sends the message, to whom is it sent, how many messages, and how far do they extend? Finally, a theory of communication makes it possible to integrate all concepts into a body of generalized sociological theory.
D. General Plan of the Study

The study consists of the following chapter topics:
In Chapter I the problem has been stated and includes the sources of data and methods used and the theoretical orientation. Chapter II deals with the hospital background and Chapter III with the organization of the volunteer program within this hospital setting. In Chapter IV the volunteer's expectations of her own role are presented. The status of the volunteer, both inside and outside the hospital, is presented in Chapter V. In Chapter VI the performance of the volunteer in her role is viewed, while in Chapter VII the volunteer's relationships with other volunteers and with the doctors, nurses, occupational therapists, and attendants are investigated. In Chapter VIII the volunteer's role is further studied relative to its marginal position with that of the doctor. Finally, in Chapter IX, the summary of the entire study is presented, together with concluding remarks on the problems investigated. The volunteer role in the mental hospital is also further considered for any relevance which it might have for other social phenomena in the society.
CHAPTER II
THE EMPIRICAL SETTING

A. The Hospital Background

1. Brief history of the hospital. In the mental hospital system of the state of Massachusetts the Boston Psychopathic Hospital fulfills a special need, namely to offer immediate treatment and care for the acutely ill mental patients. Originally established in 1918 as a "Psychopathic Department" of the Boston State Hospital, it became an independent unit in 1920, and since that time has been known as the Boston Psychopathic Hospital, more familiarly as "Psycho." It provides for an out-patient department and treatment rooms and laboratories for purposes of scientific research "as to the nature, causes, and results of insanity." The hospital's main function, as stipulated in its charter, is to offer "short, intensive treatment for incipient, acute and curable insanity." It provides for a staff and faculty who both treat the patients and conduct scientific research in the treatment of the mentally ill.

while, at the same time, offering education to physicians, nurses, and others in the medical and related fields.

The Psycho is under the supervision of the State Department of Mental Health, headed by a Commissioner of Mental Health. This department appoints a Board of Trustees to the hospital who act as a corporation. The Board appoints the Superintendent or Medical Director, the Treasurer, and the Assistant Treasurer of the hospital.

In summary, the hospital has been assigned a special function in the state system of public hospitals: combining diagnosis, treatment, teaching, and research relating to the first care of the acutely mentally ill.

The Boston Psychopathic Hospital enjoys high prestige all over the world both as a mental hospital and as a special hospital. It is recognized for its innovations, its cures, and the contributions of its research. Affiliation with this hospital is highly desirable for anyone in the field of mental health. This prestige touches not only the medical staff and the administration but also the rest of the staff and even the patients. The most obvious advantage of this prestige, and especially more so because the Psycho is not typical of most of the mental hospitals in the country, is to create a high demand for those who want to come to this hospital, including staff, students, and
patients alike.

2. Physical aspects. The Psycho is a four-story brick building located at 74 Fenwood Road. A new research wing, including a children's division, adjoins it. The hospital is situated in the midst of a fairly well populated residential neighborhood, yet is near several other hospitals and medical schools. It is small in size compared to other state mental hospitals, accommodating but 120 beds.

The location itself possesses certain important advantages, such as accessibility to a labor market, the proximity to medical centers and libraries, the availability of transportation, etc. Some of the serious problems with which other mental hospitals have to contend, such as isolation, housing, visiting, recreational facilities for staff, and many others, are eliminated by virtue of the hospital's location. Most of the staff commute to work.

The outstanding general impression of the Psycho's location, however, is that here is a mental hospital, unusually situated in a fairly busy city neighborhood, surrounded at close proximity with that larger segment of the population which is classed as "normal" and "sane." This aspect of the Psycho's location is an important consideration for the study at hand.

A few features of the physical layout of the hospital
may be described here for purposes of this study:

The hospital contains five wards for patients: Ward 1 is an open ward for female convalescent patients; Wards 2 and 3 for convalescent male and female patients are also separate open wards; and Wards 4 and 5 are for acute male and female patients, respectively. The doors to all wards are locked at night, but during the day they are kept open in Wards 1, 2, and 3. The door leading to Wards 4 and 5 is usually locked during the day, but there are occasional exceptions to this rule. There are bars on the windows in all the wards.

The occupational therapy department occupies the entire top floor of the building, consisting principally of a large, pleasant recreation room containing comfortable lounging chairs, tables, a piano, an electric phonograph; a ceramics unit; a ping-pong room; a reading room and library; a well-equipped shop; and a sewing room used also for arts and crafts. A small greenhouse is located in the farthest corner of the department.

The physical therapy department is located in the basement and leads out into the yard. The coffee shop containing movable stools and chairs and tables is near the main entrance on the first floor. The new children's unit, completed late in 1955, is not described here and does not enter the discussion of activity embraced in this study.
3. Patient and staff population. As already mentioned, the Psycho is a relatively small mental hospital compared to other state hospitals in Massachusetts. The number of patient admissions averaged about 900 in 1953. In the same year, the rate of patients discharged to the community was 80 to 85 per cent. The length of time for commitment varies, but patients are not usually kept for more than 60 or 90 days.¹ The Psycho is unusual among mental hospitals for the high percentage of personnel per patient. However, even with 38 permanent doctors and 18 residents, account must be taken of the fact that these doctors must divide their time between the in-patient and out-patient service and the Community Clinic, together with their teaching and research obligations.

The regular staff employees of the hospital consist of the superintendent or medical director, the assistant superintendent, the clinical director, the chiefs of service, the house doctors, the psychologists, the nurses, the attendants, the social workers, the occupational, recreational, and physical therapists, and the chaplain. To these may be added the affiliate nurses who are at the hospital for purposes of training and who serve as assistants to the ward nurses.

Finally, there are the volunteers.

B. Allocation of Scarce Economic Resources

A major problem confronting all hospitals, both general and mental, is a lack of needed funds and a shortage of personnel. The costs of caring for the sick are so high that no private hospital can function on a budget made of income collected from the patients alone. The situation is somewhat alleviated where the hospital is able to use trained or partly trained personnel services either on a non-salary basis or on a minimum subsistence basis as in the case of residents and interns, or where colleges or universities pay for the hospital training of medical and nursing students, or where salaries are also wholly or partly paid by outside research funds. But for many hospitals these sources of income and personnel are not available for various reasons, and the hospital must look to other sources for its support - sources lying outside the hospital.

With the mental hospitals, particularly the state mental hospitals, where no income can be realized from patients and the maintenance of the hospital must rely chiefly on state allocated funds, the problem is often more acute. The strong mental stigma which attached itself to these hospitals at their inception a hundred and
more years ago, when "dangerous" people were "put away" in isolated hospitals for the protection of society is still present today. The popular image of mental hospitals for many years as "screaming snake pits" and of filthy and crowded conditions has undoubtedly kept many prospective employees from seeking employment at their doors, including not only personnel who are competently trained to do the job but even those with no qualifications whatsoever. The isolated locations of these hospitals have not helped the situation either. The literature testifies to the neglect of the mental hospital patient over the years. Mental stigma, ignorance, poor working conditions, and low salaries have all contributed to the paucity of personnel in mental institutions.

1. The problem of funds. Under such conditions, then, the allocation of scarce economic resources acquires a central position in the establishment of hospital policy, with accompanying strains resting on the chief executive. The problems that are constantly before him in his daily work schedule often have to do with the obtaining of funds for his hospital. To obtain these funds, he must keep up a program of outside contacts in the direction of business, industrial, and personal activities. Concomitantly, the prestige of his organization is affected by these contacts,

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and, in turn, this prestige acts as a further incentive for the additional obtaining of funds.

A common approach to the partial solution of this problem of accumulating needed funds is through the utilization of a ladies' auxiliary. This approach relies on the participation of a group of women from the neighboring community for two economic reasons: first, to act as personnel themselves; and, second, to sponsor activities of one kind or another which will bring in the needed funds. These activities may be either in the form of a direct fund-raising campaign for the hospital where community members are asked to contribute a lump sum every year, or they may consist of the raising of funds through social affairs such as dances, teas, charities, etc. The chief function of these ladies' auxiliaries, then, lies in their ability to save the hospital money and to bring in money.

2. The problem of personnel. Not only does the hospital rely on outside contacts for greater fund accumulation, but the community outside the hospital is also a direct source for the obtaining of personnel. The prestige and financial condition of the hospital may be an inducement for people to seek employment within its walls if the location barrier can be surmounted. But there are always the stigma and stereotyped impressions which are attached to all mental hospitals, and for most state mental hospitals.
there is still the further barrier of low salaries. Again, the mental hospital must resort to the use of a ladies' auxiliary to help relieve the situation.

But along with the auxiliary, the hospital relies on another body of workers to relieve personnel pressures. These are the volunteer workers. The hospital appeals to them on humanitarian, altruistic grounds to help out in an urgent situation. In the mental hospital the volunteers may be distinguished from the ladies' auxiliary in that the work of the volunteer worker involves contacts with patients, while that of the auxiliary worker does not necessarily do so.

Three patterns of volunteer organization are possible within any hospital utilizing volunteers. Sometimes the volunteer group consists entirely of the auxiliary organization, i.e., to be on the auxiliary means to be a volunteer. Sometimes an entirely separate volunteer organization exists from the auxiliary group. A third pattern is to have a volunteer group whose individual members may or may not be members of the auxiliary. This last pattern exists at the Psycho.

But whether or not volunteers are recruited directly from the auxiliary or brought in from other sources, the hospital invites these volunteers from the community to
alleviate its economic pressures. However, any hospital which considers the use of volunteers to relieve its personnel problems must orient itself to political factors which are in contrast to purely technological factors. The resistance from labor unions is outstanding in this respect. Another example is the necessity of hiring only registered occupational therapists; still another, the delays brought about in hiring new personnel because of budgetary considerations and legislative procedures.

3. Economic resources at the Psycho. The situation at the Psycho in regard to the availability of funds and personnel varies somewhat from the typical one. This is due to the particular functions which the hospital has of teaching and research in which colleges and universities and research foundations contribute to salaries. Some of the doctors who come as residents for their own training are not paid. As for personnel, the hospital is able to secure well-trained people from the surrounding locality and can even choose its personnel carefully. Students in the different services are also utilized to relieve personnel pressures.

But despite the advantages the Psycho may have in respect to both finances and personnel in relation to other mental hospitals, staff people at the Psycho nevertheless feel the pressures of lack of time and overburdening. This may be attributed in great part to the goals of the hospital
and the demands made on personnel in teaching, attending meetings, etc. For this reason the hospital continues to seek appropriations in the state budget for additional workers such as occupational therapists. At a hospital staff meeting the medical director of the Psycho comments on the present situation:

So much of the work that has to be done falls on the volunteer. I asked for four occupational therapists and three assistants, but we didn't get them this year.

Partly to relieve its personnel pressures and partly for other reasons to be elaborated on further, the Psycho seeks to add volunteers to its regular paid staff. This reliance on volunteers will be discussed in the following chapter.

6. The Goals of the Hospital

A mental hospital treats human beings as human beings rather than as things; in other words, as a task group, it deals with a human rather than a non-human problem. A general or a surgical hospital treats individuals as physiological organisms. But the mental hospital starts out with the technical definition that the problems with which it must deal are problems in psycho-sociological types of behavior and not primarily physiological in nature. The distinction between the physical life and the mental life is the basis for the goals set by the mental hospital.
The major goal of the Psycho is to bring the patient to as high a level of social and psychological efficiency within a period of time consistent with the hospital's objectives. As such it is concerned with the total care of the patient. Toward this end the hospital utilizes all kinds of personnel and a combination of methods of treatment. The minor goals of diagnosis, teaching, and research for which the hospital has been specifically designated are all centered on the earliest possible rehabilitation of the mental patient. In the establishment of these goals, the one pervading consideration has to do with the nature of mental illness. On this the hospital administration bases its entire medical objectives and defines its functions.

D. The Nature of Mental Illness

In the communication system a person is considered mentally ill when a break occurs in the communication system between this person (ego) and other people (alters). The messages sent by ego are no longer organized according to alters' expectations, and those messages received by ego from alters are not the same which alters have sent to ego. Or, ego simply does not send or receive any messages at all. Ego's personality - his sending-receiving set - has been put out of commission; ego no longer belongs to a social group.
When a person shifts his own image of what constitutes the "real" world and creates his own "unreal" or non-social one, i.e., a world inconsistent with what is considered normatively as "sane" behavior, he enters into the "insane" category of human behavior. Because of these inconsistencies in his cognitive definition of the non-social world, he no longer conforms to the accepted norms of the social system; he is no longer a part of the regular system of communication. But the channels through which his messages are sent and the content of his messages are deviations in varying degree from the communication system of the mentally "healthy"; and his condition is classed as mental sickness, where the emphasis is on the sick mind rather than on the sick body.

Since mental illness concerns a breakdown in the individual's relatedness to other social beings, it is a social illness. Furthermore, cognizance of the presence of other social beings in one's sphere of activities begins early in life, and social behavior becomes more complex and inter-related as the individual is socialized. In other words, as one grows older in the socialization process it becomes possible to seek and utilize more and more channels of communication and consequently to send out more and more messages. It is precisely because of the infinite number of the channels with their varying content that those aspects most concerned with the breakdown of the individual's
mental well-being are difficult to select out as the direct causes of the breakdown of the system. In other words, which channels, which messages, and which combinations are to be considered the significant ones for the repair of the communication system? Or, put in another way, what is the essential nature of mental illness and how should it be treated?

Mental illness, unlike most aspects of physical illness, thus presents itself as a combination of an infinite number of variables with which the physician and the hospital have to deal. Although no personality as a well-oiled sending-receiving set is ever able to receive all the messages which are sent to it, the number that does reach it is vast. The matter is further complicated by the fact that no two individuals send and receive all the same messages in their lifetimes. Therefore, both to define and thence to treat the illness becomes a virtual impossibility.

In summary, what makes a person mentally sick is not known and what makes him well is not known. This uncertainty about the intrinsic nature of mental illness, or what is considered "right," affects all aspects of the mental hospital - its objectives, treatment methods, social structure, role relationships, etc., - and is the source of greatest strain for the hospital. However, regardless of the enigmatic character of mental illness, the fact that it
is in the social environment that the symptoms of the illness first appear provides an important first clue in the search for cures.

E. The Kinds of Treatment

1. Somatic therapy. The physical approach to the treatment of mental illness includes such treatment as shock and insulin, the use of drugs, lobotomy surgery, etc. In the process of caring for physical needs and administering drugs and shock treatments, the hospital functions in a manner quite similar to general hospitals. But in the case of the mental hospital somatic therapy is but one phase of the treatment process, usually a preliminary one. When such treatment is used at all, the purpose is to bring the patient more quickly to a point where his illness can be treated in its psychological and social implications. Psychological and social treatment are always a part of the therapeutic process at the Psycho regardless of whether or not any physical treatment is used. The point may be added that the mental patient spends very little time in bed, another distinguishing characteristic from the general hospital.

The use of drugs is a source of considerable strain to everyone in the hospital. When the drug is new, what is the staff supposed to do; how do you treat the patient; what do
you do?" "While a patient is on the drug, he is immobilized. Which patients should be activated?" These are questions which often come up at hospital staff meetings. The answer, "The nature of the problem is to readapt. Has the activating staff done everything they can to activate the 'zombie' patient? If the trend is for less active patients around, we may have to readapt." The constant adjustments which must be made to the use of drugs reflect on both staff and patients.

2. Psychotherapy. The psychological approach to the treatment of mental illness is known as psychotherapy. It is based on psychodynamic and psychoanalytic theory and techniques and consists of a relationship involving two persons, the patient and the therapist. Because psychotherapy in the two-person relationship is central to the problem of the marginal volunteer, it will be discussed in more detail in Chapter VIII. Group psychotherapy is also used as a method of treatment, involving a therapist who acts as leader and a group of patients.

3. Milieu therapy. That the social environment plays an important part in the rehabilitation of the patient has already been noted. At the Psycho the social environment is accorded central significance in the statement of the major
hospital goals, along with somatic therapy and psychotherapy.¹

Once physical treatment has penetrated the barriers to communication, i.e., once the patient is put in a position where he can be "reached," he becomes a part of the hospital "community" and finds himself interacting with others. As questionable a substitute for the outside community as it may first seem to him, particularly since he may once more be the possessor of earlier attitudes about mental hospitals and mentally sick people, he is nevertheless taking a necessary first step toward becoming re-socialized and thence preparing himself for his return to his own community.

The Psycho seeks to maintain in its philosophy and objectives what is now commonly known in mental illness circles as milieu therapy, or the use of the social

¹ Stanton, Alfred H. and Morris S. Schwartz, in The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment, Basic Books, New York, 1954, p. 5, point out in similar vein the importance of the social environment but lay the stress on the actual contacts which patients make with other people: "Specialized types of treatment are available in the hospital, but many patients get better 'spontaneously.' No one knows how this happens - that is what the word 'spontaneously' indicates - but most psychiatrists and many patients believe that part of the answer is to be found in the type of contacts the patient makes with other people, staff and patients, which brings about his improvement."
environment of the hospital for therapeutic purposes.\(^1\) A similar emphasis is expressed by Jones who refers to this approach as the "therapeutic community."\(^2\) The use of such treatment is not new although its conceptualization in social-scientific terms is recent. The idea of the therapeutic community revolves around the social interaction between the patient and the group. The individual receives permissiveness through group support; group support lessens pathological defenses; the group permits a gain in status; the individual gains strength through belonging.\(^3\) Since the essence of treatment of mental illness is to re-socialize the patient so that his behavior with others will be more socially acceptable, social or milieu therapy is considered to be an important step by the hospital, and everything

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1. The concept of "milieu therapy" as developed by the Menninger Foundation, however, is more sharply psychoanalytic in orientation than is the concept of therapy stemming from the utilization of the social milieu. This distinction is made in Greenblatt et al., op. cit., pp. 12-13.


3. This sociological explanation of "social treatment," which is the term used in the particular reference, is offered by Paul S. Barrabee in his *A Study of a Mental Hospital: The Effect of its Social Structure on its Functions*, Ph.D. thesis, Department of Social Relations, Harvard University, 1951, p. 103.
possible is done to carry it out. Patient government and ex-patient club innovations, a stress on occupational therapy, regular weekly scheduled prayer meetings, evening social activities, picnics, beach parties, etc., are all provided for in milieu therapy. Patients work in the hospital coffee shop in a situation which is as close to reality as possible. Milieu therapy thus becomes the nearest approximation to normal activity which the hospital administration can contribute within the institutional framework.

Director of Research and Laboratories: Psycho has become a whole university: students go through here every year in a therapeutic community. It is a concept which involves trial and error, but now that it has arrived, it is believed to be a wonderful idea. Our job is to maximize every interaction or relationship of patient and other personnel for therapeutic purposes. We are accepting responsibility for whole family treatment.

As much as the Psycho attempts to create as many of the conditions of the outside community as possible within its walls, the hospital community can in some respects be but an artificial one. There are always the bars on the windows and the occasional locked doors. The mental stigma is not removed for the patient merely because he is treated with dignity and given freedom to move about the hospital. The strain lies in the fact that the patient may be able to adjust satisfactorily and even happily to his hospital community, but the greater problem is whether or not he will be able to cope with his own community outside the hospital once he is discharged.
F. The Social Organization of the Hospital

In the attempt to encourage as much social interaction as possible between the patient and the group, the hospital atmosphere is made as permissive as possible where such permissiveness does not conflict with the functional requisites of the hospital organization, such as preventing patients from escaping and from inflicting harm on themselves and on others. The freedom given to patients to go from one place to another in the hospital never fails to astound patients, new staff personnel, and visitors alike. In the words of one volunteer on the occasion of her first visit to the hospital,

I was very surprised and very pleased with what I saw. Everything about this hospital was different - wards open, everyone friendly, patients going where they wanted to and doing what they wanted to.

At the Psycho the freedom and permissiveness that surrounds the patients is even more pronounced for the staff personnel. All are considered as "equal" participants in the complete rehabilitation of the patient, and the term "therapeutic" or "psychiatric" or "treatment team" is accordingly applied to all personnel who have patient contacts. Doctors, nurses, social workers, occupational

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1. There are exceptions here according to the type of illness. For example, in the case of manic patients, the attempt is often made to reduce interaction.
therapists, psychologists, attendants, and volunteers are all part of the "team," as are also patients and students who may be present in the hospital. With the exception of the patients, all the others are permitted to go to the various hospital staff conferences held four days a week in which an hour each day is designated for either general discussions about daily hospital happenings or specific discussions on individual patient cases. It is not uncommon to see visiting nurses and doctors, besides various research people, attending these conferences.

Visiting nurse: It's certainly a wonderfully cooperative atmosphere. This hospital is more unlocked than our hospital. This meeting has been different from any staff conference I have ever been to; it is so much more informal and everyone feels free to talk about problems. Our staff meeting is more structured, more formal. You can feel the hierarchy more than you do here.

Besides the hospital staff conferences, special departmental conferences are held at least once weekly for the staff members of the various wards and departments. Case records of patients are available to all regular staff members and volunteers if they wish to read them. In addition, all staff personnel and volunteers are permitted free access to every part of the hospital, even beyond the locked doors.

There are obvious personal satisfactions to be derived for all personnel in the pattern of social organisation.
at the Psycho. Group therapy opportunities are always open to staff people. The fact that the problems of boredom which go into mental hospitals having custodial functions are eliminated presents a challenge to staff people who can see patients actually being sent home. In the main, to be associated with the Psycho means to feel some degree of pride for both the staff person and the patient.\footnote{1} A nurse remarks, "This hospital is open to everyone that wants to come and we don't have anything to hide." Other remarks

\footnote{1. The attempt to remake the hospital into a social institution, while at the same time develop latent aptitudes and provide personal satisfactions to staff members is summarized in Brown's introduction in Greenblatt et al., \textit{op. cit.}, p. 17: "to replace autocratic administration, inflexible departmentalism, and reliance upon considerations of status, salary, and power by more democratic procedures, greater general permissiveness and delegation of responsibility, reduction of departmental and status barriers, greater encouragement of initiative, and utilization of the concept of the therapeutic team. In such institutions the belief is held, however expressed, that the best way to assure good patient care is to provide ample opportunity for the staff to grow and develop intellectually, emotionally, and in degree of responsibility assumed. It is believed, furthermore, that for persons employed in positions that are psychologically threatening, growth is possible only if support, sympathetic understanding, and recognition are generously supplied by the administration and by one staff member to another; if supervision is used for counseling purposes rather than for checking on employees and "handing down" orders; and if opportunities abound for discussion (and perhaps also psychodrama) groups uninhibited enough to permit release of tensions, and for considerable informality in working and playing together."}
from volunteers which reflect both the prestige of the hospital and the personal satisfactions derived are as follows: "This hospital is superior to any other hospital in the state because it is better equipped and better staffed." "I picked this hospital because I heard it was terrific from an attendant who is a medical student." "It's small enough to be intimate; you're not just part of a regiment; and it has such big and important people running it." "I feel this hospital is big and broad and growing and has a lot more to offer than any other hospital in New England." "Here it's most inspiring to see people come in and even though they come in screaming, you know that they can get well." The hospital chaplain adds, "One of the problems that we have here is that we get a patient well and no one will believe he is well."

G. Strains in the Organizational Setting

Some of the strains of the Psycho, applying alike to all types of hospital organizations, have already been discussed in relation to financial and personnel pressures. For the mental hospitals there is always the strain inherent in the nature of mental illness. This also has been noted.

As a special hospital in the mental hospital system and because of the particular goals which it sets for itself, the Psycho is under additional strains not present in most
of the other mental hospitals. These may be summarized as follows:

As an innovating organization, the Psycho must be constantly alert to new developments and is always in the spotlight from the outside. New ideas always bring some amount of confusion for the Psycho new drugs and medical experiments and the constantly changing pattern of social organization as embodied in the hospital goals bring about an endless shifting in role expectations and role behavior. The upsetting of standard procedures is the rule rather than the exception at the Psycho. However, many of the difficulties brought about by these innovations are alleviated through the utilization of all possible opportunities to discuss problems at meetings and conferences.

The time factor seems to be significant in the removal of many of the strains for staff members, particularly in the adjustment of role behavior: the new resident is more resistant than the third- or fourth-year resident, the new nurse more resistant than the nurse who has been at the Psycho for a longer period. Another strain, in addition to the time factor, may be best illustrated in the words of the supervisor of the male wards:
I have been here twelve years and have gone through this change - this permissiveness which goes back three or four years. When I first came, I was resistant to the entire hospital policy and philosophy, but I've been swayed to the other extreme. Parts of it have worked out very successfully, but by going overboard so much it has made the patients too dependent upon the hospital. We have a hard time trying to get some of them discharged. It is our big problem here: we are so protective of the patient.

A volunteer also comments on the same problem which is created for the patient:

My one objection to psychiatry is that they make patients think too much of themselves. A friend of mine kept going to a hospital to see her psychiatrist. She will never leave the hospital; it's her only security. They make the patients so conscious of why they do these things. They do that here, too; I've heard doctors say this. The patients have no responsibilities here; it's just an escape. They get the patients thinking too much about themselves, but that isn't life. Life is thinking of others. I wish there were a way out.

The strain inherent in the nature of mental illness and in the use of drugs as treatment which reflects on the staff and has the appearance of confusion and lack of organisation is apparent in the following words of a volunteer who is referring to the occupational therapists:

The OT's thought that they ought to know more about patients, but the hospital didn't specify enough what the patient needed - exercise, therapy, etc. - and possibly they were giving the patient the wrong thing. They wished the doctors would give them the information. They didn't know exactly what therapy would be the best for the patients.

On the other hand, another volunteer says,

You can't do anything to eliminate the confusion. People keep coming in and going out. You never know who is here but nothing should be done about it. One of the best things about it is the informality.
Furthermore, at the Psycho problems are resolved:

Volunteer: This hospital being what it is there has been a good deal of talk. There were various small group sessions about the implications, and one of the things we talked about was the relationship which might occur between the trained OT workers and the volunteers. That's why there have been no problems: they talk it over; they see it before it becomes an acute problem. This is also due to the atmosphere of the hospital, the atmosphere they see around them all the time. They have the courage to face the problems instead of paying no attention to them.

The following interchange of conversation at a hospital staff meeting presided over by the assistant superintendent of the hospital illustrates the hospital goals, the strains, and the impression of the meeting and the hospital made on a hospital visitor and a student:

Social worker: I don't see the reason for opening this meeting to anyone who comes just once, getting one impression, and not coming back again.

Dr. Hyde: It's so easy to draw barriers to exclude someone.

Nurse (turning to visiting nurse): Would you get the feeling that everything was confused here?

Visiting nurse: No, as a matter of fact, we didn't get the feeling that everything was confusing; it was just the opposite. I certainly couldn't imagine myself being able to do this at my staff meeting. I think it is wonderful.

Theology student: I thought it was excellent. I was comparing it with a college approach. This was certainly democratic.

Social worker: I wonder about a volunteer who comes here just once and never comes again.
H. Summary

The present study has as its empirical setting the Boston Psychopathic Hospital, a state mental hospital, which combines diagnosis, treatment, teaching, and research activities relating to the first care of the acutely mentally ill. Like other hospitals, both mental and general, it lacks the economic resources necessary to carry out its functions in a manner consistent with its goals. The major goal of the Psychos is to bring the patient to as high a level of social and psychological efficiency within a period of time consistent with the hospital's objectives. Because of the nature of mental illness, the hospital administration relies on all kinds of treatment and all kinds of personnel. The three main kinds of treatment used are somatic therapy, psychotherapy, and milieu therapy. The first relies on the use of drugs and other physical treatment, the second on a doctor-patient relationship in a controlled situation or in a group situation of therapist and patients, and the third on the social interaction of the patient and the group in what is termed the "therapeutic community." The hospital administration relies on regular staff employees, patients, and volunteers to carry out its objectives.

In the attempt to encourage as much social interaction as possible, the hospital atmosphere is made as permissive as feasible; and everyone is considered to be an "equal"
participant in the therapy of the patient. All staff members and volunteers are permitted free access to every part of the hospital, to conferences, lectures, and to the use of patient records. The strains which arise from the goals set by the hospital administration have to do mainly with the nature of mental illness, innovations, institutionalized role patterns of staff and patient behavior, and the dependency of patients on the hospital.
CHAPTER III
THE ORGANIZATION OF VOLUNTEERS

A. Background of Volunteer Utilization in Mental Hospitals

The use of volunteers in mental hospitals can be traced back to over 125 years, at which time only volunteers dared to venture near the mentally ill people. Volunteers may thus be said to be the original founders of the mental hospitals. As Hyde and Hurley indicate, many of these early hospitals were founded by the Society of Friends: "The tender and intelligent ministrations of the members of the Society of Friends played an important part in the successful development of these institutions."

The volunteer movement at its inception in mental hospitals thus began as a humanitarian gesture to help unfortunates rejected by society and not as any organized movement on the part of the state to separate the mentally ill from the mentally well. Not until later did the mental

institution become the responsibility of the state. Lack of communication to the community on the part of the Friends as to what they did for the mentally ill, due either to the implicit nature and objectives of the Friends' organization or to the strong stigma attached to mental illness in the nineteenth century, resulted in the early separation of mental institution and surrounding community. This physical phenomenon has persisted.

At the present time, the participation of volunteers in mental hospitals in the United States is considered somewhat of an innovation, receiving an impetus during World War II with the shortage of trained hospital personnel and the high number of military men needing psychiatric care. But the utilization of volunteers in mental hospitals is still uncommon in this country, and many hospitals have never utilized volunteers at all. Volunteer work in mental hospitals has been most common in the military services and the veterans' hospitals. 1

B. The Volunteer Movement at the Psycho

1. Brief history. The first volunteers to come to the Psycho at the invitation of Dr. Harry C. Solomon, the present

medical director of the hospital, were the Gray Ladies of the American Red Cross who came during World War II. Hyde and Hurley describe their introduction to the hospital thus:

A very active Gray Ladies program developed with from three to seven Gray Ladies present every day of the week, each coming one day a week. They worked through the whole hospital taking crafts and recreational activities to the wards, assisting at setting up food and tables, feeding patients, arranging special social events for the patients. A total of 61 Gray Ladies participated. The social service department of the hospital contributed to the early arrangements for them.

This program started with comparatively little organization. After the Gray Ladies had been told in general of the hospital needs and the various ways in which they might be helpful, they worked out much of their own schedule. They had a leader in charge of each day's activities and a leader in charge of the total group.

The end of the war saw fewer Gray Ladies at the Psycho because of renewed home activities and a shift to the veterans' hospitals. But it was felt that the few years that they had given to the hospital had been successfully demonstrated. Furthermore, while at the hospital they had been permitted to feel out their own areas of greatest contribution and to determine for themselves how they could be most useful. After the Gray Ladies had gone, the administration invited anyone who was interested in becoming a volunteer to come to the hospital. A few of the Gray Ladies

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1. For this quotation and also the following paragraph information, ibid., p. 234.
came back to continue as volunteers.

2. Characteristics of present volunteer population.

(a) Size. In 1947 approximately 19 volunteers were reported to have participated in the work of the hospital, 57 in 1948, and 107 in 1949, most of whom came in for one day a week.\(^1\) At present there is a considerable range in the number of volunteers working in the hospital from month to month due to the presence of student volunteers who come only during their college semester periods.\(^2\) In 1955, 75 active volunteers, including students and all special groups such as those in the nursing service, were reported coming to the hospital regularly at least twice during each week.\(^3\)

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1. *Ibid.*, pp. 5-6. After these first three years there was a less precise accounting of volunteer participation. On several occasions a substantial number of volunteers worked with the nursing service of whom no permanent records were kept.

2. The auxiliary chairman of volunteers for 1954-55 estimates this range to be from 15 to 30 regular volunteers who came in at least twice a week during 1954 and 1955; and that for the four-month period from September, 1954, to January, 1955, approximately 5,000 volunteer hours were contributed by all volunteers. These figures may be somewhat below the actual number, however, as they do not include all the special groups who served as volunteers.

3. This figure is based on the records kept by the secretary to the assistant superintendent of the hospital.
(b) Sources. At present there are several sources of volunteers at the Psycho. These may be summarized as follows: The ladies' auxiliary, agency and other organizational contacts, colleges and universities, physician referrals, ex-patients, friends and relatives of staff, patients, or other volunteers. A number of regular hospital staff personnel also contribute their services at certain social events and special projects on their own time.

The ladies' auxiliary is one of the main sources of volunteers at the hospital, consisting of a small percentage of the members of the auxiliary. These women, in addition to serving in the auxiliary, also come into the hospital to serve as volunteers. The auxiliary will be discussed further in the following pages.

Volunteers interested in doing work in a mental hospital are often referred by such agencies as women's clubs, church groups, and charitable organizations. The Volunteer Service Bureau of the Community Council of Social Agencies is another type of organization which may refer a volunteer to the Psycho.

Various colleges and universities in the Boston metropolitan area send students to serve as volunteers in the hospital. Students also comprise a large part of the volunteer group along with the auxiliary women. They are assigned
certain required hours a week on a semester basis by their college instructors and given credits for their participation. They usually fulfill requirements for courses in psychology, sociology, group therapy, counseling, etc. They serve in the same capacity as other volunteers.

Another source of volunteers are the students who come to the hospital through their own efforts and on their own time without benefit of college credit.

A few volunteers are referred to the Psycho by their physicians to become volunteers for therapeutic purposes. Former patients are also a source of volunteers. Some of them return to the hospital first as part of their own rehabilitation treatment, but others come as volunteers even when not requested by the hospital to do so.

Finally, and overlapping the other sources of volunteers, there are those who come to the hospital who do not fit specifically into any of the above categories but who have been referred to the Psycho by a friend or relative. The affiliation may be to a patient, a staff member, or another volunteer.

The above categorization is but an arbitrary one and can be used for statistical purposes only. For example, benefit of therapy for a volunteer touches all of these
categories, not merely the doctor referral or the ex-patient. This will be discussed in the following chapter.

(c) Hours and days of work. There is a considerable amount of variation in the number of hours a week which volunteers spend at the hospital. The range consists of two or three hours in one afternoon to the entire week on a full-time basis. Many of the auxiliary volunteers spend either one, two, or three full days a week at the hospital. Student volunteers usually spend two afternoons a week at the hospital, except those who come during the summer on a full-time basis. Some volunteers vary the time that they spend in the hospital each week, but most volunteers come at similar times each week.

(d) Age. From the above distribution of sources of volunteers it is apparent that volunteers represent all ages. However, because of the many students who serve as volunteers, the younger volunteers predominate.

(e) Sex. Both male and female volunteers are present at the Psycho, but again this is due to the high percentage of student volunteers. However, it is important to emphasize that at the Psycho the female volunteer outranks by far the male in terms of numbers, so that for purposes of this study the volunteer is referred to in terms of the female sex.
3. The Ladies' auxiliary. In 1945, at the request of Dr. Solomon, the Boston Psychopathic Hospital Auxiliary was organized, consisting at first of a small group of doctors' wives and their friends. This group was gradually enlarged to include any woman interested in membership. At the close of 1955 membership in the auxiliary was well over 400.

In the previous chapter the chief function of the hospital auxiliary was discussed pertinent to all hospitals. At the Psycho the objectives of the auxiliary are (1) to promote the welfare of the hospital, patients, and staff; (2) to increase the hospital volunteer corps; and (3) to increase the knowledge of the public regarding mental illness. The first objective is carried out mainly in terms of providing articles and clothing for patients and sponsoring social events either for the patients themselves or for the auxiliary toward the raising of funds. To help carry out its second objective, the auxiliary appoints an auxiliary chairman of volunteers. This chairman meets and helps orient new volunteers that come to the hospital, but she is not required to be in the hospital every day. The auxiliary also seeks constantly to interest new members into becoming volunteers and working directly with patients. Finally, the auxiliary, headed by a public relations chairman, seeks to interpret to the community the work and objectives of the hospital and of the auxiliary. This it does through such
means as publishing a news letter, holding "coffee mornings" at which friends of members are invited, and by enlarging hospital contacts through attendance of auxiliary members at meetings of hospital auxiliaries. The auxiliary also sponsors a panel of hospital staff workers consisting of a doctor, nurse, recreational therapist, social worker, and a volunteer, who speak to various women's organizations and church groups about an actual patient case at the Psycho in order to illustrate the work being carried on in the hospital.

The auxiliary also maintains the coffee shop in the hospital, although it is set up as a cooperative service between the auxiliary and patients in which patients receive money for their recreation fund. A chairman of the coffee shop is appointed from the auxiliary, and there is also a vice-chairman in charge of volunteers who is also an auxiliary member. Both of these chairmen are also volunteers. The women who help in the coffee shop are not necessarily auxiliary members. The patients who work there are those who are available and who are considered well enough to function adequately. They are usually obtained by having one of the volunteers serve as liaison between the wards and the coffee shop. The stated aims of the coffee shop are for the therapy of the patients, service for the hospital personnel and patients, and financial profit for the hospital.
The above description of auxiliary objectives and activities points to the close association between the auxiliary functions and the volunteer program at the Psych. It is at once apparent that the objectives of the two groups overlap. However, the pervading consideration for purposes of this study is that the volunteer, whether or not she belongs to the auxiliary, works directly with the patients in the hospital, whereas the auxiliary member who is not a volunteer may have no contacts whatsoever with patients. This distinction must be kept in mind for the remainder of this study.

C. Hospital Goals for the Utilization of Volunteers

In the major goal of the Psych not only is it stated that all kinds of treatment will be used for the therapy of patients but also all kinds of personnel. For this reason the hospital has included on its therapy team not only the professional staff member who is trained outside the hospital for his job and the non-professional attendant who is trained in the hospital, but also the unpaid volunteer worker who need have no training whatsoever.

Assistant superintendent: The basic thing I tell the staff about volunteers is that we know there isn't going to be enough money in the budget to give to the patients. There aren't personnel of all kinds. Patients will be deprived of valuable living experiences if we can't get volunteers to help in these areas. That's why we have volunteers: to give patients those experiences and things which they can't get otherwise.
Director of Research and Laboratories: One of the forward-looking practices here is that we welcome volunteers. Volunteers seem to be a tremendous source of help, very flexible, not limited by a job description. They have enthusiasm and are important in terms of relationship to the community. Part of our big problem in the future is to make relations with the outside community, and volunteers and relatives are the big thing here.

In the therapeutic community volunteers are fitted into the hospital social system on an equal basis with other personnel. "You can't open the door for patients and close it for volunteers. The whole social system has got to have the same philosophy," says the assistant superintendent of the Psycho.

At the Psycho the volunteer is viewed as relieving financial and personnel pressures, assisting in the therapy of patients, and linking the hospital with the community. The hospital policy relies on the naturalness and normalcy of volunteers to contribute to therapy, and asks them to offer friendship and confidence to patients. Beyond this point the administrative policy of the hospital does not explicitly define the volunteer's role.

As equal participants on the therapy team, volunteers are treated by the administration in the same way as are other staff members. The assistant superintendent describes his approach:
Here a volunteer can come to me and say, "So-and-so hasn't treated me well," and it is up to me as a person to decide whether to support the volunteer against the personnel or vice versa, or to try and look into the situation in a neutral, judicious manner according to what I know about the personality of the volunteer or the personnel. I tell the volunteer, "We aren't asking our personnel to cater to you in any way." We feel that a volunteer sincerely interested in the work is getting her gratifications from the patients she is helping and isn't asking for special treatment. She must choose an ordinary civil way like other personnel. I am not going to give preferential treatment to the volunteer.

Although volunteers are treated like other hospital employees, a different stress is put on the responsibility which is assumed by the volunteer as compared to that given to the staff member. Volunteers are not as responsible as staff people except where the interests of the patients are concerned.

Assistant superintendent: Volunteers I like to treat as I treat employees. They are caught in a system. The question you have to ask is, "Has the volunteer disappointed some patient? Is there some activity which was going to be given by the volunteer but he failed to show up and the patient regards this as a personal rejection?" About this I am rather definite. I coach volunteers that if patients are anticipating them, they've got to be there and there is no excuse for their not being there. If they can't come that day, they must call in in advance and tell us. But they must let the patients know; that's their responsibility to the patients, and I will scold a volunteer if it comes to my attention that he's let a patient down. It all depends on scheduled activities.

The coffee shop chairman in charge of volunteers echoes the same thought as the assistant superintendent:
One of the first things I tell my volunteers is, "You must be responsible; you must accept certain tenets of a professional person, working in a professional atmosphere with professional people. If you expect them to accept you and value your judgments, then you must be responsible." I have been very lucky; there have been few volunteers who didn't believe that from the beginning. You have to work a little harder with those who have not worked before.

D. Administration of the Volunteer Program

The assistant superintendent of the hospital administers the volunteer program and acts for the director in all matters concerning volunteers. His is the responsibility for the recruitment, selection, orientation, assignment, and training and supervision of volunteers. Because of the heavy demands made on his time in other spheres of hospital administration, he often delegates much of this responsibility to other personnel in the hospital, such as the auxiliary chairman of volunteers, the recreational director, and the occupational therapists. Much depends on who is available at the particular time a new volunteer comes into the hospital and what the volunteer wants to do. However, the ultimate responsibility for the success or failure of the volunteer program falls on the assistant superintendent, and it is on him that the strains of the volunteer program also fall.
E. The Volunteer Program at the Psycho

Despite the fact that the volunteer program at the Psycho remains relatively unstructured, there is nevertheless a general procedure or policy which is adhered to in terms of the recruitment, selection, orientation, assignment, and supervision and training of volunteers. This program will be set down in the following paragraphs. It must be emphasized, however, that this procedure is subject to considerable deviation.

1. Recruitment. At the Psycho the procedure for recruitment is a relatively simple one; in actuality, it does not even consist of recruiting in the formal sense. Since most volunteers come to the hospital through personal contacts or are referred by colleges or other agencies, the administration does not rely on any formal recruitment methods to get volunteers. Any volunteer is recruited who shows a willingness to come and be a volunteer.

2. Selection. Again, there is no criterion for selection as a volunteer except one's willingness to come and offer to assist. Not only does the administration refrain from maintaining a policy of going out and recruiting volunteers on an organized basis, but once a volunteer has admitted her willingness to come to the hospital, the administration does not select out those volunteers whom it might
prefer to have remain as volunteers. For most hospitals, however, particularly those mental hospitals maintained for veterans of military service, the selection of volunteers is usually a long, rigorous process of interviewing and screening similar to the manner in which paid personnel might be expected to be selected. It is felt by these organizations who undertake careful screening procedures that only selected individuals are able to contribute to the program of the mentally ill. At the Psycho the lack of fine screening is justified by the administration in that the time and expense involved is not worth the effort and that fine screening does not necessarily bring the best volunteers to the hospital or retain them once they get there.

At the Psycho an initial interview may be conducted by either the assistant superintendent or some other person delegated by him to determine what skills the volunteer has to offer and possibly what the volunteer's motives are in coming to the hospital. Unless some visible personality disorder is apparent, no person is discouraged from becoming a volunteer. No personality tests are administered. Prospective volunteers are asked to fill out an application

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1. See, for example, Your Job as a Volunteer: A Handbook for VA Volunteer Hospital Workers, VA Pamphlet 6-9, Veterans Administration, Washington, D.C., September, 1949, pp. 18-19, in which a description is given of the process involved in screening and classifying volunteers.
blank containing their names, addresses, skills, background, etc. Oftentimes this initial interview is not made, especially when a new volunteer comes in with another volunteer.

The risk-taking in the matter of volunteer selection is justified thus: "If hospital authorities are fearful that 'something may happen,' that a volunteer may be selected who will cause trouble, no volunteer program is possible. Reasonable risk-taking is a part of sound medical practice, and without it a hospital cannot prosper." 1

3. Orientation. A new volunteer is given a mimeographed sheet which introduces her to the hospital and answers some of the questions which may be on her mind. It gives suggestions as to what she might do with patients and how she might best fit herself into the program; it also explains something about the kinds of mental patients in the hospital and how they may be expected to act. A pamphlet describing the hospital and its activities is also given to volunteers to help orient them to the hospital. A final phase in the orientation of new volunteers - and this is often subject to deviation - is to take them on a tour of the hospital. This is done either by a volunteer or by someone delegated by the assistant superintendent who is available at the time. Students are usually taken on this initial tour, but this is not a rule. For the

remainder of the orientation procedure, the volunteer learns for herself by asking questions of any of the regular staff or other volunteers as problems arise. Or, a volunteer may receive her orientation from the friend who brought her into the hospital. A great deal of the responsibility rests on the volunteer herself, and she seeks as much direction as she wishes. Thus, what one volunteer receives as an introduction to the Psycho may vary considerably from one person to the next. It is not surprising to hear volunteers remarking about their respective introductions to the hospital in such dissimilar fashion: "When I first came, another volunteer took me around." "I went to the volunteer chairman's house and she gave me a pamphlet and a form. Then in the hospital she showed me the wards and OT and introduced me to the staff up there." "The first day I spoke to Mae and he sent us to OT; the next day he showed us the whole hospital." "I found my own way around the hospital." "I wasn't oriented and I don't know if that was good or bad. I came in and asked one of the OT people."

Since the volunteer's decision to continue or not to continue coming to the hospital after the first visit depends to a great extent on how she feels about her introduction to the hospital, a few expressions of these feelings may be indicated as voiced by different volunteers, the first two of whom are young non-credit student volunteers
and the last two auxiliary volunteers with many years of volunteer service behind them:

Volunteer: I did volunteer work at the Hospital. In that hospital you don’t have an opportunity to go around and see how the whole hospital works; they don’t have the time to show you around. Here it certainly is an important factor in making it interesting and making a volunteer contribute all she can by making her a part of the hospital. There’s no stone unturned here; they take you to see everything. It’s very important to do that because a volunteer might get the wrong idea of how to do things if she’s not shown what is done. You might get horrible ideas — people sleeping on floors and all that; that’s where the rumors come from.

Volunteer: One doctor came and asked us what we were doing and what we thought. He was curious. I think he liked volunteers, but he thought there should be more of a program for older volunteers. We said we didn’t want any more lectures or courses; we could get this in courses in school. We don’t feel that we’d want more orientation; the best orientation is what we’ve had here. Even lectures at school wouldn’t be an orientation like this; it was the best you could want.

Volunteer: I think I was introduced to the hospital in a perfect way — talking to Dr. Hyde and being so warmly accepted by the head nurse. Never once have I not been accepted as warmly. And I’m just as friendly with the doctors, nurses, social workers, attendants, etc.

Volunteer: This hospital was a wonderful place to come to. I was immediately impressed with the friendliness of everyone. You get the idea immediately that everybody — doctors, nurses, attendants — are friendly and want to do everything to make the patient well.

4. Assignment. Unless a volunteer specifically requests initial assignment to some particular department or ward in the hospital, she is usually assigned to the occupational therapy department. In OT, as it is usually
referred to, if she has some particular skill to offer, she goes to work immediately such as in sewing, making pottery, dancing with patients, playing the piano, etc. Otherwise, she talks to patients, plays cards or other games, or does various other things.\footnote{1} It is felt by the administration that the volunteer can make the easiest adjustment to the hospital by going first to this department, so that occupational and recreational therapy usually comprise the most frequent orientation activities for volunteers.

A volunteer may remain in one department as long as she wishes, or she may go from one department to another if she chooses to do so. Volunteers with previous mental hospital experience may be initially assigned to nursing service or in the wards or in social service.

Other than perhaps offering a first suggestion to new volunteers to work in occupational therapy, the administration does not adhere to any definite assignment policy. Again it is felt that the volunteer should find her own way in the hospital and assign herself wherever she feels that she can contribute the most and, at the same time, find the most satisfying experience for herself. While on any assignment, the volunteer is free to visit any part of the hospital.

\footnote{1. The volunteer's actual role performance will be discussed at greater length in Chapter VI.}
and continue her orientation at her own pace.

5. **Supervision and training.** New volunteers are told that they are responsible to the head of the department to which they are assigned or in which they choose to work. The department head has the choice of assigning definite tasks to the volunteer or merely suggesting something that the volunteer might do. The department head may decide for himself whether or not to take time to orient the new volunteer when she first comes in or to answer questions when they arise. The decision usually depends on the time available for the staff person. The responsibility of the department head in relation to volunteers is indicated in the words of the assistant superintendent:

I tell the department heads to take the same responsibility with the volunteers as they do with their own regular personnel. That depends on everyone: to give volunteers as they ask for and need to know. If they can't talk to the volunteer now, they should arrange to do it later.

Volunteers are also told to seek information of any other staff personnel or other volunteers with whom they may come in contact, i.e., to ask the doctors or ward nurses what they might like to suggest for the volunteers to do with regard to certain patients.
F. The Social Organization of Volunteers

As an integral part of the therapy team, volunteers are accorded certain privileges which permit them to enjoy almost unlimited freedom and permissiveness within the hospital community. As already mentioned in the previous chapter, they are permitted to enter the wards at any time during the day; and they may even be given keys to enter the locked wards if they are present in the hospital long enough to make it worthwhile. They may exchange departments whenever they wish to do so. They may attend any of the hospital staff conferences held on four days a week, including those which pertain to the hospital in general or to those where patient cases are discussed. They may attend the departmental meetings. They may have access to patient records if they wish to see them. They may attend psychodrama sessions and often take part in them. They may also attend patient government meetings.

That this freedom and permissiveness never ceases to surprise all new staff personnel, patients, and visitors alike has also been noted. The volunteer is no exception. "I like the openness here — the way doctors are with the patients and the way the other people work with patients and chat with them. Everyone is so friendly." "The informality of the hospital surprised me. There is no informality between supervisors and students at the hospital.
where I trained." (This remark came from a volunteer who had trained to become a psychiatric nurse.) "I certainly feel as if I belong here and I don't feel I'm a nuisance."

"I never heard of Dr. Hyde, but I'm sure I'd consider going to him with a problem if anything came up." "I think it's wonderful here. I've never found anyone who cared where I went and what I did." The same feelings are reflected by three more volunteers in being permitted to attend the various staff meetings:

Volunteer: It's the way you're accepted that makes you feel part of the team here. I would feel free to speak up at a staff meeting if I thought I had something to contribute. I certainly never think anybody would look around and say, "What is that little volunteer talking about?"

Volunteer: I've been to several staff meetings. I was certainly surprised by the fact that we were asked to go and anybody could speak up, including me if I wished to. I felt that it was my right, but I really didn't know what to ask; I haven't been here long enough. If I keep going, I certainly will feel free to speak up.

Volunteer: I certainly think staff meetings are a very healthy thing. If you can express your feelings, you can do a lot more, and you'll take an interest in what you're doing. It did occur to me that once I had something to contribute I really would do it.

The reluctance to speak up at the staff meetings is the new volunteer's experience, however, and does not occur with the older volunteers.

To the new volunteer the Psycho thus becomes conspicuous for its lack of rules and restrictions. The volunteer
senses this absence of restrictions from her very first visit to the hospital. An older auxiliary volunteer says, "For me it's been fine to be free; I'm sort of an individual and I'm feeling my way. A lack of rules and regulations helps a lot." A student adds, "A student has a wonderful opportunity at the Psycho. You're not restricted; you have the run of the hospital. You can be a fly on the wall. You aren't restricted like the staff and you aren't restricted like the patients." Comments similar to the above may be quoted from three other volunteers, the first two of whom are young non-student volunteers and the third an older non-auxiliary volunteer:

Volunteer: We were told we could do anything we wanted to but we certainly were shown it. There were no rules whatsoever; nothing was expected of us that was definite and we didn't gather that anything particular was expected. Our job would be more or less of moving around up here and circulating.

Volunteer: I wasn't told I could do or couldn't do much. I felt that they were just saying, "Let any volunteer do what she can when she can do it and we'll stand by and help her when she needs it.

Volunteer: Volunteers are given complete freedom here - a very nice laissez-faire attitude - which is one of the nicest things I've noticed here. Another thing I've noticed is that the less restrictions you put on people, the less you need to. People are more inclined to break rules when you have a lot of them.

An important consideration in the volunteer program at the Psycho, since it affects volunteer intra-role relationships, is that there is no organized volunteer group. A possible exception is the group of coffee shop volunteers
who meet occasionally to discuss the operation of the coffee shop.

G. Strains in the Volunteer Program

For the hospital administration the utilization of volunteers becomes a source of functional strain in that no criteria of selection are applied to persons who seek to become volunteers. For the volunteer herself, the use of a permissive approach rather than one based on authoritarian lines is sometimes a source of considerable strain to the new volunteer, just as it is for the new staff member or new patient. As an unpaid, untrained worker who is given the same privileges and freedom tendered the paid workers, the volunteer can be expected to feel some apprehension when she considers that the mental health of patients is at stake. She is confused and unhappy not only because she does not know how to deal with the mental patient but because she does not have any definite job specifications with which she can comply. This feeling of inadequacy applies to both young and old volunteers, to students and non-students:

Volunteer: Nothing definite has been told to us to do by the hospital or what is expected of us. Sometimes we aren't sure exactly if they'd like us to do something else; if we're lacking in a certain way. Sometimes I wonder if we're doing the right thing. It's fine to talk for awhile, but you just can't talk all the time. I think I just have to get used to it. But it does make me feel inadequate.
A student volunteer who expected to have more information directed her way adds:

I wasn't satisfied with my orientation. I didn't know exactly how to approach the patient and what to say. I didn't know whether to tell him the truth or not, and I didn't know how to go about finding out the things I was supposed to find out. I would have liked to know more about how to conduct ourselves with patients. I might have asked a question which was harmful to the patient. It is mostly the hospital's fault but it is also the lack of instruction.

Closely connected with the above aspect of the volunteer's feelings of technical inadequacy is the lack of rules and regulations which for some volunteers is a source of considerable strain. It does not matter if the volunteer is new or experienced, but it is usually the older volunteer who feels this strain the most:

It may be that the people who work around here will help you if they see you need help, but it seems to me that most volunteers are wasted and should be given more direction: "This is what we try to do; this is the purpose; this is our policy; this is what you do." I picked it up very casually. Three years ago I was too mixed up in my own problems to be an objective observer.

This particular volunteer had been referred to the hospital by her doctor for her own therapy. In the same tone an ex-patient volunteer remarks:

There's a lack of organization in the hospital. I don't feel that I'm just groping along, but I feel that new volunteers just coming in definitely have that feeling. That's why they leave; they don't feel that they're doing anything, and they also feel that the hospital doesn't care about them and that they're needed at all.
The above dissatisfaction are summarized by a staff member who contrasts the older volunteer with the younger volunteer:

Occupational therapist: This freedom threatens more volunteers; they don't know how to handle it. They're so accustomed to "Your duties are this and this and this," and you turn them loose and they're floundered; they just don't know how to handle it. Mrs. J couldn't do anything until she had a structured situation like the coffee shop. She had come over two or three times, and I never can remember her doing anything except sitting in the greenhouse. But you give her a structured situation like the coffee shop where you know that certain things have to be done and she can do it. This is the difference between the older ones and the younger ones. The older ones are afraid of tackling new situations.

New volunteers may or may not feel this strain of lack of rules and regulations, but most of them state that they do feel confused because they cannot identify patients from staff or visitors or other volunteers. Usually, the lack of identification for the volunteer is not as disconcerting as it is for the staff, and it is a strain which is often eliminated for most volunteers after the first few days at the hospital. Occasionally, however, it may even become a problem, as in the third example quoted below:

Volunteer: The first day Mac showed us around the hospital. Mac said, "You'll have to know some of the patients." There were groups of people around. I said, "How will I ever get into this group of people?" But I went up to a woman and asked her if she did any pottery. She said no. I asked her if she did any of the paintings. She said no. She kept saying no. I asked her everything in the books. Finally, I said, "What do you do here?" She said, "I'm a visitor." I think maybe she thought I was a patient, that I wasn't a volunteer at all. But it doesn't bother me that everyone gets confused.
Volunteer: A priest was visiting here one day. A patient across the room yelled a question at him. He thought I had asked the question so he turned around and explained the whole thing to me, something about leather, I think this is nice in a way. Actually, it doesn't make so much difference in the beginning. But after you've been here three or four times everyone doesn't know you as a patient but as a volunteer.

Volunteer: One thing I've noticed here: volunteers don't wear any coats or pins, and it's a regular feeling to want to know to whom you're talking. People always ask you what you're doing here. I'd be embarrassed if I asked a doctor to play with clay. I asked an attendant once if he wanted to play with clay and he said, "No, thank you." Another staff person asked me how long I had been here: he thought I was a patient. I heard of an auxiliary volunteer asking a medical student, thinking he was a patient, if he would like to play rummy because he looked depressed, and he did play. Afterwards he discovered she was a volunteer; he thought she was a patient, too! The only time it's worth knowing who you are is if there's trouble. One of the men was necking with one of the women. I didn't know what to do. If I had tried to take him downstairs, why should he go? An attendant was there, but I didn't know it and I just waited. If there hadn't been an attendant there, I suppose I would have been responsible. I would have taken the responsibility to get someone.

However, not all volunteers are able to make the decision to assume the responsibility that this volunteer did.

One of the most serious strains attached to the volunteer program at the Psycho is the factor of time. This is evident in two different instances. First, the strain is inherent in the very nature of the volunteer role: a volunteer can come to the hospital only on certain hours and on certain days (there are, of course, exceptions), and even the specified hours are subject to modification if outside activities conflict with the volunteer's hospital
schedule. Around this strain which affects staff, patients, and volunteers alike, the administration has made its one demand concerning the responsibility of the volunteer. A staff member in charge of the physical therapy program expresses this problem in his own words:

I've had volunteers come for one day here and there, and you just can't rely on them. I get a program set up and it falls through. I remember once there was a football fellow here doing some recreation, and I got a program going and talked it up to the patients for a week. I got quite a bunch of fellows lined up who were interested, but he just didn't show up. He said he had to go to some game or other, but I couldn't get the patients picked up again. You can't rely on volunteers.

The second strain involving the factor of time initially pertains to the orientation of volunteers and the part which staff members have in this orientation. Because the particular goals of the hospital make such heavy demands on the time of all personnel, volunteers are often apt to feel neglected if they are not immediately shown around the hospital and specifically told what they should do by someone on the staff. The strain thus falls not only on the volunteer who seeks direction, but also on the staff member who must give up precious time to orient new volunteers. "Volunteers are just another group needing time to help and orient. Selfishly speaking, this takes me away from the patients," says a ward nurse.

The strain which the volunteer feels in connection with her orientation, however, stretches beyond the fact that she
comes in for only a few hours a week or because the staff personnel do not have time to orient her. It may be brought about by either one or both of two reasons. First, the volunteer may not have been able to adjust easily to the behavior or even the presence of the mental patients. For this reason she may seek the protection and help of the staff and be dissatisfied if she does not get a conducted tour when she first comes to the hospital or if she does not get some definite assignment to perform. The volunteer in this position is the one who does not remain at the hospital unless she overcomes her initial fears about mental illness. Secondly, she may not have been able to define her own role as a volunteer in the same way in which the hospital has defined it for her. The volunteer fails to see that she contributes something as a person in the first place and by just being present in the hospital in the second place. An experienced auxiliary volunteer puts it this way:

It seems to me that one of the basic tenets of the hospital is that a person is valuable as a person regardless of what he or she is, and it is because of this that a volunteer is able to contribute. The volunteer has an opportunity to go further than find a place in the sun; it goes beyond the individual if you stick with it long enough.

Again, it must be emphasized that it is not necessarily the new volunteer who complains about the lack of orientation. Volunteers who have spent considerable time, perhaps months
and even years, in the hospital make remarks such as the following: "I didn't know that I could go to staff meetings." "The first time I heard about the open-door policy was when they allowed my dog to come in." "My previous hospital experience helped me a lot, but for a volunteer who didn't know some of the ropes, the orientation should be different." "I think we should have a paid director of volunteers, someone to meet the volunteer, to give her a little preliminary orientation, the literature she needs, and to take her around."

The volunteer who professes dissatisfaction in the orientation which she receives at the Psycho may become a problem to the administration and to the entire volunteer program. These strains are well summarized in the following two quotations. They are the words of older volunteers, the first of whom is a non-auxiliary volunteer and the second an auxiliary volunteer:

Volunteer: More should be done about orientation. I brought three students here, hoping to interest them in becoming volunteers. They weren't shown around at all. They were interested enough in coming over here but none ever came back. I felt that they needed a more dynamic and positive talk about how valuable they would be and how the hospital depended on just such people. If there was something more about the hospital that could have interested them, they would have come back. Someone is needed to sell these people. A great deal depends on the person who interviews them. Some come here because of curiosity, but almost all of them could be persuaded to come back. A person should be reassured that there is nothing to be disturbed about and that things will really quiet down. I was here for three
weeks before I knew the patients from the volunteers. I knew that I could ask the OT's what to do; there was enough for me to do; but I'm thinking of the people who get in the door once and never come back again and what could be done to keep them.

Volunteer: When I first came, Mrs. S took me around, but no one ever told me how to approach the patient. I just didn't know what to do. I felt that I needed someone to show me how to approach the patient. At a conference on volunteers I said there ought to be more done for volunteers, and one woman from this hospital spoke up and said the philosophy of this hospital was against training volunteers. Another woman said, "Well, if that's the kind of a volunteer she is and wants training, we don't want her anyway." Mrs. L said she personally would not tolerate training; she didn't want anyone to tell her how to train patients. That was our great dividing point: some who didn't think there was a need for orienting volunteers and another group who did think they needed something. The hospital's philosophy is against training, and I don't think that's right.

On the other hand, a young non-student volunteer professes to have been at somewhat of a loss during her first few days at the hospital but is able to resolve her problem:

When I first called up and asked to come in as a volunteer, it sounded to me that no one had ever heard of a volunteer here. Finally, I was referred to the "chief." I didn't know who he was. No one seemed to be responsible for assignment or finding out who I was. Next day I went into pottery; no one seemed to care where I went and whether I worked a half day or all day, which is fine with me; but if I hadn't wanted to do pottery, I would have been lost and I would have wondered to whom I would go, whom would I ask, to whom was I responsible. I was never told about what jobs could be done; I had no idea of what volunteers could do here; I was never put on the wards. I had only seen one other volunteer. I asked her if you could do anything you wanted to and she said, "No one has ever stopped me!" But I would have come back; I would have asked.
The above example illustrates how a volunteer is able to accept the definition which the hospital gives to her role; the volunteer sincerely interested in helping patients will find her own way and seek her own orientation. An auxiliary volunteer who had been at the Psycho for many years sums up the process of such self-orientation:

Volunteer: If the hospital were a large one and had an infinite capacity to absorb volunteers, I would say that the present system is very inadequate. With the setup as it is, I would hate to see a more rigidly organized situation because one of its strengths is the superseding process that goes on; the ones that are going to be the most valuable are the ones that make that self-orientation for themselves. They're the ones that do the work for the longest time, and they're the ones that are ready to take any criticism that the hospital is going to give them.

A student volunteer has even fewer words: "At the beginning my role wasn't clearly defined; not having a specific job, and I came to my own conclusions as to why I was here."

H. Summary

The volunteer program at the Psycho was organized shortly after the second World War but has gained its greatest impetus only in the last few years. The main sources of volunteers are the ladies' auxiliary of the hospital, agency and other organizational contacts, colleges and universities, physician referrals, ex-patients, and friends and relatives of either patients, staff, or other
volunteers. The hours of work spent by the volunteer at the hospital range from two or three to a full-time basis. The volunteer population consists of all ages, beginning with the college student; it consists also of both sexes, predominantly female. The role of the volunteer at the Psycho is discussed in this study as a female one.

The hospital goals for the utilization of volunteers provide for the inclusion of non-professional, non-trained, non-paid volunteers on the therapy team along with the doctors, nurses, occupational therapists, social workers, and attendants. The volunteer is viewed in the hospital goals as relieving financial and personnel pressures, assisting in the therapy of patients, and linking the hospital with the community. In her relationships with patients, the volunteer is asked to offer friendship and confidence. Beyond this point the hospital does not explicitly define the volunteer's role. The volunteer program at the Psycho is thus observed to be a relatively unstructured one and subject to considerable deviation from the general program in matters of recruitment, selection, orientation, assignment, and supervision and training of volunteers. There is no organized volunteer group at the Psycho and no paid director. The program is administered by the assistant superintendent of the hospital.
As an integral part of the therapy team volunteers are accorded certain privileges which permit them to enjoy almost unlimited freedom within the hospital community. The accompanying strains for the volunteer have to do with feelings of technical inadequacy, the lack of rules and regulations, the confusion of roles, and the limitations in matters of time spent at the hospital. The use of a permissive approach rather than an authoritarian one is a source of considerable strain to the new volunteer, as is also the lack of definite job specifications. For the hospital administration the utilization of volunteers is a source of functional strain in that no criteria of selection are applied to persons who seek to become volunteers. Furthermore, the discrepancy between the administrative policy which favors an unstructured volunteer program and the volunteer's dissatisfaction at this unclear structure indicates a functional clash between administrative policy and volunteer.
CHAPTER IV
ROLE EXPECTATIONS

In the communication system ego does three things. First, he sends out certain kinds of messages, either bouquets or brickbats. Secondly, he receives messages, also of certain kinds. Thirdly, he transmits some of the messages which he receives. Even in a two-actor situation he is transmitting messages. He sends one message and gets one back. The kind of message he sends out in order to get a response - whether a bouquet or brickbat - is called his social role.

The concept of role is dynamic in that one looks at what ego is doing. The concern is for ego as a transmitter of messages in the extended system of communication. If, for some reason, this transmitter ceases to function, there can be no messages and consequently no role.

An institutionalized role is one in which the alters expect this behavior of ego, and ego in turn knows that alters expect this behavior and also thinks that he himself
should behave in this way. Both ego and alter agree that they should both behave in this way: expectations are mutual. When a role is not institutionalized, there is some difference in agreement as to how ego should behave. Ego throws a brickbat to get a bouquet in return or throws a bouquet to get a brickbat in return.

In the present study an opportunity is afforded to observe a new role in the system of communication. Thus, viewed in dynamic terms rather than static, the volunteer role can be conceptualized here in terms of a development movement - the movement of ego into a social role and the development of that role into a larger system of communication.

In Chapter II the institutional framework within which this new role was to be introduced and developed was described, and in Chapter III the definition of this new role in relation to the hospital goals was set forth. In the present chapter the attempt will be made to indicate what the volunteer's expectations of her role are within the framework of the hospital social system and the hospital goals.

Perhaps the outstanding observation which one might make on the volunteer entering the mental hospital for the
time is that she simply does not know what her role will be. She has no clear image of her role because a volunteer in a mental hospital does not have an institutionalized role. She has some rather vague notions, to be sure, as to what she might be expected to do in the mental hospital, but these are all tied in with her previous knowledge and ideas about mental illness and mental hospitals, her former experience as a volunteer in another hospital either mental or otherwise, her motives in volunteering in the first place, acquaintances who have either been mental patients themselves or who have some other connection with a mental hospital, and even what she has read in books or has been told by her professors at college. Because the volunteer's experiences outside the hospital bear so strongly on how she first visualises her role, it is necessary first to look into her attitudes about mental illness and her reasons for coming to the hospital as a volunteer. It will then be possible to consider the volunteer's definition of her own role.

A. Attitudes about Mental Illness

The expectations which a volunteer brings to her role are rooted in her attitudes about mental illness and mental hospitals even before she enters the doors of the hospital. The basic feeling usually involves some degree of fear,
ranging from apprehension to almost terror. This might occur despite any previous orientation or association with mental illness or mental hospitals which the volunteer might have had. In other words, it does not matter if the volunteer is the wife of a psychiatrist on the hospital staff or if she knows someone who has introduced her to the hospital. The first emotional accompaniment to mental illness is most often that of fear, and it is openly professed. "I really didn't know what to expect when I came here," followed immediately by "I expected to find a screaming snake pit" is the most common response when the volunteer is asked what she expected to find in a mental hospital. This response comes from younger and older volunteers alike. "I thought mental hospitals all had very poor conditions, very few trimmings, patients very depressed and some very scary. I don't know where I got these ideas," says one young volunteer. A student volunteer says, "I expected to find what I had seen in the movies, the snake pit idea of a mental institution, dark and gloomy, etc. Patients weren't as bad as in the movies, but my ideas of hospitals weren't so good." Another student volunteer adds, "I expected to find patients a bit more disturbed than I did. I had the leary picture of a mental hospital." The wife of a hospital doctor has the same early impression: "I started working in a mental hospital almost the same time as my husband started training to be a psychiatrist, and I
had no background to go on. I would say my attitude was
the same as anyone else's."

Volunteers admit getting their early ideas about mental
illness "mostly from books and articles." This included
even the students who were in the hospital to add to their
training in psychology. The explanation comes from the
student volunteer herself as to how textbooks contributed
to the "leary picture" she had of mental patients: "Books
give you the extreme cases; they don't mention patients
with problems."

The impression of mental hospitals and mental patients
occasionally takes on a slightly different emphasis, but
still accompanied by fear, for a few volunteers who have had
some previous orientation to the mental hospital:

Volunteer: I really didn't know what to expect when
I came here. I thought a mental hospital would have
a lot of strange people in it - I had no idea. I
had been in a mental hospital before, so I didn't
expect to see a bunch of raving idiots.

But even here the volunteer did not know exactly what to
expect. "I approached it with some apprehension," says
another volunteer who had been first introduced to the
hospital through a relative who was a hospital trustee,
"but I have very little personal fear." She admitted, how-
ever, that she had expected to find the same "screaming
snake pit" that the others had mentioned. Again, the wife
of a doctor on the hospital staff says, "It never bothered me because of my husband. I've had a few qualms about working with disturbed patients, not because I was afraid but because I felt inadequate."

Sometimes fear is accompanied by curiosity: "I was fascinated," says a young volunteer who had neglected to mention that there was mental illness in her family. "It was something new I hadn't tried before," was her explanation for the fascination she felt. A student volunteer cites another reason: "I was curious to say the least. I was looking forward to it. I wasn't getting anything out of books." Another student who had come to supplement a college course says, "I wasn't afraid in any way. I had enough of a background to realize what I was getting into. I had read about conditions; hospitals were understaffed, overcrowded, etc." The volunteer who had been referred to the hospital by her private psychiatrist and had herself experienced mental illness says, "My impressions of a mental hospital weren't of the snake pit variety. I've done a terrific amount of reading which may have something to do with it. Any anything that horrible must be exaggerated."

Finally, for the volunteer first entering a mental hospital, the Psycho is identified as a particular hospital as it reflects on attitudes: "I expected to find this
hospital a little better than other state hospitals and found it was set up even better than I expected. I was surprised by the ratio of personnel to patients," says a young student volunteer. Another student adds, "I had heard that mental hospitals were horrible, but I had also heard that the Psycho was modern and up to date." But both students had the same "leary picture" of the average mental hospital before they came to the Psycho.

For most volunteers there is an immediate change of attitude about mental illness after the first few days' experiences at the hospital. For some this change comes the first day. These are the volunteers who begin to realize that a mental hospital is not a snake pit after all, and that the people who inhabit mental hospitals are sick and not insane. The volunteer recognizes that she is attached to a hospital which not only gives her privileges which she never expected to have but which treats patients like sick people instead of "criminals." The volunteer is able to see for herself that mental illness is an illness like other illnesses. The volunteer who describes her first day in the hospital in this manner:

The first day I wasn't sure whether I liked it at all or whether I could even do it or even if I was qualified to do it. That first night after I got home was perfectly horrible; I could never forget it, goes on to recall the few days which followed:
The second day we were taken to see shock. Eventually you're going to have to see things, and I think it's better to see these things first. You want to see all the things you have your own ideas about. The next day it becomes easier and easier and easier. At shock I really thought I was going to lose my breakfast with the first treatment, but the second one was nothing. As time went on I understood what was going on and there was nothing to be feared. Also, the first day we were told there were some criminal cases here, and we weren't sure if someone would attack us. Then you get to talk to these patients and some of your fears go, and you wonder how they ever could have done anything wrong, they're so innocent looking.

It is thus apparent that as the volunteer observes what goes on in a mental hospital the fear lessens. Such a change in attitude is reflected in the words of another volunteer who was "terrified" when she first came to the hospital and who attributes her change in attitude to the hospital policy about volunteers and the way she was treated:

Mae took us everywhere; it was the best thing that could have been done. Just the openness of everything amazed me. It took a whole lot of the fear from me. I didn't know I could cope with the unknown. The fear just wasn't there any more.

The volunteer who was once a patient herself in the same hospital describes her own change of attitude: "I used to think that mental illness was something terrible and I was scared stiff of it. After I became well, I said what a ridiculous thing to be afraid of it." But the most common expression of changing attitude about the patients is reflected in the words of the volunteer who says, "I got to realize that they are sick people just like anyone else. I
found out that they respond like anybody else to appreciation and helpfulness and kindness." The change in attitude is thus simply an understanding that the mental patient is a human being.

B. Motivational Factors

Why a person comes to the mental hospital is important for any consideration of the volunteer's role expectations. However, since this concerns the status of the volunteer in the community, motivational factors will be discussed in the following chapter.

C. The Volunteer's Definition of Her Role

As previously indicated, the volunteer who first enters the mental hospital does not have a clear image of her role. Because this image which she has on the first day she enters the hospital is likely to change even after the first few hours in the hospital, it is necessary to separate the volunteer's expectations of her role before and after she enters the hospital.

1. The volunteer as helper. The most frequently expressed expectation before knowing of the hospital's objectives or observing what other volunteers do at the Psycho is that the volunteer role in the mental hospital is
similar to the volunteer role in other general hospitals, namely, that the volunteer is to help the regular staff personnel and fill in where needed, performing chores that others don't have time to do or simply do not want to do. One of the first volunteers to come to the hospital says, "I expected to be just an extra pair of hands and feet and to run errands. I had a nurse's aide uniform and I think it helped the nurses to know that I had some training." Another volunteer says, "My impression of the volunteer's role was much like the volunteer in any other hospital: you do the dirty work." "I really didn't care what I did," says another, "anything that was given to me." Still another, "I thought that I would do what the others didn't have time to do, but I didn't particularly mind it; I expected it."

The emphasis that these new volunteers give to their role is that they will supplement the work done by the other staff members, even if this work is of a so-called "menial" nature. The volunteer thus brings with her the image of the institutionalized role of the volunteer in the general hospital. "We are to supplement and not supplant the other workers." At the same time, the volunteer realizes that in performing these chores, she is saving the hospital money.

The above expectation of the volunteer role comes from
the person who has never been in a mental hospital before or who has had no previous orientation to the Psycho, such as the wife of a doctor on the hospital staff, a student sent by a college, a relative or friend of someone who has been a volunteer, or even someone who might have been a patient herself. The volunteer who was herself a psychiatric nurse before her marriage, for example, looked on her role as a volunteer in the beginning as one in which she would fill in where she was needed. "I just worked myself in at insulin and they told me what to do. I felt very accepted immediately by everyone because I was useful. They knew I was a nurse."

But when the volunteer has had some previous orientation as to what she might expect to find at the Psycho, the expectations of her role are likely to be different. One girl who had first heard about the hospital through a friend who was herself a volunteer thought she would spend most of her time "talking and seeing that people were happy and occupied and moving along" either on the wards or somewhere else in the hospital. She still felt that she would be filling in gaps, however. "We fill in the gaps when patients can't have complete attention from the others." But her idea of filling in gaps was to spend the time with patients, not to perform ward chores like making beds or carrying trays to patients. A student volunteer
says, "Originally I thought that I would talk to any patient that happened to be around and work with him, but we were told to settle down with one patient." Another student volunteer who had done volunteer work in another hospital adds, "I was interested in Psycho because I thought it might broaden me and I also wanted to help people." In all these instances, the volunteer's expectations are to relate with patients.

Another group who believed that they would be helping patients, besides filling in for staff people, were those who had some definite skills to offer. The volunteer's early image of her role is thus often related to the skills which she herself is able to bring to the hospital. The volunteer who has had training or experience in arts and crafts can picture her role as one in which she might help to teach patients how to work with their hands. There is less guesswork as to what her role will consist of if she has these skills: her role has more defined boundaries for her. The volunteer who has had specific training to become an occupational therapist especially knows how she can put her training to use in the mental hospital. One such person looked on her work as even more therapeutic than the doctor's. Another volunteer thought that she could combine her craft work with group work, and she had come to the hospital to gain experience before applying to
a school to become an occupational therapist. But even though the volunteer who has had some definite skills to offer sees her role in more defined proportions than the volunteer without skills, even she can express uncertainty as to how she can best apply those skills when she is surrounded by mental patients.

However, except for the volunteers who knew about the Psycho goals before coming to the hospital and those who felt that their skills might be utilized, most volunteers did not visualize their roles in the light of directly helping the patients rather than the staff workers. Even the students looked more upon their role as a learning experience rather than as being a friend or sympathetic listener to a patient's problems. The volunteer who looked upon her presence in the hospital as being therapeutic for the patient was the exception rather than the rule. For the most part, the volunteer entering the Psycho for the first time saw her role as one in which she would merely help staff people out whenever they needed help in the capacity of running errands, operating the elevator, and making beds; she would be standing by to assume any task which needed to be done. She would be supplementing the staff personnel. "I just never thought I could do anything as a volunteer, but my friend told me that they do have people here who don't have any particular qualifications,"
said one volunteer on her first visit to the hospital. On her next visit she was able to define her own role with somewhat more exactitude.

2. The volunteer as friend. When the volunteer is told about hospital goals or has heard about them before coming to the Psycho to volunteer, her role expectations take on a different perspective and she begins to see her role almost entirely in terms of giving friendship and confidence to patients, of lending an ear to a patient who wants to talk to someone. She may feel considerable strain at the amount of freedom and the lack of restrictions given to volunteers, even where she has orientation to the Psycho from someone else. But for the volunteer who is able to make the adjustment to the mental patient, that is, when she comes to feel that the patient in the mental hospital is just another sick person and not a "raving idiot," she immediately begins to see her role in the friendship capacity which the hospital administration has designated as her contribution to therapy. Even after the first few visits (it may be only one), the volunteer's image of her role assumes a different direction. Tasks such as sweeping floors, carrying trays, or operating the elevator fade into the background. She sees her role mainly as establishing a relationship with a patient, as being a friend to anyone who needs friendship and contact with a social being. "The
hospital expects of me as a volunteer to be friendly, somebody from the outside to show interest in the patients," says one student volunteer. The student volunteer seize her opportunity to relate thus with patients because she realizes it is the best way for her to learn about mental illness. But the same volunteer adds, "I realize now that patients are people with illnesses and need a lot of attention and time; I feel that that's all I can do as a volunteer, just be friends." One student volunteer who said that in the beginning she was quite bored because she didn't know what to expect and would have liked definite duties adds, "but I soon realized that that was the only way you could learn as much as I did - be friendly with the patients."

Another auxiliary volunteer says,

The only thing I do is to go in and give magazines that someone might want to look at. There's that need for talk, not the way they talk to psychiatrists but as to a friend. I just sense whether someone wants to talk or doesn't want to talk.

Another middle-aged volunteer who said that she had come to the hospital because of an aunt who was mentally ill (she later admitted that she had herself been to see a psychiatrist), was able to say on the occasion of her second visit to the hospital:

I am personally thrilled to know that I as a volunteer can be useful here. I feel that although I have no special talents I can do something with the patients - play cards and talk with them just to make them feel that they have someone that cares for them.
Friendship thus becomes linked with usefulness. The patient in the mental hospital is like any other human being, and friendship is something that every social being wants and needs. The volunteer is not different from any of the staff in having this friendship to offer to patients, but the volunteer has the time to sit and talk to someone. The volunteer may still be filling in the gaps, but they are a different kind of gap - listening to a patient because the nurse or other staff people don't have time to listen. A volunteer who was herself an art teacher outside the hospital and was working in the busy occupational therapy department says, "Not only do volunteers have a part here but they are a necessity. There just aren't people to work with patients and listen to them." Two young volunteers reflect the same feeling:

Volunteer: There are some patients that are willing to talk their problems over with anybody that will stop and listen. We have the time to sit and listen, whereas most of the OT people have plenty of other things to do.

Volunteer: As a volunteer I have free hours and I can make somebody busy, and I can touch the individuals who are not being taken care of and aren't doing anything. I can fill in the gaps because the staff are busy.

Finally, the volunteer who has been in the hospital for several years expresses her role expectations purely in terms of friendship, but in a kind of friendship that comes from long acquaintance with patients and from many hours of association:
Volunteer: The moment they're in the hospital they're bombarded with questions - the social worker, the doctor, the medical student - they're being questioned all the time. But about a volunteer the patient says, "She's from the outside; she's my friend." I have nothing but friendship to give them, no authority, and the patients sense this. I'd love to talk to volunteers when they come in and tell them that we can represent an area of friendship and interest and sympathy where these people who are going about and doing their job don't have the time for. It's a warming influence that a volunteer should bring into the hospital, not one of fear.

Volunteer: Being a volunteer is an understanding of people, a sympathy for people. You want to help people in a way who are helpless. A feeling that you want to do something for people in general; you like people.

Volunteer: All that I am and all that any volunteer should be is simply a friend. Two girls on a ward are pleading for me to take them home. All I do is tell them that I'm not a doctor or nurse or anyone else, simply a friend. As a volunteer I can put over to the mental patient that she's my friend and nothing else but my friend.

Volunteer: If you're sick, you want to hold someone's hand; you want someone to hold on to. The more there is of that, the more contact, the more friendliness that someone is interested in you, the better. If I go by the ward and see some man crying, the nurses and attendants might be busy. I go over and see him and say, "I'm sorry you feel so badly. Would you like to talk about it?" It's just giving the time when it's desperately needed. Volunteers should be around all the time; it would be wonderful to be there to give the warmth that the busy nurses don't have time to give.

The volunteer who has been a mental patient herself extends her feelings about what a volunteer can give to a patient beyond the area of friendship. She knows what it is to be sick and without friends. She describes the patient's position:
It's the strangeness more than anything else. I was in Ward 5 as a patient myself for twenty-five days. I can understand how patients feel because I've felt it myself. Love means a great deal in a person's life; without it you haven't anything. The ones that have been the sickest are the ones without love. A volunteer can do something about this that the others can't do.

Finally, one volunteer contrasts her central role function of friendship at the Psycho with the emphasis at other mental hospitals:

In other hospitals you're given more definite tasks and it is easier to be at ease with patients, but here you have to use more of your resources; there's more effort involved here, and I suppose it's because you're under more pressure. But you make more of a contribution here in the sense that you have to put more into it.

For her, being a volunteer at the Psycho presents a challenge.

3. The volunteer as therapist. The fact that the Psycho also emphasizes to volunteers that in their capacity as friends they help in making patients well and also that they are to consider themselves as part of a team which works together toward the therapy of patients, gives volunteers an extended image of their friendship role, and they come to define the volunteer role in terms of helping patients to get well. This addition to their definition of their role as a friend comes only after they have had the opportunity to establish a relationship with a patient and to observe some evidence of change in patient behavior, even if they also believe that others have had a share in bringing about this change. Not only may they come to see
themselves as therapists, but some go so far as to consider themselves as essential to the therapy of the patients as are the doctors. This aspect of the volunteer as therapist is central to the problem undertaken in this study, and it will be discussed in Chapter VIII.

4. The volunteer as link with the community. The volunteer even comes to see the symbolic nature of her role. As a symbol she represents the community to the patient: she is the community. But the volunteer does not usually note her role as linking hospital with community until she has participated in the life of the hospital and becomes acquainted with patients. She has not come to the hospital for the sole purpose of being able to go back home and tell others about what goes on in a mental hospital; as a matter of fact, she is not even certain what she will find when she gets there, and this is enough to occupy her early thoughts. When she does get to the hospital, she may either discover for herself or hear from other people that besides the fact that she does not get paid for her services, her unique contribution lies in the fact that she links the hospital with the community. This function she performs by merely coming in to the hospital and going out again to tell someone else what she has seen in the hospital and what she has learned about mental illness and mental hospitals. In this respect she is no different from the patient who is
discharged, the staff people who commute to their homes every day, the medical students or the affiliate nurses who come for training, and even the visitors to the hospital. But her uniqueness lies in the fact that she has come of her own free will - that she is a volunteer - and that she represents the community as the patient has left it and will return to it. No other of the persons mentioned above can contribute this link in the way that she can.

Volunteer: Any person who goes out and talks to others about what she is doing in the hospital adds so much to the knowledge of the general public. The staff has the same opportunity to bring this out, but a volunteer can talk about it without seeming to talk shop. Someone who is doing it every day might feel that someone else might be bored hearing about the hospital all the time.

The volunteer as a link with the community may be considered in three different aspects. First, the volunteer brings the community into the hospital for the patient and keeps the patient in contact with the community. Especially for the patient whose friends and relatives may have neglected her, the volunteer may be the only contact which the patient has with the outside world. The staff person also comes from the community, but the staff person comes to the hospital to perform certain tasks and to get paid for them; he may be the one who is the patient's best friend, but in his institutionalized role of authority and job prescription, the staff member does not represent the patient's community as does the volunteer. The volunteer symbolizes
the community to the patient and brings hope to the patient who does not want to leave the hospital because he dreads to face the outside world again. The volunteer is able to remove the stigma attached to mental illness because she represents that outside world, and no matter what her motives may have been in coming to the hospital in the first place, just by being present she is proving to the patient that the outside world still accepts him. The volunteer represents the normalcy of the community, "a breath of everyday normal living." The symbolic nature of the volunteer role is reflected in the words of the patients themselves:

Patient: Volunteers are people who try and do good to people. They give assistance toward human society. They don't ring doorbells. They understand people who are ill, bring people up who have fallen down.

Patient: I think that from a spiritual point of view they give you a rebirth, a revival in life because it creates a little more love in your heart for them and for mankind also.

The volunteer who sees her role as a link with the community can also understand how she might be the person to remove the stigma of mental illness for the patient:

Volunteer: A volunteer has time to sit down and tell the patient, "It's no different to come to the mental hospital than to go to another hospital." They feel there is a stigma attached to mental illness even more so than others, so the volunteer coming in from the outside can tell them this and they will believe it. It is reassurance of a popular attitude about mental illness that a volunteer can bring into a mental hospital.
One volunteer goes so far as to mention this aspect of the volunteer's role as being valuable to the therapy of the patient:

It is this function which the medical staff recognizes as a therapeutic function of the volunteer: She brings into the hospital a taste of the outside world and helps patients keep in contact with that outside world. Her own attitudes help the patients get over fear and community prejudices - a help in adjusting the patients to their own illness and to the community.

Secondly, the volunteer perceives her role as one in which she can link the patient to the community by providing opportunities for patients to engage in activities outside the hospital which are not usually available to patients. This she can do by bearing some of the expenses herself, by providing transportation when it is needed, or by accompanying the patient to various places outside the hospital.

Thirdly, the volunteer links the hospital with the community by acquainting the community in one way or another with what is going on in the hospital in order to help remove erroneous impressions about mental illness and to attract others to offer their services as volunteers. In this respect the volunteer acts as an emissary to the hospital. "It's the volunteer who is important about the outside attitudes if she says how much good the hospital has done for the patients and what a worthwhile thing it is to be a volunteer." Other volunteers convey the same
thought:

Volunteer: The volunteer's role in relation to the community is in what she says about the hospital. If she colors it and tells horrifying stories, it could be harmful. It is important what volunteers say to people in the community because they don't know anything about it there. A volunteer contributes by setting people right on what goes on in a mental hospital.

Volunteer: The volunteer has a tremendous part in interpreting the mental hospital to the community. No one can do that better than the volunteer. I feel that even the member of the auxiliary who comes into the hospital for a meeting does public relations; that's why I've always had our meetings here.

Volunteer: All the volunteers are apostles of mental health, and even if a volunteer talks about it to at least two people a week, think of how many people can be converted and what it can do for mental health.

Those volunteers who realize that they can do for patients what others cannot do emphasize the need for additional volunteers. "The volunteer should get more volunteers and give more people the right idea about mental hospitals." "Everyone works together here, but I feel that the volunteer's part is taking the work out into the community, interest people, and get some more volunteers." The volunteer is thus also a recruiter.

The volunteer's expectations of her role often embrace a combination of functions. "A volunteer should be of service in whatever she can do," is the way one volunteer sums up her role, while another puts the thought in different words: "Each volunteer contributes something different
from every other volunteer." Again, "A volunteer has to make a niche for herself in the hospital. You have to come in and feel around - what you can do best."

The volunteer thus comes to perceive her role not only within the framework of hospital goals and policy, but also in relation to specific functions which she has defined for herself. In the process of defining these functions, she has come to define her role in terms of the symbolic characteristics which are unique to the volunteer alone.

D. Summary

The role expectations of the volunteer entering the mental hospital for the first time are rooted mainly in her attitudes about mental illness, her reasons for coming to the hospital, her previous experiences as a volunteer, her associations with other people having some relatedness to the mentally ill, and her educational background. She has no definite expectations of her role except that she will be a helper in the way that volunteers serve in general hospitals.

After the volunteer has entered the Psychos, her role expectations change. This happens because of the goals set for the volunteer by the hospital and because of her changing attitudes about mental illness; i.e., the volunteer comes to realize that the mental patient is sick and not
"insane." The volunteer now perceives her role as a friend to the patient and as someone who helps in therapy. She also comes to see the symbolic nature of her role: to the patient she represents the community. As a link with the community, the volunteer keeps the patient in contact with the world outside the hospital by bringing the community into the hospital and by providing opportunities for patients to engage in community activities. She also acts as an emissary to the hospital by acquainting the community with mental illness. Her unique contribution as a volunteer, as she sees it herself, lies in the fact that she comes of her own free will to represent the community as the patient left it and will return to it. No staff member can contribute this function in the way that she can.
CHAPTER V

STATUS

In the previous chapter social role was defined as the kind of message which ego sends out in order to get a response. His status is defined as the number of actors who send messages to him in order to get a direct response from him, and the content of the messages.

Status is a person's position in a chain of communication in which he is transmitting and receiving messages. It is really his role, plus his status. Status is static in that one looks not to what ego is doing but to what alters are doing. When a person is trying to get a higher status, he is trying to get more messages from alters.

A person has status not only in the total society but also in various subsystems of the total society in which he is a member. His status in the subsystem may be the same as his status in the total society, i.e., his role in the subsystem determines what his status will be in the total system. This is his institutionalized role, i.e., there are mutual expectations on the part of both the
members of the subsystem and those of the total system that ego should act in a certain way.

Or, a person's status in the subsystem may differ from his status in the total society, i.e., his role in the total society is institutionalized, but his role in the subsystem is not institutionalized; it is only peripheral to the subsystem. It is also possible that a person may have a peripheral role in both the subsystem and the total society, i.e., his role is not institutionalized in either system.

The question is now raised as to whether institutionalization inside the subsystem has any effect on institutionalization outside the subsystem in the total society and, conversely, whether institutionalization outside the subsystem has any effect on institutionalization inside the subsystem.

The hospital system is not a total social system but is only a subsystem in the total society. The total society consists of all the different subsystems which make up that system.

In the present chapter the volunteer's role will be investigated in both the hospital subsystem and in the community relative to motivation in becoming a volunteer.
A. Institutionalization of Hospital Roles

1. Staff roles. The roles of the professional staff members in the hospital are institutionalized. The status of executive, doctor, nurse, social worker, and occupational therapist in this hospital subsystem determines what their status will be in the outside community. The staff member as a full member of the task group within the hospital performs certain functions in the group as a means of seeking status outside the group. Or, put in another way, his chief source of status outside the group lies in his status in the group: he is expected to act in a certain way both by the members of his own hospital group and by the people in his community, and he knows that he is expected to act in this way. If deprived of his status in the hospital, he loses his status in the community. He is under strong pressure to conform to expectations not only from the other members of his own task group but also from the members of the outside community. His role is institutionalized both within the subsystem and outside it. What happens to his role within the subsystem will have an effect on his role outside. The same would hold true for any hospital, mental or otherwise.

2. The volunteer role. On the other hand, the role of the volunteer in the mental hospital is not institutionalized.
The volunteer stands on the periphery of the hospital system. The volunteer herself is not quite sure of what is expected of her (see preceding chapter). The staff members are also not sure of what is expected of her (see Chapter VII). Any role which is not institutionalized is always marginal to the system.

But the person who acts as a volunteer in the hospital does have an institutionalized role in the community. This person may be housewife, mother, or someone else. In the community these roles are institutionalized. Housewives and mothers perform certain functions expected of them in these roles. Their roles are thus institutionalized in the total society but not in the hospital subsystem.

At this point the question may be raised as to why the person is volunteering and why the institutionalized role is not sufficiently rewarding to keep the person entirely in that role activity. The volunteer, it appears, may not only be on the periphery of the hospital system but possibly may not be in the center of her own institutional system. In such a case this person who is volunteering has a role which is institutionalized neither within the subsystem nor outside it.

This constitutes a duplicate problem of institutionalization which will be investigated in the present chapter. In
other words, in respect to the staff roles such as the doctor or nurse, ego is in an institutionalized role both within the subsystem and outside it; in respect to the volunteer role, ego may be in an institutionalized role outside the subsystem but not within it; or, ego may be in an institutionalized role neither within the subsystem nor outside it.

For the volunteer the chief source of status lies outside the hospital task group in the community. If the volunteer is deprived of her status in the hospital, compared to the staff member she suffers little or no loss of status in the community. She is not under the same pressures as the staff member: loss of position in the hospital will not deprive her of loss of position in the community. Being on the periphery of the hospital, unlike the staff, she is under less pressure from the other members of the hospital system; and since she would lose comparatively little status from failure to function in an acceptable manner within the hospital, she is not under too much pressure outside the hospital. In some instances she may even be acting under less pressure.

B. Motivational Aspects of Volunteering

Why a person volunteers is central to the problem of status both within the hospital and in the community.
It is necessary, however, to make one important distinction before entering into any discussion as to the motivation of volunteers. This distinction has to do with why a person chooses the mental hospital instead of the general or surgical hospital in which to do her volunteering. For this reason, motivational aspects for both types of hospital must be considered.

It has already been pointed out that the stigma attached to mental illness and the initial fear expressed by volunteers even before entering the mental hospital would act as a deterrent to volunteering in a mental hospital. This would mean that the reasons which volunteers themselves express as to why they came to the mental hospital must be taken with reservation. One may look further into the volunteer's performance inside the hospital, but even here there is no certainty as to why the person volunteers. Therefore, one must first look for motivating factors outside the hospital in the community where the role of the person who is volunteering is institutionalized. This would apply to all volunteers who come to the Psycho except the students who are sent to the hospital for college courses. These students must be kept distinct from the other volunteers for two reasons: they are not volunteers in the real meaning of the word, i.e., they have not volunteered; and their status within the hospital is not dependent on
their status outside, or vice versa. But they are called
volunteers and function as volunteers; and in many
instances they return to the hospital after their prescribed
semester courses and become volunteers. For this reason,
and because they comprise a large segment of the volunteer
population at the Psycho, they will be included in this
chapter. But first the chapter will be devoted to the vol-
unteers whose chief status lies outside the hospital in the
community.

1. Affiliation with a general hospital.

(a) Family and social pressure. As previously noted
in Chapter I, to do volunteer work in a hospital or in some
other organization has long been a regularly scheduled
activity of women who have been able to take time off from
their domestic tasks and family obligations. For some
women volunteering is a family tradition - a matter of
noblesse obligé. All the female members of the various
family generations are expected to administer to the sick
and destitute in a manner first introduced to this country
as social work. These women have an ascribed status in the
community. One of the requisites of that status is to
perform some function in the hospital group. The hospital
selected may depend on several factors, but it is one which
is easily accessible, usually located in the local community.
The volunteer who has the ascribed status in the community is usually the wife of a wealthy, prominent, or influential professional man. She finds considerable time on her hands, even with children to raise.

Staff member: It takes leisure and money to be a volunteer; the doctors respect money. A volunteer doesn’t contribute her money but she has to have it if she’s going to prove she can operate as a volunteer in the hospital.

Personal motivation may or may not have a part in her willingness to volunteer. As a volunteer in a general hospital she represents the one instance where the volunteer role is institutionalized in the community: to stay home and do housework is not. She does not accept institutionalization of her role as a housewife. She is not only under strong pressure from her relatives and friends to be a volunteer, but the pressure is equally strong from the hospital administration and the hospital auxiliary for her to join its ranks and help bring some monetary benefits to the hospital. This she can do by virtue of her husband’s professional and business contacts and her own social acquaintances. She is not confronted with the problem as to whether or not to volunteer; she simply must volunteer, so that for her it is much less of a problem than it is for another woman in a different social position. When she volunteers, she is reflecting in the hospital the status she holds in the community: her status in both hospital and community is high. As a volunteer she is able to display her conspicuous
leisure to best advantage. Also, as a volunteer of prestige and strong affiliations with the hospital administration, she is responsible to a great extent for the institutionalization of the volunteer role in that hospital because she sets the pace for other volunteers.

The wife of a doctor on the hospital staff volunteers partly because of social pressure and partly because she herself feels that she will be furthering the acceptance and advancement of her husband's position in the hospital if she does volunteer. There is social pressure for her to volunteer when she feels that she is expected to do so, but this does not occur for all staff doctors' wives. If she herself comes from a family where volunteering is a matter of tradition, there is no problem at all as to whether or not she should volunteer. On the other hand, she may have no inclination whatsoever to become a volunteer and might prefer to spend her time at home. But it is also possible that her husband or the wives of the other staff doctors may exert pressure on her to become a volunteer, or at least to join the hospital auxiliary, if that is a separate organization. For this reason, it often happens that even though the wives of staff doctors comprise the largest part of the membership on the hospital auxiliaries and are usually the most active women in the hospital, nevertheless there are many doctors' wives who are inactive auxiliary members.
The wife of the hospital doctor is accorded the same esteem in the community that her husband receives in his professional role. Unless she becomes a problem to the hospital, she is accorded the same status within the hospital as she has outside. For her, also, as in the case of noblesse oblige, the role of the volunteer is institutionalized in both the hospital and the community. However, she differs from the first volunteer in that her role as housewife is also institutionalized in the community; she may even prefer her role as housewife. She has not volunteered to gain a higher status than she already has in the community; she is merely reinforcing her community status outside the hospital. In the hospital she has the threefold advantage over other women because of her husband's affiliation with the hospital and his role as a doctor: an understanding of hospital financial and personnel problems and the need for her services, an opportunity to make adjustments to the hospital organization and the particular kinds of illnesses treated within that hospital, and the personal satisfactions which she might feel through her husband's affiliation with the hospital. She may take advantage of her position and try to enhance her husband's status in the hospital through various means. Thus, it is possible that she may present a problem to the hospital administration and to the other staff members.
But for the doctor's wife there is also the likelihood of strain which may be a consideration in her decision as to whether or not to continue her volunteer work in the hospital, even though she may retain her membership in the auxiliary. Because of her husband's status in the hospital, she is never able to ascertain accurately whether she is appreciated for herself alone and for what she contributes to the hospital or whether she is recognized and tendered respect because she is the wife of the doctor on the staff. Thus, the woman who is making a genuine effort to be of help to the hospital is not volunteering to further her husband's position, and such a person may feel extremely sensitive as to how she herself stands with other hospital personnel.

A second strain may occur for the doctor's wife if there is hostility in the hospital against the doctor himself for some reason or another by one or more of the staff people. Again, the doctor's wife cannot be certain if the attitude of the staff person toward her is a reflection of the same attitude toward her husband or if she is being judged for herself alone.

To summarize the above two examples of volunteers, the volunteer role for both the woman of noblesse oblige and the staff doctor's wife is institutionalized both in the community and in the hospital. Both have an ascribed status in the community and in the hospital. In the first instance,
however, the housewife role is not institutionalized in the community, but for the wife of the doctor it is. Institutionalization of the housewife role depends on whether or not the volunteer herself wants to accept the role. In both instances status is high both inside the hospital and outside it: the volunteer simply reflects her community status inside the hospital. It is a different situation, however, when the wife of a doctor volunteers at a hospital where her husband is not a member of the hospital staff.

(b) Personal motivation. For a woman who may not be able to claim volunteering as a family tradition or as a part of her ascribed status or who is not the wife of a doctor in the hospital, to join the woman’s auxiliary or to volunteer to do work in a hospital points to other motivational factors: it may mean that she is seeking a way of raising her status in the community. To volunteer means to be able to show off one’s leisure time; this for her would be an indication of a higher status. She lacks the ascribed status which the women in the first two examples have: any status which she has in her community has been achieved.

The women who comprise this group of volunteers come from a cross-section of the community. They may or may not be the wives of professional men. Oftentimes they are the
wives of fairly successful business men, some of whom may have come by their financial positions in the manner of a get-rich-quick pattern. At any rate, the leisure time which a woman in this position finds on her hands when her children are grown is directed toward social climbing. She sees volunteering as the way in which she may raise her status in the community. For her the housewife role is institutionalized in the community, but the volunteer role is not. There is no social pressure for her to volunteer. Neither her husband nor her friends encourage her to do volunteer work; for them the time might be more profitably spent in her home and in other pursuits. The housewife is trying to crash a higher social group to raise her own status: she attempts to add to her circle of friends — the "right" friends — by joining the ladies' auxiliary of the hospital and by becoming a volunteer. The fact that she does not have the security of her own family and community behind her may well mean that she is not going to be satisfied with her position in the hospital system. But several things may happen: she may latch on to the hospital system and restructure herself and make a good worker, or she may go in and become a problem to the hospital.

The woman who is seeking a higher status and joins the hospital auxiliary or becomes a volunteer is thus acting for personal motivation. The institutionalized role of
housewife for her is not sufficiently rewarding to keep her in that role activity. She is bored with housework, her children are no longer a problem, and she is seeking some outlet which will take her out of the house and a humdrum existence. But the fact that she does not wish to accept her institutionalized role as a housewife indicates that she is not in the center of it. Since the volunteer role is not institutionalized for her either in the hospital or in the community, she thus stands not only on the periphery of her own institutional system but also on the periphery of the hospital system.

(c) Altruism. Although altruism may be considered as another example of personal motivation in that the person satisfies certain gratificational needs, it is treated separately here because the appeal to the public by any organization needing volunteers is made on the grounds of altruism and embraces a large potential source of volunteers. It is possible that a woman who volunteers in a general hospital may do so because of altruistic motives primarily. She is in somewhat similar circumstances as the woman in the example just cited above in that she has the time available to her; she hears of a hospital need for volunteers, and she is likewise anxious to bring her humdrum existence to a close. However she differs from the above example in that she is not seeking to raise her social
status. Altruistic motives are most prominent during emergencies or wars when personnel are seriously needed in hospitals and women can either feel for themselves or be easily made to feel that they should contribute whatever time they can as volunteers. The woman who thus volunteers may also find her institutionalized role as a middle-class housewife not sufficiently rewarding for her to remain in that role activity. She may be bored with her women’s clubs and feel that she would like to get out and do some good to someone and end a purposeless existence. There is neither social pressure nor family pressure for her to become a volunteer. Unless the sight of physical illness presents a strain for her, she sees no reason why she should not become a volunteer in the general hospital.

Women who comprise this category of volunteers are usually persuaded to become volunteers by representatives of the hospital, by local publicity, or by other volunteer acquaintances. They are usually not interested in joining the hospital auxiliary unless the volunteer group is made up of auxiliary members. On the other hand, there might be pressure by the hospital auxiliary women to keep such people out. But the chief interest of the woman who has altruistic motives is to provide a few hours a week in helping to relieve the regular personnel of some of the simple routine tasks that need to be done. As such, these women constitute
a valuable source of help to hospitals.

Often the woman who has the altruistic motives is active in other endeavors in the community, such as club activities, church groups, etc. For those women who enter the hospital as volunteers there is often competition for their time in other activities. This is as true of the mental hospital as it is of the general hospital:

Volunteer: I've told several people about coming here and several of my friends said they would; but they're busily engaged in other activities, and I'm hoping they'll come next year.

Volunteer: If I didn't have other responsibilities, I would come more often. If you belong to another organization, you can't do things like this, which is the reason why I never came before.

Volunteer: I also got involved in the League of Women Voters; then this thing came up with the coffee shop, and I couldn't put much time on that with my work here.

But the altruistic motive takes on a different emphasis when the hospital affiliation is not of the general type but treats mental illness instead. This will be discussed in the following section.

2. Affiliation with a mental hospital. Thus far the role of the volunteer as it affects the status of the institutionalized housewife role of the woman in the community has been discussed in relation to her status in a general hospital organization, one dealing with aspects of physical illness. It has been necessary to make the distinction
between motivational factors in the general hospital and those having to do with the mental hospital for two reasons: first, because volunteers to mental hospitals are a relatively recent phenomenon and the role is not institutionalized; and secondly, because the mental hospital presents the variable of mental illness which has different connotations and treatment approaches than has the general hospital. Again, and perhaps even more so than in the case of the general hospital, one must look to the community for motivational factors in the case of the volunteer who comes to the mental hospital.

A person might want to do volunteer work in a general hospital but have no inclination whatsoever to go into the mental hospital. Fear of being harmed by a mental patient, the impression of mental illness as a stigma, and attitudes connected with mental hospital conditions and treatment methods are the chief reasons why someone might prefer to keep away from the mental hospital. None of these threats presents itself to the person who volunteers in the general hospital.

But the reverse inclination is also possible. A person may have no inclination to do volunteer work in the general hospital but may prefer to go to work in the mental hospital. The same person may have the same attitudes about the mental hospital as someone who does not particularly care to go
there. For these people it may be the mental hospital or nothing. Why this preference for the mental hospital when there is all likelihood that another kind of hospital exists closeby which needs assistance and which offers no threats to the volunteer? Why does a person volunteer in a mental hospital?

To be able to carry on work as a volunteer in a mental hospital necessarily implies that the person volunteering must make an adjustment to mental illness, unless she herself has had previous experience with mentally ill patients within a hospital environment. This would refer to someone who has either been a former psychiatric nurse or held some other position in a mental hospital, has been a patient herself in a hospital, or who has known a mental patient confined to a hospital. The volunteer knows even before she enters the hospital doors that she must make this adjustment to the mentally ill. She realizes that if she cannot do it, she will not be able to remain, no matter how willing she was to come in the first place. It appears, then, that the reasons for a person’s willingness to volunteer in a mental hospital must be directed first toward attitudes about mental illness and mental hospitals. This was done in the previous chapter. Family tradition, relationship of a wife to a doctor on the hospital staff, social ambitions to raise one’s status, and even altruistic motives are secondary
compared to the factor of mental illness. One must first cross the threshold into the hospital from the outside community. In this respect motivational factors show a sharp difference between the volunteer in a general hospital and the volunteer in a mental hospital. The remainder of this chapter will be devoted to the motivational factors which bring the volunteer to the mental hospital.

(a) Family and social pressure. The strongest pressure to join the mental hospital auxiliary is exerted on the wife of the doctor on the hospital staff, but again it is usually the wife herself who feels that she is expected to join the auxiliary to further her husband's position in the hospital. She may refuse to go into the hospital and work directly with patients, but she usually joins the auxiliary and contributes to hospital and patient welfare in this way, unless she further chooses to remain inactive. However, if the hospital auxiliary holds its meetings in the hospital rather than elsewhere, she may encounter considerable strain by just being in the hospital. On one occasion during which the ladies' auxiliary at the Psycho held a meeting in the hospital, the observer had the opportunity to witness the screaming of the wife of one of the doctors. She had just entered the hospital to attend the meeting. She herself was a mentally ill person and had previously been a hospital patient, but she was also a member of the ladies' auxiliary.
In this respect the wives of the young residents who have young children at home may have a legitimate excuse for not spending too much time at the hospital if they do not care to do so. The point to be stressed, however, is that the wife of the doctor on the hospital staff may feel some pressure to become a member of the auxiliary, but there is no pressure for her to become a volunteer in the mental hospital and work with patients. When she does become a volunteer, i.e., when she has been able to make the adjustment to mental illness without showing any personal insecurity or fear herself, she usually makes a valuable contribution to the hospital and is often one of its most active workers. One such volunteer at the Psycho says:

I've had every position in the auxiliary, every chairmanship. There isn't any phase of work that I'm not concerned with. And frequently I'm the one they come to for advice. My husband thinks I do too much; he thinks a hospital like this can be quite demanding.

But again as in the case of the doctor's wife in the general hospital, the doctor's wife in the mental hospital may also feel the strain of not being able to ascertain whether she is accepted for herself alone and for what she contributes to the hospital or whether she is accepted because of her husband's affiliation with the hospital in the capacity of a doctor.
(b) Personal motivation. (1) Therapy. A considerable number of volunteers who choose the mental hospital come for the sole purpose of receiving therapy for themselves. These people fall into various categories and cut across all groups in the hospital in respect to family background, age, sex, education, etc. The only large group of volunteers who are not concerned (although there are exceptions here, too) are the students.

Because of the principal fact that the average person is reticent about admitting, even to a doctor, that she has relatives who are mentally ill or that she herself has doubts about her own state of mental health, the person who comes to the mental hospital for purposes of therapy is more prone to disguise her true motivations than to admit them. Such a person cites other reasons, usually altruistic. But she chooses to come to the mental hospital for one or both of the following reasons: first, because she feels that she may be able to reduce her anxieties and solve her own problems without having her friends (or perhaps her own family) knew about them; and, secondly, because working in the mental hospital is the most inexpensive way of getting this therapy or getting questions answered. "Up until recently," says the chaplain at the Psycho, "we were getting volunteers who needed help themselves and could get it cheaper here than anywhere else." The fact that private psychiatric care
is usually too expensive an undertaking for most people is an accepted fact.

For two main groups of volunteers, however, the reason for coming to the mental hospital for therapeutic purposes may be willingly confessed to. These consist of former mental patients who have either themselves been confined to a mental hospital at one time or who have been referred to the mental hospital by a psychiatrist in private practice. In both instances either the hospital doctors or some other medical expert has endorsed the volunteer role for the former patients: it is considered that such activity will help this person make a complete recovery by helping others who are experiencing similar illnesses. Having the security of medical opinion behind them, besides the fact that their illness is known to their family and friends, these volunteers are willing to admit that they are in the mental hospital as volunteers for their own therapy. But these volunteers also recognize that they might be able to help others because they are sensitive to the problems of the mentally ill through their own experiences.

Volunteer: Coming to the Psycho was suggested to me by a psychiatrist. I was physically well at the time but going through a divorce. My doctor thought that if I could project myself on others I would not be so interested in my own troubles. I've had a lot of troubles. My personal affairs were so chaotic and my own mental condition so low that I just knew that people were there and you just tried to help them.
Those volunteers who themselves have been mental patients present a somewhat different pattern in regard to status than any of the other volunteers. Because they are known to have been mental patients, they have no status in the community, even after they have been discharged as well or "cured" by medical people. Although they come back to the hospital to work as volunteers, they are still looked upon as patients by both the staff members and other patients. These volunteers also have no status within the hospital.

Ex-patient volunteer: A person who was ever a patient feels that it was a kind of a stigma. People say to me, "Why do you go back there; why don't you stay away from there?" But it has the opposite effect. They don't realize that mental illness is being sick. It's a terrible thing when they shy away from you. Once you're a patient you're always classified as a patient. I have even felt it in the feelings of the personnel; they try to make you feel you're one of them, but you still have that feeling that you always will be a patient - that you're set aside as a special person. No matter how you try, you can't get away from it. It is openly said to you from the outsiders. I would say that they just don't know.

But a volunteer may also come into the hospital through the referral of a private psychiatrist and may be able to withhold from both staff and patients the fact that she has been under psychiatric treatment elsewhere. In this instance she may have her doctor's support to become a volunteer, but she may lack the support of either family or friends, or both. "I started being a volunteer because I liked ceramics. I was doing it on the outside, but it was too expensive and
I came into the hospital," says one such volunteer as her reason for coming.

Another group of people who come to the hospital for therapy and who serve as volunteers are those who feel themselves to be mentally ill or insecure or who have some kind of personality disorder which they themselves recognize either because they have been given medical advice to this effect or because they are subject to emotional disturbances which have upset them. The psychotics and neurotics fall into this category — people who are not ill enough to be confined to mental institutions yet who themselves feel that they need help. Since these people constitute a large proportion of the people who are classified as mentally ill, it can be expected that many of the hospital volunteers who come to the hospital for therapeutic purposes would fall into this category. Their own insecurities may be exaggerated if there is mental illness in their families.

As has been mentioned before, the people who come into the mental hospital for purposes of therapy comprise all ages and various family backgrounds. Students who come to the hospital on their own initiative without benefit of college credits might be expected to fall into this group, but these are actually relatively few. The main group of volunteers who come to the hospital with the idea of getting
therapy for themselves are usually identified by both volunteers and staff as the older auxiliary volunteers, although there are usually older women included who are not members of the auxiliary.

Occupational therapist: Mrs. X is here for help for herself. I've been noticing her in groups of discussion. She's deliberately pulling things out, searching constantly in her contacts with patients. Basically, she's afraid that she will become mentally ill, and she tries to see if her symptoms may correlate with those of the patients. If she should get into an intense relationship with a patient, she might feel very threatened by it.

The identification of the mentally insecure volunteer with the auxiliary may be explained in the first place because auxiliary members at the Psych are not under any compulsion to become volunteers; they can serve the hospital by being active auxiliary members and helping to make money for the hospital; they can also work at public relations for mental illness. The fact that a volunteer prefers to work with patients, however, even if she is a member of the auxiliary, may certainly point to altruistic motives, but these are usually secondary. This feeling that the auxiliary woman is seeking therapy for herself is observed by a young volunteer:

I've noticed that some of these auxiliary women act insecure and afraid. They are the kind that come in for their own therapy. Patients don't like them; they can sense it. The snobs, the do-gooders.

The occupational therapist has the opportunity to observe such "do-gooders" at closer range:
Some of the auxiliary volunteers are around for therapeu­
tic purposes. Instead of working with patients, they'll come in and sit and talk with us and completely ignore the patients. Patients set their own pace; they just ignore these "henry pennies"; they just don't want de-gooders. They want the volunteers to be sociable, and they can tell very quickly if the person is here for her own good or for the hospital. But these volun­
tees always come up with the excuse that some relative or friend or someone else is sick.

This type of volunteer is thus often observed as someone who is not going to be of any help to the patient and who might even be rejected by the patient. But the staff member also rejects this type of volunteer:

Occupational therapist: Mrs. P at the staff meeting brought up the issue about the student nurses. She has a need for punishment and she's going to get it. A person that puts herself in the position that she has put herself in can be doing nothing but fulfilling her need for rejection and punishment. She's getting what she's asking for in the attitude of the staff toward her.

The women who volunteer in the mental hospital for their own therapy come because their status in the community is threatened. They are afraid of revealing to their friends that they might be mentally ill. In the hospital they not only hope to be able to regain their mental well being and thus be accepted again by their friends and relatives who already may have doubts about them because of their actions, but, by volunteering and acquiring therapy, they hope to be able to regain the community status which they had before becoming ill. For this reason they are particularly careful to disguise their true motives. The very nature of their
illness makes them perhaps the biggest problem to the hospital administration and staff members, especially those who are able to withstand the strain of seeing the more acute cases of mental illness around them and who stay on as volunteers. Usually, however, the number of volunteers who remain indefinitely for their own therapy is small because the strain is too great; it may also happen that their own illnesses become more pronounced as they continue to stay. However, as one attendant puts it, "They are always coming."

The problem which these women present to the hospital often begins in the form of criticisms leveled at the hospital or at any of the personnel or at other volunteers. At the Psycho, the most common complaint is the lack of orientation given to volunteers. It means that these volunteers are not only having difficulty in making the adjustment to mental illness and to what little they can do to help, but also that they are seeking to cover up their own insecurities by finding excuses of various sorts:

Occupational therapist: Mrs. G came here with a definite need, but we didn't back and courtesy to her for her need. She didn't get her psychotherapy; she will say that she didn't get the guidance or the orientation.

As one social worker sums up the volunteer who comes for her own therapy: "Their acting on their own needs does get to be a hindrance."
(2) Curiosity. Although curiosity may be a principal motivating factor to both the student volunteers who are curious to learn about mental health and also to those who are seeking therapy for themselves, it has its most obvious manifestation in those volunteers who have come to the mental hospital because they have friends or relatives who are mentally ill. In the case of the friends it may consist of a genuine desire to ascertain for oneself if the friend is really ill and can get well and that the volunteer might be able to help this friend; or it may also be that the volunteer feels that she might be of some help to others whom she realizes through her own friend are sick people. This would indicate that the altruistic motive may be present for these volunteers. The curiosity may also be merely a fascination for mental illness: one sees it in the friend and wants to learn more about it:

Volunteer: I've always wanted to do volunteer work in a mental hospital because I had a friend who had a nervous breakdown and went to an institution. It's mostly out of personal curiosity that I'm here.

Volunteer: At first I was quite terrified to come, but it was sort of a personal challenge and I was curious to see if I could cope with it.

Nurse: I had someone come in from a factory to be a volunteer and he was just a pain in the neck, asked questions and that sort of thing. This is the sort of person who is curious as to what is going on here and just doesn't want to give. "Watch him, he's a spotter," is what the attendants said about him.
There is a different emphasis, however, with the volunteer who comes to the hospital because there is mental illness in the immediate family or even with close relatives. This person wants to reassure herself that she does not have mental illness herself nor any of its symptoms. Even her own doctor might not be able to dispel her fears: she must see for herself. Because of her experiences at home, she is likely to have many questions about herself and about mental illness. This curiosity may of itself be a symptom of personal insecurity leading to mental illness; but for most volunteers coming to the hospital is looked upon as an opportunity to set their minds at ease about their own mental health. Again, this constitutes an example of a threat to one’s status because of what might happen; furthermore, one’s status may already be threatened in the community because of the presence of mental illness in the family:

Volunteer: I had an aunt who was mentally ill and that got me interested, particularly after I found out that she recovered after shock treatments. My husband thinks I’m too emotional about this; I got all wrought up about my aunt and went overboard in my feelings for her.

This same volunteer admitted later that she herself had recently been to a psychiatrist for treatment. Another volunteer indicates her own insecurities by mentioning her relationship with a friend who was a mental patient:
Volunteer: At first it seemed like a big nebulous thing. I'm interested in learning more about mental health. I feel that it touches us all in one form or another. I have a friend who has been in a state hospital for thirteen years. Disease is a part of the personality, and under certain stresses and strains, if you have a particular type of personality, you're hooked like a fish on a hook. There's no difference between any person in this hospital. We are all trapped in certain situations, and some are more fortunate than others. I came through her because I felt that way.

But the volunteer who comes to the mental hospital because of curiosity about mental illness may overcome her own insecurities and fears and become a valuable source of help to the hospital. The fact that mental illness has touched her personally, either through family or friend, may provide for her the incentive to help others. One such volunteer who came to the Psycho through personal curiosity remained as a volunteer for a full year. Her stay at the hospital is first related in her own words and then in the words of a staff member who was able to observe her closely:

Volunteer: I wanted to find out more about the field so I went to the Junior League. They referred me to the chairman of volunteers here, so I came in and I liked it. I've been interested in psychology and I had the time, so I decided to find out about it. I didn't want to be a secretary; I didn't know what I wanted to do.

I had many skills to offer. I was an art major in school and could do ceramics, painting, etc. I was told to help in ceramics and to learn to teach it.

I felt quite natural with the patients. At times I felt much more natural here than at places outside the hospital. You use fewer of the artificial devices here than you use outside the hospital after you get to know the patients so well.
I've just known occasional acquaintances who are mentally ill at home. My friends think my being a volunteer is just a great big joke. My brother thinks I should get some paying job. My younger brother says it doesn't appeal to him at all. Daddy doesn't recognize it at all: anyone that's mentally ill is weak.

For mother it's a nice talking point - daughter giving full time as a volunteer, etc.

I'd like to work here on a full-time paid basis. I like the work, I am happy in it and feel that I might be doing some good. And I want to live on my own money.

Occupational therapist: M is young, has a lot of questions about her family, and she thought that this was one place where she could learn what makes people tick. There has been mental illness in her family. She has a name like ------ which is fine, but also she feels the blight of mental illness. She's coming for her own self-satisfaction. We give her an awful lot of what she's asking. We care about her and we care about her in a far more different way than her family does. She has to act like a ------ at home, and they forget that she's just a young girl wondering why there is mental illness in her home. Her family disapproves of her being a volunteer - she's too young.

Everything she saw she thought she could do. She started with pottery and after awhile she got fed up with it. She has never yet found anything that will hold her. When her interest fails, she will try something else. I think she's grown an awful lot, mostly because she really wants to.

At the end of the year this volunteer left the hospital and entered college. Her case presents a striking example, however, of the type of volunteer who enters the mental hospital because she is curious but finds in her experience not only the answers to her questions but also some purpose for her own life. The other point to be noted has to do with her relationships with staff personnel in the department in which she worked, but this will be discussed in a later chapter.
(c) Altruism and changing motives. The case illustrated above also points to changing motives on the part of a volunteer. A change in motive may also affect the status of a volunteer in the community. Because the altruistic motive is the one in which hospital administrators rely chiefly to get volunteers to come to the hospital, altruism as a motive may indeed bring a volunteer to the mental hospital in the first place. But, as indicated previously, no matter how much sympathy one may have for a person who is mentally ill, it is one thing to have the sincere feeling of helping less fortunate people and another thing to try and overcome the initial fear of entering the mental hospital, especially if one makes the decision to go to the hospital without benefit of introduction from a friend or relative. For this reason, volunteers who first enter the mental hospital for sheer altruism are few in number. They may be afraid of being accused by their friends or families of ulterior motives, of being "queer" themselves. Certainly their own status is likely to be threatened by their willingness to come to the mental hospital.

But altruistic motives have their place in the mental hospital. The first consideration is that altruism usually accompanies another motive. Examples of this have been cited above. An additional example of the ex-patient volunteer may be cited because of the very strong altruistic
intent:

It's been a wonderful thing to be a volunteer and be a part of things and feel a usefulness and have a purpose in what I can do for others - that little hope that I can give to others.

The second consideration is that a person may enter the hospital as a volunteer for any one of several reasons but may remain as a volunteer because she has not only made the adjustment to the mentally sick patient but also because she realizes that she is being confronted by people that she can help to get well. Many volunteers, when asked, will respond that they came to the hospital because they wanted to help; and although this is often not the main reason why they came in the first place, it is often the reason why many of them remain. One has but to study the number of years which some volunteers have given to the Psycho to be convinced that they do not remain because they will get therapy for themselves, because they are still curious, because they are related to a hospital executive or doctor, or because they want to raise their status: these are all beginning motives. One volunteer who had been at the Psycho for over ten years admitted that she had had some private psychiatric help previously; yet the staff considers her one of its most valuable volunteers. Another volunteer who had come to the hospital out of curiosity about mental illness admitted that she was seriously considering becoming a doctor.

It is because of this fact that many volunteers change
their ideas about mental hospitals and mental illness and begin to realize their own contribution to patient therapy that the hospital administration does not make any effort to dissuade prospective volunteers from coming to the hospital or remaining as long as they wish. Even the neurotics and other emotionally insecure volunteers are permitted to stay if they have not expressed any inclination themselves to leave (which most of them do). If, during the course of such a person's stay at the hospital, any therapy may have been effected, the hospital will have accomplished the double objective of eliminating this person's coming back to the hospital as a patient herself and, at the same time, may have gained a permanent volunteer with altruistic intentions.

Occupational therapist: You notice changes in the younger volunteers as time goes on. You can see them maturing. They come in leery the first couple of days; they're shocked and amazed that this isn't a snake pit. Then they'll go through a little lull. Then they're so high, and then they're left to their own resources. Then they reach out and try to reach patients, and then it starts to get interesting and enlightening. They begin to seriously think for themselves, "Why is so-and-so different?" and "What can I do to help them?" They think of it on their own.

The above example illustrates how the young student volunteer is able to see her experience in the mental hospital as something other than a learning experience after the first few days.

On the other hand, a person who comes into the hospital for one reason may change her motives in directions other
than altruism. One example of this is that of the volunteer who wants to raise her social status. However, this refers usually to a particular hospital, and it will be discussed in the following section. A volunteer may also come to see the hospital as an opportunity to work there on a full-time paid basis. One volunteer who was also an art teacher in a neighboring college said that she "would really enjoy very much a full-time position here," and the same thought was voiced by the volunteer whose case was cited on pp. 136-137.

A final word concerning altruistic motivation with reference to both the mental hospital and the community may be noted. As the pattern changes in the mental health area, i.e., as the community shifts its image of mental health from the various stereotypes that it has of mental patients and mental hospitals, it can be expected that the altruistic motive will take on a gradually increasing emphasis, although volunteers will still seek to become volunteers because of all the other motives mentioned here. In this respect the volunteer's status in the community will not be threatened because she chooses to work in a mental hospital any more than it is threatened because she chooses to work in a general hospital. An "altruistic development" is referred to in the words of a staff member, but it is illustrative of this extension of the volunteer role into the community:
Up until recently we were getting volunteers who needed help themselves and could get it cheaper here than anywhere else. Up until some of the volunteers got interested in this other sense last year. And since then, the newspapers and public and churches have become interested in it and it has gotten to be rather fashionable. This last year we've had more of an altruistic development.

One volunteer explains how she came to the Psycho through community information:

Just this year with the mental health drive I realized that a volunteer could do something. I always felt badly that I hadn't done anything that was worth my effort at all. I probably would have gotten into this earlier if I had only realized that I could. I also saw a program on TV, but before that time I didn't realize that I could do anything.

3. Affiliation with the Psycho. In the preceding section the emphasis was placed on why a person volunteers in a mental hospital in contrast to the general hospital. One more distinction needs to be made which is important for volunteer motivation and for status both within and without the community. This refers to why a person volunteers at a particular mental hospital. Since the Psycho is not always the mental hospital which is most accessible to the volunteer, the question may legitimately be asked as to why she chooses this particular hospital.

There are three main reasons why a person chooses the Psycho in which to do her volunteer work: first, because of its reputation in the medical world as a teaching, research, and diagnostic mental hospital; secondly, because of the
objectives which it sets for volunteers; and, third, because of the high percentage of "cures" which it is known to have brought about in the past. A volunteer chooses the Psycho usually for a combination or all of the above reasons.

(a) Personal motivation. (1) Social status. Unlike the average mental hospital, the Psycho is often chosen because any affiliation with it will raise the social status of a person in the community. Its connection with Harvard Medical School and other colleges and universities in the Boston area is also a consideration. To join the Psycho is to have prestige. This applies to all staff members, as well as to volunteers.

Occupational therapist: I don't know if we have a different variety of volunteers here, but I heard one volunteer from another hospital say at that conference on volunteers, "Well, we don't have the rich bitches that you have ever there." Volunteers who work here certainly have the prestige. Being a volunteer here gives many volunteers the social prestige they want.

But the point must be emphasized again that the person does not first join the Psycho to work as a volunteer and thus raise her social status; she joins the hospital auxiliary instead. She may become a volunteer after she joins the auxiliary to raise her social status if she thinks that such activity will provide more contacts for her with other auxiliary members and with the administration. But here
there must always be the willingness to work with the mental patient. The women who thus aspire to raise their social status by coming to the Psycho are those who do not have an ascribed status in their communities in respect to social position; they are also very frequently the ones who are dissatisfied with their own middle-class housewife's role. The wife of a salesman who had been a volunteer for over a year reflects her innermost thoughts when she says, "I imagine they all think we're doctors' wives and wouldn't be here except to help our husbands." A staff member remarks about the woman who was now "getting more into the life of the hospital":

> For a long time she liked to come up and impress people from society. She would let the patients into her house to see how the other half lives.

The staff people who see some volunteers for long periods of time are extremely conscious of the volunteer who is attempting to raise her status in the hospital (see Chapter VII). One nurse remarks, "Everyone is trying to impress the other by their attitude and by the way they talk." Another nurse adds, "It takes a long time to know Mrs. K. My feelings about her is that I couldn't build up a good relationship with her if I were a patient because she is a snob." Still another, "If I ever went into a hospital as a volunteer, I would be so glad to fill in here and there and not be concerned if I'm more important than
the other volunteers." Even the volunteer who is not a member of the auxiliary notices the "do-gooders." "They're the ones that are doing volunteer work for snob appeal; there are always some around."

A possible exception may be cited of the woman who becomes a volunteer directly instead of joining the hospital auxiliary to raise her social status. This instance would apply to all mental hospitals. Because mental health is gradually coming to be regarded as an important area of community concern on the local level and medical health concern on the national level, but mainly because it still has the aura of stigma encompassing it, becoming a volunteer in a mental hospital and working directly with patients presents a challenge to some women. It may be that the woman has had her fill of general hospitals and would like to try something else. She may not have been successful at raising her status in the general hospital. She may not have been able to meet the social requirements of admission to the general hospital because she lacks the ascribed social status in her community. At any rate, it makes an impression on one's friends to be able to say that she has been working in a mental hospital, even though her friends may themselves have no inclination to go near the hospital. This volunteer perceives the mental hospital as a challenge because it requires more "courage" to go into one:
Occupational therapist: This is conspicuous leisure and extra talent to go into a hospital and be a volunteer. I can't help but think that of some of them, particularly one, who says, "I'm a volunteer with the BPH," and another volunteer from another hospital says, "How can you possibly stand it?" Then it brings the Psycho volunteer up in the eyes of the other volunteer to say, "Well, I'm strong enough to do it!" This is greater prestige; this is greater talent. "I can do this type of work." It is even more impressive when their talents are recognized. With them it is almost like a daring adventure that they can brag about to their friends. "I'm just a little bit stronger than you are."

In summary, to a considerable extent it is usually possible to identify the person who enters the mental hospital as a volunteer to raise her social status. This depends on where she concentrates her efforts. If she joins the hospital auxiliary but does not become a volunteer, she is usually interested in raising her status. It may be that she is particularly resistant to making the effort to relate with mental patients, but the question arises as to why she joins the mental hospital auxiliary rather than the general hospital auxiliary. The answer may be that she sees the mental hospital auxiliary as a means of raising her status, perhaps to an even higher degree in the mental hospital because she is entering the more challenging area of mental illness. If she also becomes a volunteer and adjusts to the hospital environment, she may even have something more to boast about to her friends because of her contacts with patients.
(2) Therapy. Because the Psycho is known for its high percentage of "bureas," volunteers often choose it who want therapy for themselves. They may merely want to get certain questions answered or because there is mental health in the family, and they seek out this particular hospital because they know that many patients leave it to return to their homes.

(3) Learning. The volunteer also seeks the Psycho because as a teaching hospital and also as a research hospital it offers opportunities to learn about mental illness. Student volunteers who have a choice as to various institutions to which they may go for various course requirements often choose the Psycho because of the opportunities which it offers them. For the same reason many colleges and universities choose the Psycho and send students in many disciplinary fields.

The students who come to the mental hospital to learn find their early experiences revolving about this desire to learn:

Student volunteer: I had the opportunity to become familiar with the hospital and the patients and to look on it as a social problem. I think everyone should spend some time in a mental hospital just from the point of view of education if nothing else, even if they never do anything in psychiatry or psychology, just so they'll know about mental illness.
Student volunteer: I wouldn't go back as a volunteer because I learned all there is to learn and I'd just as soon go somewhere else where I could learn something else. I think one semester is enough unless you're going on in psychology or sociology. If I do have time later, I'd go in with a different attitude.

There is also the example of the volunteer who continues his association with the Psycho by coming to work as an attendant after completing his student volunteer assignment. This applies to the male student and not to the female student. Medical students, as well as students of the social sciences, apply for positions as attendants. The desire to learn is strongly apparent in the following remark by a volunteer who became an attendant:

After I got here I increased my number of hours as a volunteer and it started snowballing. I got interested in psychodrama, electric shock, then EST. As I get more interested, I applied for a job as attendant. I stayed on in a volunteer capacity after my course was over as I sort of leashed on it as the equivalent to work. Then I increased the time on EST. Then someone asked me if I had ever been to "Glucose Alley," the insulin ward, and I started to divide my time between insulin and EST.

The motives of the students and those of the older women are contrasted by a staff member:

Volunteers fall into two groups here: We have a big student group, some of them here for credit and some here for experience. We also have a group of older women — do-gooders — who mother patients and bring them things. Each of them has a different reason for coming here. Students come to learn and to grow and to see life, to see what makes people tick; they come to learn about people and to learn about themselves. The program that suits students and the program that suits auxiliary women are two different things. The ones that learn the most are the ones that get to know the patients best.
The older volunteer herself concludes that the woman who has her institutionalized status outside the hospital does not fit into the volunteer program as easily or as successfully as the student:

It's one definite pattern here. This hospital and its volunteer work is a completely unstructured program. The older volunteer who has her own home, her outside interests, may find it very difficult to fit into the unstructured program. And it takes many of them some time to get the idea, and some never get the idea. It is the person with the outside responsibilities that doesn't fit as well.

C. Summary

The role of the volunteer in the mental hospital is not institutionalized as are the roles of the other staff members in the hospital. But the person who acts as a volunteer does have an institutionalized role in the community where her chief source of status lies. The question is raised in this chapter as to why the person is volunteering and why her institutionalized role is not sufficiently rewarding to keep her entirely in that role activity.

In the consideration of motivational factors, the distinction is first made between the volunteer in the general hospital where the volunteer role is institutionalized and in the mental hospital where it is not. The person who volunteers in a general hospital does so mainly for reasons of family and social pressure, boredom, and possibly altruism.
But because of the stigma and the fear attached to mental illness, the person who volunteers to work with patients in the mental hospital does so for other reasons: she comes mainly to get therapy for herself and to satisfy her curiosity because there is mental illness in her family. Her status in the community is threatened because of the stigma of mental illness attached to her. Altruism becomes an important motivational factor only after the volunteer has entered the mental hospital. There may be social or family pressure to join the hospital auxiliary but not to work with the mental patients as a volunteer. Finally, the person chooses the Psycho in which to do volunteer work in preference to another mental hospital because of the reputation of the hospital and the goals set for volunteers. The volunteer who comes to the Psycho can raise her social status, receive therapy for herself, and learn about mental health.
CHAPTER VI
ROLE PERFORMANCE

Not only does the volunteer expect certain things of her role in the mental hospital, but she also performs certain task functions in relation to these expectations. Her performance depends mainly on her attitudes about mental illness and the way in which both the hospital and she herself have defined her role.

In the present chapter the volunteer's role performance will be viewed in relation to her role expectations. These were set forth in Chapter IV.

A. Attitudes about Mental Illness

The initial apprehension that the volunteer expects to feel when she assumes her role in the mental hospital is evidenced particularly in her performance in the first few days that she comes to the hospital. The volunteer admits her feelings readily. The following accounts by volunteers when they approached their first patient illustrate more dramatically what the first sensations were and what the volunteer did:
Volunteer: I was scared to death. I went up to a person and she was looking longingly at the pottery, and I asked her if she wanted to make a piece. But she was normal. She worked out as very normal and sane.

Volunteer: I went up to a woman, said "Hi," and sat down and said, "I'm E--." She was doing pottery. We talked about her children, art, painting. Once I had said "Here I go," it was easy. But before I actually went up and spoke to her it was sort of terrifying. I picked one by herself. She responded fine to me, seemed quite warm from the beginning and stayed that way.

A student volunteer tells her story about her first encounter with a patient:

It wasn't the easiest thing to go and just sit with the patients. I just felt uneasy. The first time I went over and sat down near a young girl sitting by herself and started to talk with her. She asked me about school and I asked her about school, etc. I felt perfectly at ease. She reacted favorably, seemed to enjoy speaking with me. She seemed to like volunteers. She was usually by herself.

In all these examples the patients were approached in the occupational therapy department where the least sick patients spend a great deal of their time, but even here the volunteer feels uneasy about approaching her first patient, even though she can take her time before making the initial move. One volunteer recounts how in her first day at the hospital a patient came up to her and put his arms around her but would not talk, "I immediately went to Mac and told him. He said, "Just tell him to move away; treat him like you would anybody else who did that."

The above examples all point to the sudden realization
on the volunteer's part that patients act like other people and that they are "normal" and "sane." It is significant, however, that until the volunteer herself makes her own contact with a patient, she cannot calm her initial fears merely by observing that patients act like everyone else. The patient observes the behavior of the new volunteer thus: "When we come toward them, they don't come toward us; they look at us and act as if they're afraid of us. We can sense that."

As the volunteer becomes more familiar with her surroundings and begins to relate to more patients, she feels more at ease. "I feel a little more at ease with them now than when I first came. Now I don't feel the nervousness that I had at the beginning," or, "The first day there are all strange faces. Gradually you get to know more patients and say 'Hi,' and it's much easier to talk to them."

As indicated by volunteer performance, does a volunteer ever completely rid herself of this early fear? One volunteer who had been coming to the hospital since the early days of the war explains her first encounter with mental illness leading up to her present attitudes:

My first day was a perfectly horrible one and I began to get butterflies in my stomach because I heard a bad scream. But I came in the next day and I thought I'd better work in the nursing office and get oriented that way. I started doing errands and then I'd stay and talk to the patients; I would stay. I got on the wards without knowing it! I didn't
realize I was in the wards. I thought that anyone in the wards would be crawling around in filth, etc. Of course there's an element of danger, but there's an element of danger in driving a car. In the twelve years I've been here I've only been touched once when a girl kicked me in the stomach because she wanted to get me out of the way. I can't say that I haven't at times felt uneasy.

The ex-patient volunteer tells about her experiences in the hospital elevator after she had become a volunteer:

A boy was riding the elevator at the same time I was. We kept riding up and down for ten minutes. I was afraid to move. He said to me, "If you move one step, I'll let you have it." I was terrified. Finally he let me out.

But these occasions are the exception rather than the rule. They serve to illustrate, however, as the first volunteer quoted above points out, that the situation inside the hospital is no different from a situation outside the hospital involving danger and that there are occasions for fear in both instances.

B. Task Performance Inside the Hospital

1. Patterns of distribution. In Chapter II it was indicated that unless volunteers specifically request to work in a particular department of the hospital or have some previous experience which might be used elsewhere, they are usually assigned to occupational therapy. "First the volunteers feel most comfortable in OT - even the residents do that. Then they often want to go down to insulin. The ideal situation is pure fallacy and actually impossible,"

says one of the occupational therapists. Some of the volunteers remain in occupational therapy, especially those who work at arts and crafts. "I've been in OT ever since the beginning," says one volunteer. "I started at the ceramics table and gradually branched out all over the department. If they needed someone, they just came to me." Others spend part of their time in occupational therapy and also visit patients on the wards. "I worked mostly in OT but I would go down into the wards and help out with the patients and entertain them. Sometimes I was asked to work with certain patients." It is the younger volunteer, however, who tends to remain in occupational therapy, whereas the older volunteer usually visits patients in the wards. "All I do is come in with magazines and visit patients on the wards; there's that need for talk." One volunteer who had had previous training as a psychiatric nurse describes a combination of assignments:

I stayed in the insulin ward about nine months when I first came, then two years in research, one year in OT, part of the time in the wards. This year I've been almost entirely in OT.

The volunteers who contribute their time to the coffee shop usually do so on a definite schedule that is set up beforehand. Although these volunteers may continue to work in the coffee shop once they have learned the routine procedure followed there, they also often visit patients in the
wards. One volunteer describes a particular task which she had in relation to the coffee shop:

I was asked to keep the coffee shop staffed in the beginning. My job was to make the patients feel that we have to have their cooperation. They didn't want to go at first. My job was to get the patients down to the coffee shop and work when they were needed. I would talk it over with the head nurse on the ward and ask, "Who do you think could be sent down?" I would go up to the men's wards to get patients. I had to smooth out the problems when someone didn't want to go.

Besides the departments or wards in which they may be located at some particular time, volunteers often attend staff meetings, departmental meetings, psychodrama, patient government meetings, and assist at the social functions which are given for patients by the ladies' auxiliary. Although the new volunteers are reluctant to speak up at first at the staff meetings, many of them come to participate freely in the discussions. At psychodrama volunteers often take part in the problems that are presented for the benefit of the patients. The student volunteers are especially eager to attend these meetings because of the opportunity afforded them to learn about mental health problems.

Student volunteer: I attended staff and psychodrama every time I was in the hospital and I found out a great deal about the backgrounds of the patients. Staff meetings gave me a chance to learn things about therapy treatments.

2. Age and sex patterns. Perhaps the one most definite pattern of age groups consists of the younger volunteers with
the younger patients:

Student volunteer: We concentrated on the younger ones; most of them were younger. The students all more or less went toward the same patients. You couldn't help noticing one because she was so noisy, and another girl was so pretty that we were curious to know what had happened to her.

Another young volunteer who was not a student adds,

Young patients particularly value contacts with volunteers. Where else would a young man get an opportunity to talk to a young girl? He gets a bit bolder as time goes on.

But there are many variations in the age and sex preferences of volunteers. One unusual one is the older male patient with the younger female volunteer:

Volunteer: I've noticed that the men are delighted to have a pretty young girl around; it does terrific things for them. Some of the older ones I imagine have a new breath of air. On one occasion we were weaving something together with this man and he wanted me to work with him again. Then they flirt and put an arm around you and kid you and joke with you. And they really get a kick out of it. They do the same with the young nurses. Otherwise, if you get a whole bunch of old men in a hospital, they sort of deteriorate in old slacks, but they just spruce up when there is a young girl around. I think it makes a difference.

The remainder of the age and sex patterns usually depend on individual preferences, but one group receives less attention from the volunteer than do the other groups - the middle-aged person:

Occupational therapist: We have a handful of older women who go to the very sick patients and sort of mother them, and as often as not it happens to be the patients that need mothering. Mrs. L usually goes to younger ones she can mother. Mrs. B is different: she'll go to an older one - someone she has something
in common with. But she goes to the younger ones, too. Occasionally, you have an older person getting attention, but the in-between with the middle-life depressions I'm afraid doesn't get too many volunteers attracted to her.

3. Individual-group patterns. Again, as for age and sex, volunteers vary considerably as to whether they prefer to be with one patient or with several. The new volunteer usually finds that she prefers one patient, but this is not always because she does not feel she can handle more than one patient at a time:

Volunteer: I would rather talk separately to patients and not in groups because in groups they're much more apt to talk amongst themselves and we feel kind of left out. But it's much more interesting to hear them talk amongst themselves.

But as the volunteer comes to feel more at ease with patients, the pattern is likely to change:

Volunteer: In the beginning I would just as soon not be left alone completely with patients. But now I don't care at all. At first I thought it was easier to talk to one patient but now I find it easier to talk to a group.

4. Activity patterns. (a) Menial tasks. As indicated in the previous chapter, the volunteer's early expectation that she would assist in menial tasks around the hospital changed considerably after her first few days at the hospital. Most of the tasks which are undertaken by volunteers consisting of housekeeping duties are usually done in connection with clean-up activities after arts and craft work, sewing, etc.; and in occupational therapy this was
usually a cooperative venture between staff, volunteers, and patients. But the young student volunteers are often asked to do errands, escort visitors on tours throughout the hospital, and also take patients from the wards to occupational therapy and back. That volunteers never find such duties objectionable is attested to by the fact that the volunteer omits any mention of such tasks from her role definition. This is perhaps due to the fact that there is never any compulsion to perform such tasks. As one volunteer puts it, "Staff never tells you to do something; they ask you if you'd like to."

(b) Skills and recreation. Volunteers also express preferences for relating to patients according to certain activities which either utilize their skills or draw on their resources to entertain. First, there is the area of art, ceramics, sewing, etc. Often this preference is given by volunteers who find it easier to make contacts with patients in this way. "I think it would be dirty to take a volunteer into the wards the first time, whereas it is easier to make contact with your hands than if you're face to face." Another volunteer also sees the patient's side of the adjustment that must be made: "I think it is better to be doing something with patients than just talking because it makes them more at ease." A common approach used by many volunteers is to attract patients by working themselves
rather than trying to seek out the patient who might be reluctant to join the activity. "I've had anywhere from one to thirty-two patients working with me at a time, depending on the number of people interested in art work at the moment," says one volunteer in occupational therapy. The following two extracts from volunteers present a complete picture of the volunteer who works with her hands:

Volunteer: As I sat doing ceramics the patients would come and talk to me. They will come to you quicker if you're doing something than if you go to the patient. It draws the crowd. I have had as many as twenty men doing ceramics by just sitting and painting. It is easier to do something than trying to start a conversation with someone who doesn't want to talk. I keep busy myself and by keeping busy they come to me. I get more responses that way than by going to them.

Volunteer: Patients often say to me that they've enjoyed watching me work and get a lot of ideas from me. I always work at my own things, and they'll ask what it is and we'll have a nice guessing game as to what it is. I always do my own work, and half of my patients are usually conversing with me and criticizing my work. Last week I was working on a modernistic deer, and everyone guessed that it was different things, and it gives them a chance to guess and becomes a conversation piece. And then the next person comes up and he'll ask what we think he's made, and it becomes a game. Sometimes I've been working with patients, just sitting there and not doing anything for hours, just myself working. It's easier to converse with a patient if you're doing something. A patient would come up to me and neither of us would know what to talk about, whereas if you're doing something it will eventually come to some easy subject such as what color shall I use, and then you gradually work into a conversation relating to their problems. The point is that if you can't think of anything to say, you're just not required to say anything.

Another volunteer thinks that it is better to go after the patients who are reluctant to come to occupational therapy:
Volunteer: I used to go into the wards with the pottery on huge trays and try to engage patients into doing something with clay. Many patients thought they could never do anything with their hands. I would go around to different patients and try rounding them up, both the ones that you knew had done it before and the ones who you thought might be induced to be interested. We would get an occasional one. Once you get a core to start with, others would amble in, then it didn't look so hard, and some of them could be urged to try.

The volunteers who play games with patients such as ping pong or cards or those who play at sports outdoors usually talk to patients while they are playing, although more than one volunteer will admit that there are often many minutes of silence until the patient gains the volunteer's confidence. It is not uncommon to see some of the younger patients dancing with volunteers in complete silence, but at the same time showing no indication to stop the dance. This pattern of recreation combined with conversation is the most popular with both the young volunteers and the young patients, but again it varies with individual preferences. One volunteer says she talks more to the women than with the men: with the men she "plays games mostly."

(e) Conversation. It is of course more the rule than the exception that conversation enters into all volunteer-patient relationships, including occasions when craft work or games or sports are being participated in. But just talking to patients instead of combining conversation with work or play activities is also a preference for many of the volunteers. This is the common pattern for the older volunteers - "there's that need for talk"; but it is also
preferred by many of the young volunteers who do not have any specific art skills. The student volunteer who says, "I felt more at ease when I was talking with them," is also thinking about how much more she will learn through conversation. Another young volunteer says:

You aren't getting too much personal satisfaction yourself if you play ping-pong. I think if you can get someone to talk who finds it difficult to talk, then you are doing a great deal of good. It might be better for some people to play ping-pong, I really don't know.

The relationship which the volunteer establishes with the patient is also an important part of her task performance. Because this presents many aspects which do not pertain to the pattern of the relationship alone but has to do with the volunteer's expectation of her role as therapist, it will be discussed in Chapter VIII.

C. Task Performance Outside the Hospital

1. Activity patterns. Volunteers often take patients out of the hospital either because staff members request it or because the volunteer herself desires to do so. Activities outside the hospital consist of a variety of things, such as going shopping or to the hairdresser's, attending recreational events like movies or baseball games, or various other events. Most of the time, however, it is the volunteer's
own idea to take the patient out, even though she must first have the permission to do so. "I've often taken patients to buy records or picture framing," says one volunteer in occupational therapy. Another volunteer finds pleasure in "taking the girls out for a cup of tea, just to get them out." The same volunteer took three of the male patients on a tour of some new buildings of one of the nearby colleges. A nurse reports this incident as follows:

One patient here was alone, didn't have any relatives here. He had used his last cent to come. Mrs. B decided to take him on tour with her auto; these patients never stopped talking about it. She did this on her own. She said to me, "I'd love to take him, but I'd like to take someone else, too." So I grouped the three.

Volunteers who take patients out of the hospital either for entertainment or for shopping usually bear the expenses themselves. "Mrs. G is always seeing that patients get clothing and things that they need." Those volunteers who are able to secure tickets for recreational activities are especially appreciated.

Occasionally, a volunteer entertains patients at home. One such volunteer makes such an occasion an important event:

Volunteer: Every year I have thirty-five of the patients and about ten of the staff come out to the house. In the last two years they've brought some of the sickest patients. I have never put away any of the liquor, etc. I've gotten a letter from patient government thanking me and a note.
2. Extension of the volunteer role. "The volunteer's influence extends beyond the hospital: she may follow a patient to another hospital or help find jobs for patients." The volunteer role, in other words, is not limited to the time she goes into the hospital or takes patients out of the hospital during the day. She may keep up her acquaintance with the patient because of a strong attachment that has developed while the patient was in the hospital. One volunteer says that patients become particularly attached to her "to the point of telephoning when they get out. They write me letters after they've left the hospital. My house is filled with ash trays, letters, and Christmas cards that they've sent." Or, the volunteer may assume the role of the social worker in her follow-up of patients after they leave the hospital. In this capacity she may be instrumental in securing a job for a patient. She may also follow a patient's progress when he is sent to another hospital for further treatment or for custodial purposes, and this is particularly appreciated by the patient who does not have other visitors. "I went through the Hospital on a governor's commission tour, and all my friends were throwing hugs and kisses at me," is the comment of one volunteer whose friendships extended to other hospitals. Another ex-patient volunteer has often gone to visit patients at other hospitals, "people who were patients when I was one;
I got to know them very well when I was here. One girl said I was the only one who ever came to see her." The same volunteer also admits of having other ex-patients call on her at home. "But I don't have any strong attachments. I'll always say, 'If you're in town any night, come in and see me.' One girl often drops in on Monday nights."

For most volunteers, however, follow-up of patients either at home or in other hospitals is not a common practice. One of the main considerations in this respect is that such follow-up is frowned on by some of the staff personnel. "I wouldn't encourage taking the relationship out of the hospital, even after the patient left, unless the hospital knew about it," is the kind of remark which causes volunteers to hesitate about following patients up after they leave the hospital. This aspect will be discussed further in Chapter VIII.

3. The volunteer in the community. Because part of the volunteer's uniqueness lies in her power to link hospital with community and thus communicate to the outside world what goes on in the hospital, it is especially important to note to what extent the volunteer actually does provide this link. In the present connection, however, it is necessary to separate the volunteer's ability to convince friends and relatives at home that mental patients are sick people like other sick people and quite another
to convince these same friends and relatives that they should come to the hospital themselves and be volunteers.

The young volunteer shows the greatest amount of enthusiasm in talking to people outside the hospital. One volunteer who came to the hospital through a volunteer friend tells about her talks to family and friends:

My family are glad I'm a volunteer. But I don't think they know too much about it. I've told them what kind of work I have done. I talk to people about my experiences in the hospital, mostly about the beginning when I first came and what we saw and what was said. I tell them a little about my changing impressions. They are amused and surprised. But I haven't asked anyone to become a volunteer. But if an opportunity came up, I certainly would ask them.

And a student volunteer:

My family approves wholeheartedly of my being a volunteer. They're interested and thought it was a good thing. I also tell other people that I do volunteer work. If we're talking about mental hospitals, I'll talk about it. But I've never persuaded anyone to become a volunteer. As a volunteer I can tell people on the outside what it is like and urge them to help.

Another young volunteer who had also come through a friend volunteer feels that she might be able to get friends to come to the hospital because of the particular advantages that the Psycho offers:

I've had two or three people say they would like to come in on their off day. I talk about experiences in the hospital. Many people have misconceptions about this hospital, but this is the ideal mental hospital. You don't see people getting well in the other hospitals; you don't see things getting done; they don't have the care and attention. You might be able to do more there, but this is certainly a much more pleasant atmosphere to work in.
The three volunteers cited above have spent no more than three months as volunteers in the hospital. Occasionally, volunteers do persuade friends to become volunteers. One volunteer often has friends come to visit her at the hospital when she is working and introduces the patients to her friends.

But the older volunteer also talks about her experiences in the mental hospital. The wife of a doctor who is a specialist in a field other than psychiatry says,

Some of my friends think I'm crazy. My husband doesn't understand why I like to do it as much as I do. He doesn't like my dealing with mental patients all the time. The neighbors say, "I think you're perfectly wonderful to come," but they won't do it. I talk about the patients, what they do, and what you do with them, and of course they always ask about lobotomies, electric shock, insulin, etc. After you describe some of them they say, "I don't see how you can stand it." But after you tell them about what the patients do, they don't call it a nut house as often as they used to.

The wife of a hospital staff doctor usually waits for people to ask her first about her experiences in the hospital, but her approach is to get them to come and see for themselves:

When I meet people at a tea or somewhere, they ask me if I like it and I say, "Have you ever been inside a mental hospital, and if you're interested, we'll take you around."

Another volunteer with many years of service says,

I scream and holler if I get an ear on and my friends say, "I think you're wonderful," but people don't want to sit and listen about mental patients all the time. But when I hear anyone say, "He's nuts," I always say, "Mentally ill, boys."
One distinctive group must be mentioned in connection with the reactions which they are able to get from talking to people outside the hospital. These consist of volunteers who have either themselves been treated in a hospital for mental illness or who have actually had help from a psychiatrist in private practice. One volunteer who had been referred to the hospital by her doctor says,

> My family and friends think I belong in the hospital; they think there's something the matter with me because I'm a volunteer here. I've tried to tell my family about my experiences in the hospital, but there's no sympathy. My friends think it's a mistake to work here, too.

But the same volunteer has also been successful in getting her own students from art school to come to the hospital:

> I'm all bubbling with enthusiasm on Tuesday nights, and I got a student to come to play the piano once. The ones that do come have admitted that they were wrong. I've persuaded one girl from the art school to become a volunteer, and she's coming next September.

The ex-patient volunteer has the same difficulty with friends and relatives:

> I tell my friends that I enjoy coming here. I've never been able to get any of them to come back and be a volunteer, even my close friends and relatives. They don't realize that you can be completely well. They figure you're the same when you come in and when you go out.

D. Examples in Role Performance

1. Variation in task performance. Although the pattern of task performance varies from one volunteer to the next and
from one day to the other at the Psycho, sometimes the variation itself becomes a pattern of activity for certain volunteers, particularly those who have been at the hospital for many years and who do not work at art or craft specialties. In this connection it is possible to witness the amount of freedom that a volunteer enjoys at the Psycho.

The energy of youth is easily apparent in the young volunteer — and this is a common remark — who says that every time she comes into the hospital she does "everything from playing pool to visiting, dancing, and doing something with ceramics." Another common pattern is illustrated by the volunteer who says that a typical day for her is "going all over the hospital, seeing whoever happens to be around, talking with them, going through the wards, getting yarn for anyone who needs it, and telling all the new patients that I'll look them up on the following Tuesday."

2. Specialization in task performance. But the volunteer is also a specialist. She may spend one day doing various things such as those cited above and the next day doing just one. There is the volunteer, also, who comes into the hospital and follows the same pattern of activity every time. Following is an account of the volunteer who spends her two afternoons a week with arts and crafts in the occupational therapy department:
It appears to me unusual in that most of the patients are getting well: I see it in their pottery, less careless, more creative. One particular patient started out by being so afraid of tackling pottery. She came up and asked if she could do it. Then I told her, "It's really simple, but it just looks confusing." And I showed her how simple it was to make an ash tray. Some of them also you see doing it straight along even though they have never done it before, and when they get ready to go home they say, "Oh, how I enjoyed the pottery; I hate to leave it." Then they want to take it up outside and many of them do come back evenings and continue it across the street. Many of them discover that they can make really beautiful pots and vases, and now they've got a hobby. In the beginning some of them refused to do anything creative, and then you suggest something and they'll eventually get to tracing a design or copy it. Then they'll make their own design or make a free-hand design. Some of them felt that they could never do anything when they first came and they're always saying how inadequate they are, and they make excuses that they just don't feel well that day, and I'll suggest that they leave it until the next day. They don't want to do something that they know is going to be bad. Starting with the molds guarantees that they are doing something that will turn out well, and it's a terrific feeling of accomplishment on their part. Patients are so scared at all of this equipment that you would scare them away if you said, "Try making a horse out of all this clay." It's better to start slowly.

Now down in the pottery room there's a mug with a crude cartoon on it of a man and a boy, and the father is saying, "So you really want to go to college, son?" And there's the boy that had been at four different hospitals who put the initials of the hospitals in the four different corners of an ash tray and in the middle of it his name and 1955. He was so pleased about it that he came down every day to see if it was ready. Another patient just wants to pour things all the time, claws things up after that.

The volunteer is also a specialist in the way she relates to patients. The student presents a good example of the conversational approach to the patient who has passed the most serious stages of his illness. In the following example,
it is interesting to note the student's attempt to analyze the patient's illness:

I was given J to work with by Mac. The boy was quite depressed and had had trouble with girls. He improved an awful lot from the time that I was there. I understand that since, he has changed quite a bit. He had a hard time expressing himself, but once you got him talking he would talk. But I could get him relaxed, and once I drew him out, he would go along. On occasion he would make the comment, "It's nice of you to spend your time with me." I was there two days a week, and if he came in, and he usually did, he would talk to me. When I stop and look back on it, I was really attempting to get him to work things through.

There were three or four patients that I got to spend more time with than the others. I became quite interested in them. They were all different ages and different types. I really don't know why I was drawn to them except that I was up in OT for quite a bit. They would ask me when I was coming in again, and then I would see them on these days. I think some of them looked forward to having me come back. One of the girls two or three years older than I used to like to give me a lot of advice, advice about boys and about the world. She had a very negativistic attitude toward men and most of her advice was correlated with her experiences. Actually, she was bringing out her problem.

There is also the approach of the older volunteer with the very sick patients in the wards:

The other day I went and took Mrs. L's hand and she said, "I'll never get well." I said, "You got well once before; you could do it again. The idea is to get you well. Say, now, didn't you know all about this place? We're going to get you well." It gave her a good lift. Another day I calmed down a patient while the medical students gasped. They said afterwards, "I never saw anyone have such an effect on patients; I thought she might be an ex-patient." Another time I made another patient take a bath that no one else could do. I asked the nurses to leave. One girl was naked and I got her to take a bath. Her record said that she was shy in front of men. Also, she is embarrassed in front of anyone. I said to the
nurses, "She's shy," and I put a sheet around her. I walk around the wards and I say to myself, "There but for the grace of God goes me!"

The variation in role performance of the volunteer in the mental hospital can be explained in several ways: First, the volunteer role itself allows for varying interpretation by each volunteer: by being "herself" in her role performance she can exercise as much range in her approach to another human being within the hospital environment as she does to any other human being outside the hospital. This range becomes even greater when one considers that her role prescription does not include the performance of definite tasks but deals with the entire gamut of human behavior. In addition, the volunteer performs her role in terms of her own definition of the situation, i.e., in terms of her attitudes about mental illness, the personal satisfactions she derives from her participation in the life of the hospital, the way in which she perceives her own status level both inside and outside the hospital and how she relates the two, and the relationships which she has to the other members of the hospital organization.

E. Summary

The volunteer in the mental hospital not only has certain expectations of her role but she also performs certain tasks in relation to these expectations. Her performance toward
the mental patients changes as her attitudes concerning mental health change. She comes to feel more at ease with patients as she relates with them and defines her own role more precisely and in accordance with hospital goals.

The task performance of the volunteer inside the hospital varies according to patterns of distribution, age and sex preferences, individual and group preferences, and activity preferences. Volunteers serve in all departments of the hospital, most frequently in occupational therapy. Age and sex preferences vary widely, as do also preferences in working with patients individually or in groups. Activity patterns consist mostly in providing skills and recreation for patients, talking with them, or in a combination of these two.

Outside the hospital the patterns of activity consist of such tasks as taking patients to recreational events, shopping, entertaining patients at home, following-up patients after they have been discharged or sent to another hospital, or finding jobs for patients. In other words, the volunteer role is also extended beyond the point where the patient is still a patient. The volunteer also communicates to her family and friends what she sees and does in the hospital and is occasionally successful in persuading someone else to become a volunteer. In this respect she is fulfilling the expectations of the role which the hospital has defined for her.
The volunteer's performance of these tasks both inside and outside the hospital varies from one volunteer to the other and from one day to the next. Variation in performance is possible because the volunteer role itself allows for varying interpretation by each volunteer: by being "herself," she can exercise as much range in her approach to another human being within the hospital as she does to any other human being outside. Also, she is dealing with human beings and not specific duties. She performs her role in terms of her own definition of the situation such as attitudes about mental illness, personal satisfactions, status image, and relationships with other members of the hospital organization.
CHAPTER VII
INTRA-ROLE AND INTER-ROLE RELATIONSHIPS

In Chapter IV role was defined in the communication system as the kind of message ego sends out in order to get a response from the alters. The emphasis was placed on ego's performance as a transmitter of messages; in other words, ego must first send a message in order to get one in return. The volunteer first entering the mental hospital is sending messages by being permitted to come to the hospital in the first place, by her willingness to come and volunteer her services and her time, and by her actual performance as a volunteer. The volunteer's relationships with all the other persons in the hospital may be thus determined not only by the number and content of the messages the volunteer sends out but also by the number and content of the messages returned to her by these other persons.

In the present chapter the volunteer role will be first observed for intra-role behavior patterns which are significant in themselves and which might also have relevance for the volunteer's relationships with the staff. Secondly, each of the staff roles will be considered not only for any
implications which it might have for the volunteer role, but also the actual performance of these role interrelationships will be considered. It will then be possible to arrive at the definition which the various roles give to the volunteer role.

A. Volunteer-Volunteer Relationships

In speaking of any relationship which one volunteer has with another volunteer at the Psycha, one must first distinguish between the auxiliary volunteer and the non-auxiliary volunteer. This distinction has already been made in connection with the volunteer's status and the reason she becomes a volunteer rather than a member of the auxiliary, or vice versa. As indicated previously, only a small percentage of auxiliary members are also volunteers; the remaining volunteers are not members of the auxiliary but come into the hospital from other sources.

In the first place, the auxiliary volunteer must have her loyalties in two places at the same time; oftentimes this places a strain on her as to what activities she should devote her time and energy to - working toward auxiliary goals or spending time with patients. "I have functioned more as an auxiliary member than as a volunteer," says one volunteer, and adds, "I'm divided in my feelings from the
auxiliary's point of view besides the patients", but I try
and make reasonable demands of the patients." This volunteer
was referring to the situation in the coffee shop where the
objectives of making money for the hospital conflict with
the therapeutic objectives when the patients do not function
efficiently.

The volunteer who is not an auxiliary member does not
have the problem of divided loyalties within the hospital
system. Furthermore, since the hospital administration
frowns on such practices as having an organized volunteer
group or group meetings of volunteers, hiring a paid
director of volunteers, or even allowing volunteers to wear
some mark of identification, most of these non-auxiliary
volunteers do not have contacts with any other volunteers,
except when a volunteer has been instrumental in bringing
a friend to volunteer at the Psyche or where the volunteer
might herself meet another volunteer in the hospital who
comes in on the same day and works in the same department.
Volunteers meet especially when one volunteer acts as a
guide to a new volunteer. Student volunteers also know
other students who are in the same classes at college with
them, but the only problem which might arise from such
acquaintance or contact would be when more than one student
decides to work with the same patient - "We all went more or
less toward the same patients" - or when the patient himself
chooses between volunteers - "The patients know the volunteers they like the best; they all decided to like Joan best because they thought Barbara was prettier." For the most part, however, student volunteers "go separate ways in the hospital."

It would be a reasonably safe assumption, however, to say that non-auxiliary volunteers neither know many other volunteers (except as cited above) nor care whether they do or not. One volunteer who had spent many months teaching art in occupational therapy confessed to knowing only two other volunteers. Another volunteer who had spent eight hours a week talking to patients for three months, also in occupational therapy, sums up her contacts with other volunteers thus: "I don't think there are too many volunteers. I have only known three in all the time I've been here. The rest are the women's auxiliary." During the two afternoons a week that she spent in the hospital there were other volunteers present in the same department of which she was completely unaware. She did not even know that auxiliary members could also be volunteers.

The problems which arise between volunteers are centered among the volunteers who are also members of the ladies' auxiliary. But even here there are notable exceptions. At a meeting of the auxiliary one volunteer who had been spending three days a week in the hospital for many
years before and after the time in question pointed to the woman who had been chairman of volunteers for eight months and who was spending two days a week in the hospital and said, "See that woman over there? I never knew who she was until this morning!" The chairman herself was an active volunteer and thought she knew everyone in the auxiliary. But when asked about this particular volunteer, she said, "Who is she? I never saw her before!" Another volunteer who was also an auxiliary member indicates the reasons for her inactivity in the auxiliary thus: "They're a catty bunch, come in all dolled up with their gardenias, and the hospital can't do without them, but I've never seen any of them do anything with the patients." The same volunteer says, "Since I've been here, I've never joined up with a volunteer group. I have never been to any meetings. I wouldn't know if there were any." This points to the deliberate effort made on the part of some volunteers to avoid entanglements with other women and to concentrate on being volunteers. They are members of the auxiliary not because of the prestige which such association might bring them but usually because they are related to hospital staff doctors or administrative members of the hospital.

The volunteer who seeks power and prestige at the Psyche gains it mainly as a member of the auxiliary, but as a volunteer she has the added advantage of being in closer communi-
cation with daily happenings in the hospital and in becoming better acquainted with staff and administrative personnel in the hospital, particularly the latter. As a volunteer she sees the opportunity to make some contributions to the hospital which she cannot make merely as an auxiliary member and to gain recognition for them. A staff member notes the struggle for power which involves the volunteer who is both an auxiliary member and a volunteer against the auxiliary member who is not a volunteer:

Occupational therapist: Mrs. D was chairman of volunteers when I came, then she became president of the auxiliary. She has always been a very powerful figure - a power-driven person, an organizer; she's at it all the time. She started the coffee shop; the coffee shop plans had not been completed when her term ended. Before that she had set up Mrs. G as chairman of the coffee shop. Then Mrs. T became president and Mrs. D was stripped of her powers. From the stories that I've heard there were certain commitments that had been made, and just after her defeat (I think she ran for reelection), she thought that there were certain things that had to be completed; and because of this Mrs. T, the new president, said that Mrs. D was no longer in office and that nothing had to be done. Mrs. D wasn't even on the committee, I don't think. But now she is the liaison between the hospital and the Rutland corner house. Now she has prestige but she's thumbing her nose at the auxiliary. She was a very active volunteer.

This struggle for power creates a dividing point not only between the auxiliary volunteer and the non-volunteer auxiliary members but also serves to create factions between members of the auxiliary itself, whether or not they are volunteers:
Occupational therapist: There are two factions in the Auxiliary — the Brookline crowd, then the other miscellaneous group from Weston-Belmont. Mrs. W is from Weston, but she's not part of the accepted social crowd. It's the Brookline crowd that's in power now.

The same staff member quoted above notes the problem that is created for the volunteer who is "not part of the accepted social crowd" in her relationships with other auxiliary members:

There has been more trouble in the auxiliary this year since they've opened the coffee shop because of money. They're getting to the point where Mrs. W didn't think they should have a great excess of money because when a person gets a certain amount they just want more and never put it back into the hospital.

The above examples of power struggle between auxiliary members, some of whom are volunteers and some of whom are not, illustrate how a volunteer who is also an auxiliary member may become a strong contributor to hospital and patient welfare and be thus considered as extremely valuable by both administration and staff yet, on the other hand, because she divides her loyalties between two different groups either for personal or other reasons, may become involved in situations of strain. This strain which is created by such divisions among auxiliary members continues in relationships outside the hospital, and the volunteer herself who is involved can make such statements as "I'm so sick of the women's auxiliary; they're all so mad at each other!"

This situation reflects directly on the patients in the hospital when lack of agreement keeps the auxiliary from
donating to patient welfare or from sponsoring parties or other social functions for patients. It also reflects on attitudes of staff members who are able to observe some of the situations which arise in the hospital:

Attendant: Once in a while I've heard it talked about that there are a few volunteers who want to come in and take over. "Who is he?" "He's a volunteer." Immediately you think it's one of these people who are going to build the hospital over again. A volunteer can stir things up.

Occupational therapist: There are some volunteers who are not only happy with their relationships with the patients but they're also seeking areas where they can become more powerful in the hospital.

Social worker: We don't want to daunt these individuals from the community who dare to cross these echelons. Also, the higher echelons would not want us to cross the tees of some of these people from the point of view of higher relations.

But the strain falls most heavily on the hospital administration which must rely on the auxiliary not only to provide the "extra" things for the patients but also on their outside community contacts to keep the hospital a going concern.

B. Volunteer-Staff Relationships

How the various staff members define the volunteer role depends first on how they define their own roles within the hospital social system. This is particularly important in a hospital like the Psycho because the hospital goals which it sets for itself are different from those set by most mental hospitals. New staff members coming to the Psycho for the first time must themselves first make the
adjustment to the idea of the therapeutic community. Resista-
tances to milieu therapy and the utilization of social
dynamic practices which staff members experience either in-
dividually or as groups reflect directly on their interpre-
tations of the volunteer role. The equal emphasis on all
roles is more disturbing to some staff members than others.
At the Psycho institutional role patterns break down; the
institutionalized role becomes uninstitutionalized. Expec-
tations for all roles take on different emphases, so that while
the staff person is viewing out of one eye this new role of
the volunteer in the hospital system, with the other eye
he is also noting changes and making the adjustments in
his own role behavior. In other words, the staff member
must re-define his own role at the same time that the vol-
unteer is defining hers.¹

It is thus necessary not only to consider each insti-
tutionalized role within the system separately but, insofar

¹. It must be also noted that institutionalized role
patterns are broken down in all mental hospitals, but
that at the Psycho the hospital goals contribute further
to this breakdown. Stanton and Schwartz, op. cit.,
p. 143 ff., mention particularly the roles of the doctor,
nurse, and patient as being different in the mental
hospital. There are uncertainties in all the roles, but
the role of the psychotherapist is still "experimental"
in the hospital and "has not crystallized into such a
reliable pattern as that of the psychoanalyst in private
practice."
as possible, to point out also how the volunteer role might be a factor in contributing to the change or breakdown of the institutionalized role of the staff member. It is not possible, however, within the scope of this study to accomplish either of these two objectives adequately. All that will be attempted here is to present a few of the more obvious characteristics of the staff roles insofar as they relate to the volunteer role.

The following interchange of conversation at a hospital staff meeting illustrates the way in which the various staff members discuss a problem involving the utilisation of volunteers in a specific situation. It provides a clue as to the definition which each staff member gives to the volunteer role and also points to the fact that the role itself has no definite job specifications but is subject to varying interpretations and flexibility according to existing hospital needs:

Dr. Hyde: Is there something a volunteer could do to relieve on the wards? Would volunteers be useful if you had them? It would seem as if they could be.

Doctor: I don’t think so.

Volunteer: Couldn’t volunteers take patients on picnics and thus relieve students here to do things where they’re needed? I mean use student volunteers just for the first week that student nurses come in. We could have volunteers help right at the door between Wards 4 and 6.

Nurse: I wouldn’t put a volunteer at the door.

Dr. Hyde: Are there any jobs that the volunteer could do, thereby relieving the personnel?
Nurse: If the volunteer comes in and doesn't know the patients, I think we're giving the volunteer too much responsibility as far as knowing where the patients are.

Nurse: Could you conceive sending a volunteer upstairs to stay at the door?

Nurse: But if we send a volunteer outdoors, aren't we asking too much?

Dr. Hyde: But if we want volunteers to take out five patients each in the yard--

Nurse: This has been done every summer; this is nothing new.

Occupational therapist: I would certainly trust the theology students out in the yard.

Attendant: No reason why volunteers couldn't take the patients down. She would have only five patients and the elevator would take them. Then I would take them.

Volunteer: We could have volunteers available but we don't really feel that they are wanted. Maybe I'm under the wrong impression, but I had thought that previously volunteers had taken patients around and no one had ever worried about the volunteers.

Nurse: But it is asking too much of a person to ask her to stay at the door to watch the patients. But we could use them somewhere else where they could relieve the personnel; this should be a possibility. (Turning to volunteer) Do you think we could get together and arrange a schedule of volunteers for this orientation week for the nurses?

Dr. Hyde: This has been a problem for a long time. One might think also of working with the Harvard group of volunteers to help out.

Nurse: These are several possibilities.

1. The volunteer and the doctor. Of all the staff people in the hospital, the doctor feels himself least necessary to the hospital organization. This is particularly
true of the new resident who begins his work at the Psycho
with the initial strains engendered by the hospital goals.
The point has been previously stressed that the person who
is skeptical about the benefits of social interaction as
embodied in the concept of the therapeutic community will
feel this strain the most. Since the doctor has the most
to lose, he suffers accordingly. The new doctor expresses
his own resistance to the hospital goals:

Here you never know who is seeing the patient or what
they're saying to him. Communication is oversimple.
It is very demoralizing to professionals, one of the
ights that goes on all the time - everyone is looked
upon as equal. The issue has never really been settled
or discussed; it comes up over and over again. I think
that really it's part of a general open trend of denying
differences. I think it's artificial and anything
artificial creates strain. Everyone says here that all
therapists are equal, and yet they're not. It is almost
like negating the worth of professional training. It
comes from professional people; this is where it all
started. It is irresponsible, and this Jones from
England is a perfect example. He says everyone is
equal; but yet it comes down to an issue that points
to an ultimate authority, so he really can't fool
anybody. But it is a general trend and to a certain
extent it is a very good one. But when it comes to
denying the obvious reality it is wool-gathering.
Both the prestige of the profession and the ego suf-
fers. Also, there is the feeling of not being backed
from the top; everyone has groups except us.

The same doctor focusses this strain directly on the
volunteer:

I don't think that they should be allowed to go to
some of the staff meetings; it all seems to turn on
them. There are certain problems which are extremely
difficult to understand even with training. The two
things - training and going to staff - go together;
you can't have one without the other. I have a feeling
that the staff meetings just have a cheap thrill for
them. It isn't harmful to the volunteer but it is
harmful to the teaching staff. The professional staff
avoids talking about some of the more complicated
feelings that they have. Having volunteers there
reduces the staff conference to a mere layman level,
and there's a time and a place for this. Tuesday is
our ward management meeting and there's a case pre-
sented, and they could go to this. Thursday is the
day that we have been utilizing lately for long-term
cases, and they should be restricted from this.

The presence of the volunteer both in the hospital as a
member of the therapy team and at staff meetings is thus
seen as a contributory cause for the loss of dignity which
is suffered by the new resident. "Dr. Solomon says he
doesn't give a damn if the doctors quit; he can run the
hospital without doctors; but he can't run it without the
nurses. And if the janitors quit——!" is the humorous
comment of a third-year resident.

The image which the doctor has of his own role is
broken down in an atmosphere where the social relationship
is stressed. As indicated previously, part of the volun-
teer's early confusion when she first came to the Psycho
was because 'doctors didn't seem very doctorish - a whole
new situation.' But the new resident is especially unhappy
about the loss of his professional prestige and is willing
to admit it. However, these institutionalized patterns of
the doctor's role are broken down only within the hospital;
in the community he still enjoys his high prestige as a
doctor. There are other aspects which affect the doctor's
prestige as a marginal man of medicine within his own profession, and although these strains are not directly related to his position at the Psycho, nevertheless they reflect on his own role image and help to contribute to any loss of prestige which he may feel. The new volunteer who says, "I would think the doctors are the most important here," or "I think the doctors are looked up to by the patients the most; that's why they're the most important," is reflecting the feelings of any person coming into the hospital for the first time: the doctor is the most important person in the hospital. Even the patient feels this strain:

All are in the same boat here - everyone - and it's too peculiar. It's not right. You have to face reality that someone is above you and that it's just one person that you have to obey and that should be the doctor.

The volunteer who goes to her first staff meeting and says, "Everyone participating was a great idea: doctors were looked on less as people and more as doctors, and that's why the patient can talk freer to the volunteer than to the doctor," is either revealing a resistance on the part of the doctor to become a part of the therapeutic community or is expressing her own expectations of the doctor's role. The

1. See Harry L. Smith's treatment of the psychiatrist's marginal position in medicine in "Psychiatry in Medicine: Intra- or Inter-Professional Relationships?" unpublished paper read at the September, 1955, meeting of the American Sociological Society, in which he emphasizes the strains which occur for the psychiatrist within his own profession and which revolve around his status in relation to the practice of psychotherapy.
staff members who have been at the Psycho long enough to have made their own observations comment on the doctor's dilemma:

Nurse: Many things happen to the doctor: he is used to being very effective, being a magician. The patient in the hospital may not know he's a doctor, may not believe he's a doctor. The doctor is insecure; there's none of the things he can fall back on. It's his position to help and yet he can't help.

Supervisor of male personnel: I would say that the new residents are the most resistant to volunteers. This is their first experience with volunteers and they just can't place them on the hierarchy. They don't seem to know just what their position is, their capacity; and when you find someone in that position, you are a little doubtful about them. This is one of the odd things about this hospital. In other hospitals most of the doctors are on a pedestal by themselves, but that is broken down here.

Social worker: Where you get the antagonism is when patients say, "I don't even know who my doctor is," and that is why the doctors get upset. They don't know what is going on; they feel that it is all out of their hands. It's the aura and magic and power of the doctor; he can do more with it. We are not so important.

Thus, it can be expected that the behavior of the new resident, who feels the greatest strain because of the hospital goals, and also possibly the behavior of the other doctors, will be affected in their relationships with the other staff members, the patients, and the volunteers; and the opposite is equally possible. The doctor is at a further disadvantage because of the demands made on his time with teaching, conferences, admissions, etc. "Doctors are always in such a rush," says one volunteer. "If I were a patient,
I'd be so annoyed because they're always running somewhere."

Also, the fact that he is a student himself and must take some of his instruction from other personnel is a source of great strain to the new resident:

Social worker: Here is a resident in a ward which is in turmoil; he doesn't know what to do when a patient is breaking up a wall. The attendant knows what to do but the doctor doesn't know what to do. This is where doctors are most threatened. They don't have any way of expressing themselves.

There are other aspects of the doctor's role which might have relevance to the volunteer's role, but only one more will be mentioned here. It concerns the central role function of the doctor - that of his relationship with the patient and the fact that it is the doctor in his institutionalized role who "cures" the patient. Since this topic bears directly on the problem of the volunteer in the mental hospital as stated in Chapter I, it will be dealt with in the following chapter. However, it is necessary to point out now before entering into any discussion of the volunteer-doctor relationship that it is not possible to separate any relationship which the doctor might have with the volunteer from this central role function of therapy.

The first point which must be made in respect to volunteer-doctor relationships is that the volunteer does not have many contacts with the doctor. "You don't get to know the doctors too well." This is of course explained
by the doctor's busy schedule and the fact that most volunteers do not work in departments where doctors may be usually expected to be present. Whatever contacts are made between doctors and volunteers are most often made by the volunteer who seeks out the doctor of a particular patient to ask him what she should do with the patient. Sometimes the volunteer may ask to work with a certain doctor. However, the volunteer who undertakes to seek out the doctor by her own effort is the one who has accepted the hospital goals for volunteers and feels that it is the obligation of the doctor to give her the help she asks for. "We're supposed to be able to go to a doctor, but I don't go," is the feeling expressed by one volunteer who had been at the Psycho for a year, and "I've often gone to get in touch with a doctor and if I find it necessary, I'll ask him a very pertinent question," as expressed by a volunteer who had also been at the hospital for a year, are the two opposite extremes in volunteer-doctor contacts. It is not always the new volunteer who is the reluctant one. A student volunteer who had been at the Psycho for only a few weeks says,

The only doctor I've talked to so far was Dr. C in electric shock and he would tell me about patients sometimes. I asked about a man I had seen around up in CS and in the locked ward when he first came in. If there was anything that I was curious about and a doctor happened to be there, I felt free to ask him about it.

Not only the student and the volunteer of long standing, but
other volunteers feel free to ask out the doctor. The wife of a doctor does not feel any hesitancy: "We have marvelous relations with the doctors; they're willing to accept us as part of the team." Neither does the volunteer who has been at the same hospital as a patient:

If I needed help on a problem, I would go to a doctor. It's to help, not to hurt. If something turned up, I would ask them if they would like to know. Often times I've seen things that have happened while I was working and I've gone down to the ward to have it taken care of. I've called a doctor when a girl was very upset. Today one of the doctors asked about a little boy, what could be done for him. So I spoke up and said he was interested in ceramics. The doctors all speak to me or nod to me because I was a case here, I guess.

For other volunteers who do have contacts with doctors, however, this contact may be the result of the volunteer's presence in a certain place or doing something in particular which evokes a response from the doctor:

Volunteer: I don't feel that I'm completely comfortable yet, and I still have the feeling. I go up on Ward 5 and see two or three special patients and say hello when I come in. One day I knocked on the door and there was a resident there. He opened the door and I said, "Thank you very much, doctor; I'm Mrs. F, a volunteer." He kind of frowned and let me in. While working in the ward, one man was about to hit another man on the head with ash tray. I stood there with the rest of them and looked. The resident came up to me and said, "Are you going to the insulin meeting?" I said, "No." He said, "Don't you think you had better go along?" Some day I'm going to ask him who he thought I was. I turned around and left. I was so taken back and so embarrassed that I left. I didn't have enough sense to say, "I'm making my ward rounds."

Another volunteer who was stroking a patient to soothe her tells how shocking a blow it was to her when a doctor said to
her, "If I were you, I would use a more formal approach."

The strain in relationships between volunteer and doctor does not necessarily come through actual contact, however. This is as true of the volunteer as it is for the doctor. For example, it happens to the coffee shop volunteer who thinks that the doctor may be sending patients down to the coffee shop to get them off his hands:

Volunteer: The coffee shop is a real opportunity for patients. It's only one out of ten that may be too sick to work. I often wonder if the doctors evaluate at all a patient's inclination to work in the coffee shop. Where the patient is borderline, do they really give it any thought or is it really an experiment? I have a feeling that sometimes they send patients down because they don't want to be bothered with them. Sometimes the patients are so confused that I wonder if they know what they are doing. Doctors may just want to get patients occupied, but is the inclination all that is necessary? The therapy team does know what is involved and how much demand is going to be put on the patient. Many times the patients just want to eat. This is perfectly all right with me so long as I think it's not a substitute for something that's better for them.

But most of the actual contacts which do occur between the volunteer and the doctor are not unpleasant ones:

Occupational therapist: Most of the doctors look to volunteers as extra attention for their own patients, and unless it goes to an extreme, they use volunteers. I wouldn't be at all surprised that they like personal care for their own patients. Some of them have asked about having volunteers work with their patients and will interview the volunteers.

Coffee shop volunteer: Some doctors do accept you much more readily than others. It's tied up with the individual philosophy of the doctor. It's tied up with ethics about patients in general - whether or not the
patient is always right. Some of them do have the feeling that the patient is always right and must always be given the benefit of the doubt. Sometimes when a patient is extremely difficult to handle they tell you either to handle him any way you want, "I can't tell you what to do," or they say, "Refer the matter back to me and I will try to tell you what to do in the situation." Or, "This is your area; I won't tell you what to do. If you find the patient can't function down here, send him back to the ward." We do this mostly with out-patients; they're supposed to be functioning well, and it isn't always easy to get a conference with a doctor.

It is usually the doctors who have been at the hospital for the longest period of time that feel the greatest acceptance of volunteers. The third- and fourth-year residents can themselves look back on a change of attitudes from their first year at the Psycho. These doctors will themselves offer such remarks as "Some of the younger residents are more resistant, and in the first year they're likely to be more jealous of their prerogatives," or "Psychiatrists, especially in their early years, certainly do feel certain competitiveness and rivalries revolving around the patient." Again, as still another doctor puts it.

Volunteers do need the medium of staff meetings to express themselves. I don't know about the case meetings, but I suppose if they're going to work close to patients, they should be able to go. It would be all a part of their finding their job.

The doctor who works in the insulin unit who is described by another staff member as having "a very good understanding of people and a respect for youth and appreciates what people can do and gives them quite a bit of responsibility" herself
This is a unit with a highly organized system and with many personnel, and it is all covered. What the volunteers do here are the things that need doing. One could live without them, but it's awfully nice to have them.

The same doctor does not feel any competition with volunteers: "Doctors aren't threatened by volunteers so much as they're threatened by the regular staff because volunteers aren't here all the time." However, the patients undergoing treatment in the insulin unit are not the same patients who sit and talk with volunteers in the occupational therapy department.

The above discussion points to the fact that not only are volunteers less of a threat to the doctors in certain of the functions they perform for the hospital, but also that the definition which doctors give to the volunteer role depends to a large extent on what contacts they have with volunteers and under what conditions these contacts take place. The doctor would accept the volunteer at the staff meeting, but the same doctor thinks of the volunteer's role in terms of the following: "I think volunteers could be made to start a sewing class or different types of groups; this would be one way in which they might have a special part to play." Another says, "The hospitals will always be understaffed and there is always room for added personnel; and in a practical way they can always fill in. They can also pay for things from their own pockets." The volunteer
is thus seen as a "practical" solution to a definite need. The volunteer who becomes very friendly with the patient "goes beyond the call of duty."

But the doctor also sees the volunteer in a role which is different from one of merely filling in for needed personnel and performing "practical" tasks. This refers to the volunteer as one social person relating to another social person, irrespective of whether or not such a relationship is therapeutic or not:

Fourth-year resident: Mrs. G has asked me if she can take a patient out. I haven't felt the need to allow her to do anything different; I haven't prescribed anything different for her. The contribution of Mrs. G and Mrs. L is in ways not provided by anyone else. They are responsible women of the community without any particular aura of do-goodness; they come in and show real insight with the patients; it's a significant thing. The volunteer contributes in the role of human relations — in a group of mature women housewives and doctors' wives somehow contributing to the hospital. The student volunteers do an important job particularly in Of and again provide a background of social fellowship for the less healthy people.

Third-year resident: Mrs. B and Mrs. S are exuberant people and aren't easily discouraged by hostile people. They even do some of the things that the attendants do. They do things the way they would for anyone in a situation. They do extra things for individual patients, but they are friendly to all of them. They usually settle down to some of the most difficult patients. On the other hand, there was the student who helped feed them, dress them — a mixture of cook and attendant; we got to depend on her. Inasmuch as nobody knows what helps these patients, I don't think you know if you're doing the right thing.

But the doctor who reflects these same feelings of accept-
ance and says, "There's no limit to what a volunteer can
undertake to do on her own," separates the role of the volunteer as a friend from that of the volunteer as a therapist; and it is with respect to this difference that the doctor's definition of the volunteer role must be further clarified. This will be done in Chapter VIII.

2. The volunteer and the nurse. The relationship which the nurse at the Psycho has with the volunteer springs directly from the goals set by the hospital. First, she may be as resistant to social dynamics as the doctor. This may be true even more so in the case of the nurse who has undergone rigid training procedures to become a nurse and whose role expectations are based on authoritarian patterns. If the statement is true that "nurses are insecure people," the insecurity of the nurse may be even greater in a hospital like the Psycho which serves to change her role expectations from the authoritarian pattern to that of permissiveness and equality. Even the nurse with the psychiatric training may not be able to picture her role as a therapist:

Nurse: I don't say my relationship with the patient is particularly therapeutic, except in a sense of attempting to produce a community in group living. I certainly don't see my role as an individual therapist. I can see individual nurses working as therapists but I don't see the head nurse's role as this.

Thus, the nurse may be expected to be resistant to the volunteer who is given all kinds of privileges and freedom to do as she wishes: "Volunteers are given too much freedom here."
I wouldn’t know what to do as a volunteer. I’d be lost.”
As a person trained to be a nurse, she does not welcome freedom. Also, because she does not set herself up as a therapist, she does not resist the volunteer as a therapist.

Secondly, as a member of the hospital therapy team, the nurse is expected to relate to patients in the same friendship role which the volunteer assumes. "It’s the nurse’s role to socialize, but it’s also the volunteer’s." But for the nurse there is a strain which makes itself immediately apparent: "It’s the nurse’s role to socialize, but she doesn’t have the time to socialize." On the one hand, since the nurse’s expectations of her role are not as a therapist, she may not be eager to relate with patients to the extent that the hospital goals would encourage her to do so. She may feel that as a head nurse supervision is a function which gives her more security because it meets her own role expectations. This point is brought out by the head nurse in one of the acute wards:

You get too bogged down with baths and feeding that you never think of anything else until you really take time out to think about it. This is sort of an excuse for nurses, but the things you want to do you can find time for. Nurses set up all sorts of standards for themselves and then set up rationalizations trying to meet these standards, never considering that there are only certain hours that these things can be done in.

On the other hand, the nurse may welcome the opportunity to function in her friendship capacity. She is part of a
hospital organization which is "different" from other hospital organizations, and she is keenly cognizant of her privilege in being affiliated with the Psycho and the fact that she is on the therapy team. But since most of the regular nursing staff at the Psycho consists of the head nurses on the wards, assisted by the student nurses who spend three months' training periods there, most of the nurse's time is taken with routine nursing duties and administration of the wards which she supervises, and also in training. Although the affiliate nurses and the attendants relieve her of much of the routine tasks, the time left for her to sit down and talk with patients after she takes care of patient records, conferences, teaching duties, etc., is extremely limited. Thus, if affiliation with the Psycho brings added prestige to the nurse, giving her a status which ranks her on a plane equal to the doctors, these same hospital goals create the strain which she experiences with the volunteer.

The contacts which nurses have with volunteers are confined principally to the wards where the nurses spend most of their time. The number of volunteers who visit patients in the wards, particularly the acute wards, are fewer than those who remain in the occupational therapy department; and the nurse thus has an opportunity to form very definite impressions of the volunteers who come to her ward regularly to visit patients. In this respect the feelings of nurses
tend to be often directed toward certain volunteers, while the doctor is apt to direct his feelings toward all volunteers.

Because the nurse sees the patients the most, except possibly for the attendants, she is competing directly with the volunteer for the patients' favor in her friendship role. The pattern of competition is noted first by the volunteer:

Volunteer: The volunteer may be taking over some of the work of the nurse. The nurse does function in the same way as the volunteer.

Volunteer: We weren't getting patients in the coffee shop because we were competing with the staff who needed the patients, so two volunteers now go up to the wards and get patients. At first we weren't getting the cooperation. Here's a volunteer asking for patients and here's the ward nurse trying to round up patients for ward chores. They can't leave their own chores and just round up people for us.

Volunteer: A nurse will often ask me for information on what I did with the patient if it looks like I had a successful talk with that patient. If there were more volunteers on the wards, they might be a threat. That's why it's hammered into us to supplement but not to supplant workers.

And the nurse:

Nurse: Volunteers are just another group needing time to help and orient. Selfishly speaking, this takes me away from the patients.

Nurse: I have seen a patient go to Mrs. B instead of a nurse all the time. Mrs. B was instrumental in getting the patient here from another hospital.

Nurse: Many times I wouldn't doubt that the nurse is threatened by the volunteer - this person being able to spend more time and do more of the nice things for the patient that we'd like to do.
Nurse: If volunteers are to be used on a large scale, there would have to be limits. You couldn’t have too many around, and you couldn’t let them have everything they wanted to do because they would get in people’s way. We have to set limits even for patients, and it would be the same for volunteers.

Nurse: Here you are in charge of a ward. You know you have to say no to certain patients, and you know how hard it is to have someone else come and make it possibly harder. We had a very disturbed patient who wanted to make phone calls, and these two volunteers come in and say, "Of course you can make phone calls," and the patient has upset her family three times. It’s unfair to the patient. A volunteer shouldn’t take the initiative when it comes to certain things — giving permission — making an agreement with the patient ahead of time; and then the nurse never knows what to do. She asks herself, "Am I being unfair to the patient?"

A word must be said here about the relationship between volunteers and the affiliate nurses. The affiliate nurses often function in a fashion similar to the volunteers, more so than the head nurses because of the time which is available to them. They are also "activators," performing such tasks as taking patients out on picnics and going to museums and ball games. They are thus in direct competition with the volunteers for the favor of patients, particularly with the young volunteers. The strain is aggravated by the fact that these new students often look upon the volunteer’s role as one which is similar to the volunteer’s role in general hospitals. The situation is not helped any when the young student nurse must leave her training duties at the hospital because her time is up; she does not remain in the hospital long enough to understand hospital goals and
the part that the volunteer program has in these goals:

Volunteer: The student nurses seem a little puzzled by the volunteers on the wards sometimes. A couple of times they've asked me to do something like get something from a kitchen.

An additional problem presents itself because the volunteer has been told to be responsible to the head nurse of the ward and to seek help from her. But the nurse herself points out the disparity: "Theoretically, there's supposed to be some connection between the head nurses and the volunteers, but there isn't." This disparity may be explained in any one of several ways, but a clue is tendered by the volunteer who makes the following observation:

In general, my feeling is that they are in a peculiar position. They're professional and non-professional. They won't offer the advice that the doctors or social workers do; they always feel too timid.

The social distance which is thus apparent between volunteer and nurse comes not because both are performing a similar function or getting in each other's way, but because the nurse is reluctant to interfere in anything the volunteer may choose to do, particularly in respect to the older auxiliary volunteers. The nurse is sharply conscious of the fact that certain volunteers are women of considerable influence in the hospital. "You sort of hesitate as to how to advise Mrs. Y because she's sort of up in the things she does for the hospital," is the comment of one nurse. In the presence of such a person of influence the nurse is apt to
feel insecure: she may even fear the loss of her job:

Nurse: We were told that she was somebody important here. The only difference that it made to me was that I wondered just how much influence she had as far as Dr. Solomon or those people were concerned and that this might affect my standing.

Nurse: A lot of it has to do with how much weight the volunteer carries with the hierarchy. If someone has been around and knows the hierarchy, you don't know where you stand without twisting everything up.

The above remarks explain why the nurse does not indicate to the volunteer if she is unhappy about having her in the ward. One simply does not tell the wife of a hospital doctor what she must do and what she must not do unless the wife asks for instruction. Thus, because of this reluctance on the part of the nurse to speak to the volunteer about something which she should or should not be doing, the volunteer herself feels no antagonism toward the nurses and contacts with them are usually "pleasant." The director of nurses, however, admits that she will talk to a volunteer who may be overstepping her bounds; but even she expresses a certain reluctance to do it:

Mrs. S does more damage than she does good but not meaning to, just by coming in and drawing a conclusion; she takes the patients' side without consulting anyone. But I can tell her this and she respects me, but it makes it pretty hard to tell her.

With the younger student volunteers, however, the nurse is not so likely to feel the resentment that she does for the older volunteers, except when she feels that they are
becoming overly involved with the patients. This lack of resentment occurs for two reasons: One is that the students or other younger volunteers do not visit the wards too frequently but remain in the occupational therapy department. The other is that the student is more likely to ask the nurse what she should do with the patient and to seek help whenever a problem arises. Most of the nurse's contacts with the young volunteers occur when the nurse herself visits the occupational therapy department or takes patients there: the volunteer in occupational therapy sees the nurse in a friendly, relaxing atmosphere, and such contact elicits responses from these student volunteers such as "I like the nurses—they're lots of fun." A nurse comments on a student volunteer who did visit the wards:

We had one girl who was real good. She came up to the wards and said, "I plan to take patients on walks or whatever is wanted." She took the time to let me know that she knew nothing about it; and when she was ready to go, we would talk over who would be good to take and how to handle difficulties. You felt that you were working together.

The nurse is not only stressing the recognition of her authority by the student but also the fact that other volunteers did not do the same thing, i.e., come to her and seek instruction. This is evident in further remarks:

Nurse: The people that come here—the volunteers—should go through these two volunteers who were the pioneers in the hospital. But there should be unity—work together and not separately.
Again, the nurse is not only emphasizing her reluctance to offer instruction and direction to volunteers but is even suggesting that other volunteers assume the authority that she feels unable to offer. The nurse stresses the need for cooperation:

Dr. P says that volunteers like Mrs. E don't know how far beyond their calling they have gone. A volunteer should not overstep her bounds on a ward that is run by a head nurse. She should voice her questions with the head nurse so that there won't be a conflict. She should really try to cooperate. The too aggressive volunteer doesn't get along with the head nurse, but the one that is willing to talk things over can be of great value.

As indicated previously in the preceding paragraphs, the nurse seems to be more concerned as to who the volunteer is than how she relates to the patients. As already mentioned, the nurse does not feel that her chief function is to be a therapist. In this respect she differs from the doctor in that she does not feel that she is threatened by the kind of relationship which a volunteer has with a patient, although she may be considerably annoyed at the way some volunteers handle patients and become involved with them. After all, she must cope with the patient after the volunteer goes home. "I don't like the way they handle patients: it's a mushy, smothering, gushy sort of thing, and I don't think that's good." The cool, crisp nurse cannot picture herself doing the same thing. She, also, like the doctor, can see a relationship between volunteer and patient as one that is
fraught with danger:

Nurse: I think Mrs. H could have helped much more in the situation if she had had some supervision. She should have talked about her feelings with the patient with the patient's doctor. She was especially attached to this patient and became emotionally involved. She felt very upset when the patient went out and got drunk. Sometimes people need help in their own attachments. She got so involved with the patient that she didn't see the patient as herself, that this girl had problems, that this girl was an individual. You stop when it becomes inconvenient for you. I feel that I can help patients and relate them on the wards, but I think it becomes inconvenient when I have to take them home. You can't work with personal friends; you become too involved in the situation itself.

Nurse: When volunteers work with individual patients, they should be open to discussion. They can become too independent. But it should mean talking things over with someone because it hurts the patient and causes a rift in the patient-ward relationship. A volunteer can create jealousies among patients by attaching herself and singling out certain patients.

The nurse's chief problem however, that of lack of time, predominates in her relationship with the volunteer. The nurse may feel insecure in the presence of a volunteer; she may feel that volunteers don't cooperate, that they don't seek her help. But she still needs extra help in her ward. She can afford to overlook the disadvantages:

Nurse: It would be advantageous to have more volunteers in the wards because you get bound up and fouled up with medication, having ward meetings, etc.; but it isn't extremely necessary to have them.

Another nurse objects to the way volunteers get attached to patients but adds, "I don't think there are more volunteers who are a nuisance than there are nurses or attendants."
The nurse who thinks volunteers have too much freedom in the hospital also says, "But I think volunteers should have keys to make them feel better; if she's going to be with a patient all the time, she certainly should have a key of her own."

In the light of the above discussion, the question is thus raised as to what the nurse's definition is of the volunteer role. Foremost among the nurse's expectations is that the volunteer functions best as a helper and saves her time. The volunteer meets some definite, concrete, tangible needs. "Volunteers can help out in a lot of situations." "Volunteers can be great assets, and you can certainly utilise them for many things." The nurse sees the volunteer mainly as someone who can perform certain ward activities such as assisting with meals, providing material things for patients, and transporting and "activating" patients. And, "You can't put a price on their value in the insulin room."

Nurse: I do think that they function very well in replacing the attendant when they're understaffed. Years ago when I first started on the ward and everything was short, we just used them as we used attendants before patients were more willing to go with them.

Nurse: Mrs. T is very valuable in many ways, and one of her ways is seeing that patients get clothing and things that they need; and she is very valuable as far as it goes.
Nurse: Mrs. B can get baseball tickets; she can get things for you that others can't get. You don't want to lose this relationship that can get things for you.

Nurse: Mrs. F meets real needs but they're less tangible. Her talents are that she brings material things to the hospital which I think are her biggest contribution. The one who contributes most is the one who comes and brings the little p ansies; she doesn't feel she is being pseudo-therapeutic with these patients; she deals with behavior as it comes up, one woman relating to another, not a therapeutic need.

Nurse: I found volunteers helpful in the acute wards, and they were sincerely interested in the patient and were helpful at times when they were needed. They would take patients to the movies and we sort of depended on them.

Nurse: We should have more volunteers to have classes at certain times for certain things. Now the patients have to be accompanied by someone when they go to OT, so they do have a need for someone coming here. It's also good to have a group of volunteers come down and take a whole group of patients upstairs instead of having them wait until nurses can take them. Volunteers could do more motivating to take patients upstairs.

Nurse: Volunteers can take patients and transport them down here to the EEG lab, tell them that I'm not going to hurt them or the EEG examination isn't going to hurt them. Play therapy with children also works if a volunteer can do it. There are so many things that they can do - bedside care, assist you when you're trying to make a patient's bed; and it's wonderful to have volunteers feed patients. Many of them are very generous with cigarettes which patients need. Helping patients to get out to get their hair done and get a new dress is also something they can do.

Nurse: Mrs. A who brings the music to the patients is someone I see as meeting some concrete needs; she makes a real contribution. She does something definite, something planned, something that you can expect to happen and something you look forward to.

The nurse also recognizes the special contribution which the volunteer makes to mental patients in the hospital: the
volunteer links the hospital with the community. It is a unique function in that she, the nurse, cannot contribute the same thing:

Nurse: The volunteer is the community into the hospital; somehow the patients can feel that they're not forgotten, that the community will come into the hospital. The personnel are expected to accept their behavior, but the volunteer is the community. If patients can relate to the community before they leave, it is easier for them when they get outside. The volunteer comes to welcome the patients back into the outside community. The biggest difference between volunteer and nurse in their relationships with patients is the identification of the volunteer with the community and the nurse with the hospital.

Nurse: I think that the volunteer's contribution is giving a service that is far more valuable - giving their time here. They're also more or less in contact with the outside world.

Nurse: The role that they play because they're from the outside of the hospital gives patients a much nicer feeling. I think that the volunteer's lack of knowledge in psychiatry and in dynamics and her naturalness works very well for the patient. Many times patients are embarrassed in the first place to be in a psychiatric hospital, and then to see someone come in who is not sick and is not connected with the hospital gives them a lift. It's a big lift to see a layman who does not place a stigma on them.

The nurse knows she represents authority to the patient; and because she wears a uniform, she knows that it is the authority which accompanies the institutionalized nurse's role. She can never be the friend to the patient in the same way that the volunteer can, even though she might be a particular patient's best friend. "I don't think the volunteers can take the place of paid personnel. They add something over and above the paid personnel," says the nurse.
3. The volunteer and the occupational therapist. The center of volunteer activity at the Psycho is in the occupational therapy department where four full-time staff members, including the recreational director, two occupational therapists, and the shop supervisor are in charge of patients who come up from the various wards during each day to spend their time either playing, talking, or merely sitting. The occupational therapy department is the place where all student volunteers are first sent and usually all other volunteers who first come to the Psycho. "We’re overwhelmed up here; when they don’t know where else to send volunteers, they send them up here." This department, with its several rooms of varied activity, is not only the center of the volunteer program but also of much of the hospital activity, and it is not unusual to see sprinkled among the various rooms, besides the volunteers and the patients, hospital personnel such as nurses and attendants and also guests of patients and various other visitors. Because of the pivotal position which the occupational therapy department occupies in the hospital community, the success or failure of the volunteer program depends largely on what happens to the volunteer in this department. For many volunteers the only staff contacts which they may ever have are with the staff members who come to this department or work here; on the other hand, the regular staff personnel of the department usually know all
The opportunity afforded the occupational therapists, therefore, to become acquainted with patients and to listen to their problems place the staff members of this department in direct competition with the doctors at the Psycho. It is not uncommon to hear a patient say, "I can get more in talking to Mac for a few minutes than I do for a half hour with my doctor," or to hear a volunteer say, "Mac is probably the most important person in the hospital." One volunteer says, "I heard a doctor call up Mac and bawl him out for bringing about a cure. Doctors are threatened; doctors get tired of hearing patients say Mac, Mac, Mac." This pattern of competition, which involves mainly the recreational director, reflects on the volunteer program for two reasons: first, because doctors are reluctant to talk about patients' problems in this department or to discuss possible ways in which volunteers may help their patients. "The only time a doctor talks to me about volunteers is when they become involved with his psychotherapeutic patients," says the recreational director. Secondly, the new volunteer observing patient approval of both the atmosphere and the personnel in this department tends to adopt the same attitudes as patients in hospital matters, particularly in respect to the other staff roles in the hospital. A student volunteer says, "Mac introduced us to all the doctors but I was more likely to go to Mac for any questions." Thus, the volunteer who has been
denied the support of a volunteer group comes to feel this
support in the occupational therapy department with the staff
members there. Even the first impressions by volunteers
on their introduction to the Psycho concerning the informality
of the hospital atmosphere and the freedom and acceptance
they feel comes from association with this department. A
new volunteer says,

Everyone here is always willing to accept any questions,
and I feel very definitely accepted in this hospital.
Nobody is in so much of a hurry that they can't stop to
say hello. They always ask you if you have any ques-
tions. Today Mac said, "You must see a brain wave," and
we're going to do that today. I certainly feel
that I have gotten more from this hospital than I am
able to give.

The acceptance which volunteers feel from the staff
members in the occupational therapy department is not felt
in any other part of the hospital. There are three reasons
for this feeling of acceptance on the part of the volunteers:
First, staff members here are willing to admit that volun-
teers are desperately needed at all times in the department:

Occupational therapist: We are involved in more things
all the time. We have to go to meetings - it stretches
way out - planning of the new wing, patient government,
etc. Actually, we spend very little time here and we
count on volunteers and student nurses to help out.

Occupational therapist: I'll often call over volun-
teers and ask them to do things - man the sewing room
for me or something else. Volunteers never cause a
nuisance. My big problem is that I just wish that
they would somehow feel free to come and come more
often. I think one of Mac's greatest assets is that
he can get them to come.
Secondly, volunteers are made to feel that they can make some kind of contribution in this department, especially those who have entered a mental hospital for the first time:

Occupational therapist: You don't suspect someone playing checkers as you do someone sitting on a bed. Volunteers reach out and feel that they're doing something up here, holding on to something. "Look, I'm working!"

The volunteer is able to observe at close range how the staff member handles the patient and talks to him; it becomes easier for the volunteer to do the same thing:

Student volunteer: The way Mac talked to them you thought, "How horrible," but then you realize that he is their doctor. I could see that you just talk to them just as you do people; you make similar distinctions as to how to approach them as you do people.

Finally, the volunteer in the occupational therapy department is made to feel that she is a part of the department, even though she may recognize the ward as a greater challenge:

Volunteer: In OT you feel more on a par with the staff because you do everything they do, but in the wards you don't do everything the staff do; you're only a part. But on the wards it's more interesting because you have sicker patients and you feel that you've done more than if you worked in OT.

On the other hand, the presence of the volunteer in the occupational therapy department may become a source of strain to the staff member. This may happen for two main reasons. First, many of the volunteers who work in the department have skills equal to those who are regularly employed in the department; that is, the volunteer may be well trained in arts and
crafts and may even be an instructor elsewhere. Occasionally, a volunteer may have exceptional ability in her specialty. As such she is competing with the regular staff people whose training covers all the arts and crafts. A volunteer may even feel critical of the registered occupational therapist: "OT's here have learned nothing about creative art, mostly mechanical work. Mrs. L is creative in herself but can't project it onto others." But the same volunteer says,

I felt that they were delighted to have me here and that any attention I could give the patients was very welcome. They have wonderful people here in OT. There is a wonderful feeling of cooperation with everyone. I would really enjoy very much a full-time position here. They'd like to hire me full time but they're bound by state rules; they've got to have registered OT's.

The problem of competition thus resolves itself for two reasons: first, as another volunteer puts it, "I might be a hindrance, but they know I can't take over their jobs and therefore I'm not a threat." In other words, the registered occupational therapist has the same professional security that the doctor has with his M.D. degree: the volunteer cannot assume the occupational therapist's role, i.e., cannot be called an occupational therapist, because only a licensed person can have that position. Secondly, the reason mentioned above in respect to why volunteers feel accepted in the department applies even when the volunteer is a person of considerable skill. There are simply not enough volunteers with creative skills to take care of the existing needs. Also,
the volunteer who only comes in for a few hours a week can never become a severe threat to the staff.

But occasionally a volunteer will spend many hours in the department either in art work or in playing games or in talking to patients. This is the second possible source of strain to the occupational therapist. The instance may be cited of two volunteers who were coming in to the hospital on a full-time basis to work in the occupational therapy department, one of whom remained at the hospital for a year. These two young volunteers were asked to assume complete responsibility for the entire department for two weeks during the absence of the regular staff who were attending a conference. One of the volunteers relates the relationship she had with the patients during the absence of the staff:

The patients were working with us. If anybody did anything wrong, they would run to clean up and quiet them down. They were wonderful. Why this sudden burst of enthusiasm? I don't know. They said they were awfully glad I was here. Several of them said I should go into the field.

She goes on to describe the return of the staff members:

It was very threatening for them to go off for two weeks and to come back and find out we had held their jobs. It's upsetting to find out your job has been taken care of. We had to sit down and talk it out four or five times. We talked out the fact that they were paid workers and we were the volunteers and that we really didn't threaten them - we just weren't qualified to hold the position. Frankly, it was hard for me to step down from a position of authority and give it back. It was also hard for them to go away after five years of college and come back to see that someone here who had not had the college training had done a good job.
One of the occupational therapists describes the same incident from her point of view:

When we left for two weeks to go to a meeting, they did a beautiful job. We felt funny coming back; they were having such fun. I was afraid our coming here would dampen their spirits and they would go back to the volunteer role, so we worried and worried to see what we could do or say to them. When we came back it was awful for about two weeks. We felt badly that our being here would stomp their ambition and would dampen their spirits a bit; and they felt that we were threatened by them, I think. And we felt the way you do when you come home from a vacation and look around your own house — it all looks strange. They had put curtains up and made a couple of other changes. They tried awfully hard to do well.

Another volunteer who had been observing the whole episode from the sidelines records her impression of it:

When the volunteers took over for the OT’s, they did the best job they could, gave their all, but on the return of the OT’s for some time to come there was always some mention of little things done wrong during these two weeks. The volunteers never stopped hearing about it.

Finally, the volunteer quoted above who was involved in the situation and who had always felt welcome and accepted from the beginning in this department has one more thought in the matter:

I became more closely accepted after this. Three people working together as a unit rather than each separately. Now I feel that I’m sort of a fourth personnel in the department.

And the staff member sums up her thoughts:

Actually, she’s here more than we are and she’s considered to be one of the staff. She’s very reliable. More people consider her as part of the staff than a doctor. We do. I would leave her in charge any time.
The fact that this volunteer was able to remain for a full year and spend a forty-hour week in the department testifies to the mutual feeling of acceptance. It points to the same fact, however, which was mentioned previously in connection with the volunteer who felt that her creative ability exceeded that of the occupational therapists, namely, that both the volunteer and the occupational therapist realize that the volunteer cannot take over the position of the licensed worker, no matter what her abilities are and how much time she spends in the department. But the need for the volunteer exceeds any personal insecurity that the staff member might have in occupational therapy.

Another instance may be cited when the occupational therapist might feel threatened by the volunteer. The female occupational therapist is extremely conscious of the social status of the volunteer, particularly those who spend a great deal of time working in her department. But her concern in regard to this status differs from that of the nurse: the occupational therapist might feel some envy for the volunteer but she is not afraid of losing her position because of any influence which the volunteer might have in the hospital. "This is conspicuous leisure and extra talent to be a volunteer," says one occupational therapist, and "It bothers us because she's a ______ and it bothers her because she doesn't give herself what she could as a _______,"
and "Many of the older ones that come - volunteering is their work, their meat, their debt to society; they just come in to say that they're doing volunteer work in the hospital." A staff member says about the occupational therapists:

They're threatened by the volunteer; they have jealousies about status. They're striving for upward social mobility themselves and are threatened by the ones who are there.

Thus the occupational therapist at the Psycho may feel more insecure about the social status of the volunteer than the fact that the volunteer might have greater talent or might take over her job.

The occupational therapy staff member defines the volunteer role first in terms of a recognized need that the patient will benefit from the skills and companionship which are offered by the people who come in from outside the hospital. "Everyone has the skill of recreation; it is at their fingertips, and this is where volunteers are most comfortable in." But to the occupational therapist the skills are not necessarily the most important contribution which the volunteer can make:

Occupational therapist: We actually expect volunteers to man this department - to activate patients - get them to play cards, games, etc., to get to know the patients, talk to them and dance with them.

Occupational therapist: The idea of having specific skills or talents is important but there's so much more that you can have that is more important. I'd much rather have someone come in and sit with people and talk with them comfortably.
Also, to the occupational therapist the volunteer is not someone to do menial tasks, even though there are plenty that need to be done in this department. Housekeeping chores are only a small part of what the volunteer can contribute. More important, the volunteer must be happy at her work:

Occupational therapist: I see no use in having a volunteer do something she's not happy to do. If she likes to do menial tasks, it's all right with me; but certainly not to come exclusively to do all the stinking jobs no one else wants to do.

The emphasis is placed on the satisfactions which the volunteer herself may derive from her relationships with the patients. The volunteer's role is not merely one of giving to the patient: the volunteer must receive for herself. The patient must share the benefits of the volunteer's presence in the hospital with the volunteer herself. The best volunteer is the one who learns while she is helping the patient at the same time:

Occupational therapist: Everyone has a different viewpoint as to the function of volunteers. I look on them as activators in the therapeutic community. They should also be learners in staff conferences and elsewhere in the hospital - letting them see everything until they find their neck.

Occupational therapist: Mae usually handles volunteers because he has an extra sense of handling them. He teaches them and knows how to give the very satisfying experiences. He constantly asks, "What will the volunteer get out of this? How will the volunteer grow?" rather than "What will the hospital get from his being here?" His prime concern is the volunteer and it is certainly mine, although I can't carry it out as easily. It is, "How will the volunteer grow and at the same time help the hospital and the patient?"
Occupational therapist: A volunteer should be very definitely interested in learning. I think that you'll find a great number of the patients begin to realize that they aren’t quite so sick as other people think. Deep down the patients feel that they can in their own small way be a help to the students — to be part of their learning process. The ideal student volunteer can learn through this process; she can still build up a friendly relationship with the patient, thereby giving of herself to the patient. The patient gets something in that he accepts the friendship, the interest.

The occupational therapy staff member also points to the younger volunteer as needing less orientation than the older volunteer. It is usually the younger volunteer that does the most for the patients, but there are of course many exceptions to this:

Occupational therapist: The greater number of our hospital patient population is relatively young. With most of them people, their own age is very important. But if you have a volunteer that is a good mother figure, that’s a good thing; they are invaluable, too.

Occupational therapist: If it is an older person, much more care and time should be put in; and this should be done by an older person, not by someone like myself. The older person needs more guidance and watching, because the do-gooder quality is in some of the older people. They get sucked in by what the doctors call transferences — “Can I do something about this? She’s suffering.” Older persons could do more administering with patients. The younger people do the most for the patient. There are rare exceptions in this, but these are real people that are of the world, who like this and show it by the reaction of people to the world.

Occupational therapist: It’s interesting that of the volunteers that we have, with the exception of two that I might name, that a fewer number of the younger volunteers leave than the older. Over a period of time during the summer we’ll have quite a few that will come in for a full day or two. They’re really accepted, whereas some of the older ones aren’t really
accepted. It is the exception to the rule when the older one is accepted rather than the younger. Maybe it’s because the younger ones feel more secure and have a more secure feeling in doing things. The older ones are the ones that want the orientation, the guidance, the step-by-step procedure, whereas the younger ones don’t.

The occupational therapy staff member has thus defined the volunteer role in terms of acute personnel needs, a unique contribution to patient therapy, and a satisfying experience for both the patient and the volunteer. The recreational director sums up his definition of the volunteer role:

A volunteer is generally a reflection from the outside world— in clothes, appearance, personality, She should be more interested in the reaction and happiness of the patient and from mutually gaining from this relationship. Volunteers should be given the hospital right to learn from hospital mediums and conference groups; their contribution can be invaluable to the patient because they haven’t got the psychiatric approach. They want to learn or be with people because they care for them, want to help in every small way. The patients feel this; they know that volunteers aren’t just trying to probe into their illness. The non-uniformed look, the young college crowd—even facially they can be therapeutic. They also fill in the intimate details of the social worker— getting glasses, getting hair done, all of which can be done more quickly by volunteers. They are a large part of what helps to make for a healthier, happier atmosphere. A great area they help in is in their enthusiasm for things in the outside world of the hospital which they manage to pass on to patients in the inside world of the hospital whose enthusiasm has been lost.

4. The volunteer and the social worker— The relationship which the volunteer has with the social worker at the Psycho can be understood largely in terms of the struggle
which the social worker has had to attain a level of recognition in her own profession both inside this particular hospital and outside it. "Social workers have started off being a volunteer group, and we are not secure enough as a profession." This is the problem of the social worker and she is the first to recognize it.

Social worker: When we started as social workers we came in on a charitable payment and we were to do all the things that involved people in trouble that none else wanted to do. We would get the referral only when everyone else couldn't do it. They told us, "You people are trained to deal with people." They tried to make us feel that we had special skills. But it was a large area of skills, all kinds of things.

Social worker: Social work as a profession has not yet drawn its own conclusions as to what its limits are. Social work is sort of trash barrel, particularly because we are in this setting doing a lot of things that volunteers could legitimately be doing. Most of our work is case work with families, and it is very different from friendship.

Social worker: Social workers are a very jealous bunch. Here in the hospital we're an appendage ourselves and we're more insecure in a hospital than in an agency where you're the chief cook and bottle washer.

The recognition which the Psycho has accorded the social worker by including her as an equal member of the therapy team in the hospital goals has not brought the social worker the complete security that she needs, because the problem reaches outside the hospital into the whole field of social work. In the hospital itself the problem has not had time to resolve itself: the social worker is still looked upon in her institutionalized role outside the hospital.
Social worker: Up until two years ago the social worker was the scapegoat. Our status changed at that time, the minute we set up what our role was as social workers and defined it ourselves.

The uneasiness comes for two main reasons: First, in defining her role within the framework of the hospital goals, the social worker has become a "therapist." As such she is torn between dealing with families of patients and working with individual patients who have problems and need someone to whom to talk about them. But in a hospital with a high turnover in patient population as is the Psycho, for the social worker to accomplish both objectives is almost an impossibility:

Social worker: My contacts with patients is secondary: I deal more with families. We're all carrying large case loads. Ideally, I should be working a lot more with patients, but I can't possibly do it.

Thus the social worker finds it necessary to keep to the institutionalized definition of her role and concentrate on her work with the family of the patient. Nevertheless, she also attempts to carry out her prerogative as a friend to the patient; and it is here that the additional strain lies: not only must she re-define her role as social worker to include that of therapy, but she must also compete with the other staff members, particularly the doctor, for the patient's favor. The strain is most intensely felt against the doctor:
Social worker: Casework is becoming so formalized. We have gone overboard on therapy, but with the bulk of the work we do with the patient, the therapy is an appendage to the doctor. In this hospital we are more secure than the doctors, but we are afraid of being more threatened, and we're trying hard not to be. We are one of the very few professions who are taught how to interview, and here are these guys that hop out of their internship and plunge into it, knowing nothing.

A volunteer observes the strain between social worker and doctor:

Volunteer: There's quite a bit of teamwork lacking here. Miss G, the social worker of one of the patients, asked me and another volunteer to make a very free relation with a patient. Her doctor recommended that we do exactly the opposite thing - leave her alone. The social worker was a little upset when I told her. She said, "Well, he hasn't told me that."

In her role as therapist, the social worker feels the same strain, but even more pronounced, with the volunteer as she does for the doctor; and she may even be competing with both the doctor and the volunteer at the same time:

Social worker: My only close contact with volunteers has been an unfortunate one. It has to do with two people who have been here for years with all the good will in the world. I was working very intensively with a catatonic. These two volunteers swamped this patient with candy bars. I don't know if they did much damage. The nurses and doctors were disturbed. The doctor actually handled it, but the volunteer was terribly hurt that the doctor had spoken to her at the time. She took it as a personal insult. They're giving but if what they give is not good, they're hurt. We all knew this without speaking to her about it.

Social worker: The social worker has this same feeling for the volunteer that the doctor has for the social worker - this person coming in as therapist.
But the social worker has yet another problem. She has professional training and a degree, but she does not have a legal license which sets her role apart from that of others:

Social worker: Social workers are not licensed as yet. As social workers we have seen limited uses for those who have not been trained.

The volunteer thus becomes a threat to the social worker for two reasons: First, the social worker does not have the security of a license which can keep other people from assuming her central task functions such as do the doctor, the nurse, and the occupational therapist. Second, the social worker does not have the time, as does the volunteer, to establish the relationship with the patient which would fulfill her role expectations as therapist. The volunteer not only has the time but may even have the inclination to act as a social worker herself, particularly the volunteer who takes patients out of the hospital, follows them up after they leave the hospital, and who might even help them find jobs. "I'm just a frustrated social worker anyway," says one volunteer; "I would have liked to be one." She had come to the hospital because she expected to do social work as a volunteer. But as an untrained social worker, the volunteer is not only assuming the institutionalized role functions of the social worker, but she is also in a position to take on the very role as friend to the patient which the social worker wants to do but does not have the time to do.
In view of the above, it is perhaps understandable why the social worker has as few contacts with the volunteer as she possibly can. "It hadn't occurred to me to get volunteers or get in touch with them," says one social worker who later defined the volunteer's role with a great deal of precision. Another social worker mentions the lack of time available which would be required to train volunteers, but there is an underlying note of strain in her remarks:

Part of our resistance comes because when we really have needed volunteers we have had the feeling that it isn't quite right to just give them errands to do unless we could really integrate them, and some of it is going to take a lot of time to give instructions for. Here we put our social workers through a rigid two-year course, and then to have someone just stroll in - we feel that it is going to take so much work. The volunteers who have been here a long time know what to do; but if we have to call someone in from the outside, it wouldn't pay us with the amount of discussion and interpretation.

The resistance to the use of volunteers in social work is reflected again in the brief summary quoted below of how volunteers actually have been utilized by the social service department. The emphasis this time is on the unreliability of the volunteer:

Social worker: We have had a long time in discovering where volunteers could be used. They started out with clinical work; then they worked with patients but with another social worker there, too. Then they drove patients to places. Then we used student volunteers as hostesses. Then we tried to use ex-social workers as volunteers. Then, having spotted where the ex-social workers were going to be more useful, we found out that they had to stay home because the baby was sick. The amount of supervision, plus the extra orienting, have made it an extra special problem. We did use one girl with training to do a few home visits.
The social worker also feels that the volunteer's lack of training in dealing with patients can be detrimental to the patient. For this reason the social worker stresses that the volunteer should not be encouraged to follow a patient outside the hospital but to confine the relationship to the hospital itself. As previously noted, patient follow-up is the exclusive domain of the social worker and the community clinic:

Social worker: If the volunteer gets too involved with a patient, the extent depends on the volunteer and the therapist. If you were doing any orientation of volunteers on this aspect of their work, you should caution them to be more conservative in their relationships than the doctors, and it would be wise to almost fall over backward in their conservativeness. They should be encouraged to do only things that deal with the hospital situation. It would be easier for a volunteer to turn it over to the doctor. I wouldn't encourage taking it out of the hospital even after the patient left, unless the hospital knew about it. A lot of the follow-up is being done by the community clinic, but many of the current troubles are seen by the social workers.

Thus it is seen that although the social worker may lack a license to practice social work, she nevertheless feels that she is a professional and that the volunteer is the "layman." It is for this reason that she recommends that not only should the volunteer-patient relationship be confined to the hospital, but also that volunteers should be closely supervised:

Social worker: There are so many people around here that are lay people, students or anything else, that it swamps patients. I'm not sure that the volunteer could work with patients. They can be used very constructively like Mae uses them, but this idea of
having them wandering around the hospital just bothers me. They need supervision. I'm sick and tired of seeing all these people wandering around without knowing exactly what to do.

The resistance to the volunteer is voiced in even stronger words by the same social worker: "When the day comes that volunteers are put into the planning - when that day comes, I'll resign." She might even prefer that the volunteer not be a part of the hospital at all: "I can see volunteers used so much more creatively in a chronic hospital which is open to suggestions and new ideas."

The younger social worker also carries the additional strain of being conscious of the volunteer's social status - "Some of these doctors' wives irritate me no end" - and also the influence which some of the volunteers might be able to exert on the "echelons":

Social worker: We don't want to daunt these individuals from the community who dare to cross these echelons. Also, the higher echelons would not want us to cross the toes of some of these people from the point of view of higher relations.

Social workers also do not share with the occupational therapists the idea of the volunteer's receiving something from the relationship with the patient: "The students want to get something: they have the ulterior motive of wanting to learn from the patient."

The lack of acceptance which the social worker feels for the volunteer is reflected in the attitudes of the volunteer toward the social worker. The volunteer notes the
social distance:

Volunteer: It's all on a competitive basis here. We are competing in essence with the social workers. I don't think they're conscious of this. Maybe we're overstepping sometimes. There isn't the friendliness, the comradeliness that you have with the others. Even the doctors get friendly and chat with you. I only know two social workers by name, but they don't call me by name. As a general group, they don't seem to be warm, so you question it and wonder why. We've been forced on them in a way; they've just had to accept us, and I think only a few of them have. I think they're jealous. But I also think they overstep themselves. I can't really see why social workers take patients into therapy; they can be invaluable in the family relationship, in finding out what there is in the family. If I go to a social worker, she'll just answer my question; she'll just give me what I ask for, yes or no.

Volunteer: As a whole the social service department doesn't accept the volunteer program. Because the kind of work they have to do is work that demands that they must be at a certain place at a certain time, and volunteers are expected to do that. It's a matter of time and being able to put the social service job first. The social service department is willing to cooperate with volunteers working in other departments of the hospital, but they won't have them working in their department.

Volunteer: Although the social workers use the coffee shop almost as much as the doctors, they are not in quite so close contact with the volunteers as are the doctors. I have a feeling from the few that I have contact with that possibly they have their therapy session with the patient, and when it is over they don't carry their job over like the doctor. It is rarely that the social worker will come to me and tell me anything. I always have to go to her and ask about a patient.

The above quotations are from three volunteers who had been at the Psycho for one, six, and nine years, respectively.

The social worker has refrained from contacts with the volunteer to the point where the older volunteer identifies her
intentions as deliberate, and the younger volunteer simply
does not even know who the social workers are or that there
are any in the hospital, unless she sees them at the staff
meetings. "I don't know any social workers," is the common
response of the new volunteers.

But the pattern of volunteer-social worker relation-
ships is not a completely uncommunicative one. "I think
Miss G's ideas of volunteers have changed since she first
came to the hospital," is the observation of one of the
occupational therapists. The social worker referred to
speaks for all the social workers in her department:

Except for Miss D, the others in the department haven't
developed this idea of using volunteers. But Miss D
has theories that she can use her volunteers very well
to do a lot of the special work with patients, sort of
special work. But I have not seen eye to eye with her.
She has also been using college volunteers at the
----- Hospital to try and place patients at jobs. The
rest of my department was a little bit more loath to
let volunteers cut and relate with patients. But
anything is better than nothing.

The volunteer thus becomes a source of strain between the
members of the same department who do not share a similar
definition of the volunteer role. The social worker who
is being discussed above - Miss D - loses the support of
her own group because she thinks the volunteer can be useful
to her. She tells about her contacts with volunteers:

I certainly can see using a volunteer in social work.
I have had constant contacts with volunteers, several
working under my supervision with patients. I person-
ally have found a volunteer can do things that we could
do that are very good social work practices. Mrs. C has
done some specific social work activity within an area where experience isn't 100 per cent necessary. She has time and again taken patients shopping. It wouldn't do in my relationship to tell a patient how her hair looks. She can do some things that I couldn't do; actually, she does better than some of the screened personnel. I'm very dependent on volunteers, and I think it's tremendously important to get the community behind us.

This social worker not only has used volunteers extensively but recognizes their unique contribution to the hospital community. Volunteers can do many things that she can do and they can also do some things that she cannot do as a paid staff member of the hospital in an institutionalized role. Training is not necessary for all phases of social work. The same social worker, however, feels that the volunteer may prove to be more of a liability than an asset; for this reason any volunteer entering the social work area should be screened:

Social worker: I approve of volunteers working in all the areas. But I have seen some pretty dumb volunteers do some pretty stupid things that have been pretty distressing. They mean well, but I feel that volunteers should be carefully screened if they're going to have personal contacts with patients. I'd like to have a pretty good idea of why they want to come here because we're friendly here; and if they haven't got the integrity to keep information to themselves, it can be very detrimental, such as "Do you know who is at the Psycho's," and "I went to the staff conference and this was said." They should have limits, not only for their own sakes but also for the patients' sakes. And it isn't every volunteer that I would have to do with patients as I ask Mrs. G to do. Volunteers are must useful in defined situations like insulin and occupational therapy, but just freedom on the wards - I just think that is dangerous, I just do. Also, if a doctor is having intensive therapy with a patient and the volunteer is coming to see the patient two or three times a week - this may also be disastrous.
The social worker who accepts volunteers for social work practices is reluctant to let the volunteer establish close relationships with patients. Also, the volunteer is an important link with the community, but what she tells the community may be a source of strain to the hospital and to the patient.

The social worker quoted above thus defines the role of the volunteer in terms of social work and not therapy. The volunteer can perform certain task functions of social work which take her out of the hospital with the patient. The once resistant social worker whose idea of volunteers was considered to be changing since she first came to the hospital can also see the volunteer’s use in the rehabilitation of patients:

Mrs. J has another idea that I can see has a value: to take patients who have been quite dependent on us who have to be weaned from the hospital and need some faith in themselves—have them come to her house and learn to come out by themselves, then to learn how to cook, go shopping if this could be done. Volunteers could do this re-training job very well. Here it is more difficult to use the non-trained volunteer, but even the non-trained social worker volunteer can be fed into the picture. For instance, a patient who had hair growth and it was felt that a social worker couldn’t spend the time. The volunteer has to see the relatedness of what she’s doing.

On rare occasions, the volunteer might even work individually with a patient if there is enough supervision:

Social worker: A volunteer can contribute to a relationship with a patient; first to the adolescent girls who need a friend, a sort of a friend, but this might not be highly successful with a volunteer because it’s a delicate thing, and I should really be in touch with a doctor.
Social worker: As an extended arm of the nursing service, volunteers could help supervise those patients from the closed wards that aren't terribly disturbed and when the nursing service can't possibly do it.

The volunteer can be utilized elsewhere in the hospital.

"The coffee shop is more of a project which is needed within the hospital community." "The volunteer's role can be one of two things: the Harvard boy that ran a class in models, or the kids that can teach dancing. Also, OT needs a lot of help."

Social worker: I would turn to volunteers to do things that I couldn't do for myself. If anyone is the scapegoat, the volunteer is certainly the one. The things that I would call a volunteer for are the things that I wouldn't want to do myself.

Finally, the social worker defines the volunteer role in terms of how she has defined her own role:

Social worker: The volunteer has to define her own role for herself. She has got to work it out for herself. The volunteer has got to say, "I feel that I've got to do this, this, and not this." She's got to see it for herself.

5. The volunteer and the attendant. The role of the attendant at the Psycho presents an opportunity to compare a non-professional role of a paid staff member of the hospital team with the non-professional role of the non-paid volunteer. Other than the fact that the attendant is paid for his work, the distinction must also be made as to the training which the attendant receives in contrast to that of the volunteer. For the attendant the hospital
administration advocates and carries through a policy of "minimized formal training and maximised on-the-job training." This means that the attendant is given special attention for his training, in addition to having a status accorded him as an "equal" member of the therapy team.

At the Psycho the role of the attendant is thus one of high prestige in contrast to that in other mental hospitals. The attendant is not a custodian or "a keeper of the keys." He is told that he has an active part in the therapy of the patient. The role of the attendant at this hospital is thus completely broken down in its pattern of institutionalized role expectations:

Attendant: I did have a preconceived notion about the attendant before I came here - that the attendant was just to look after patients and take care of the physical needs. But here the attitude and the program is so much different.

Nurse to new student nurses in orientation meeting: No doubt this will come as a shock to you that the attendant here has a much higher status than the attendant in other hospitals. We consider him of equal status with the nurses. We feel that the attendant does have a very important role because he is with patients a great deal, and we rely on his observations. We don’t look down on him or indicate that we are superior to him. Occasionally, a student has felt that she should come in and order someone else around. Particularly do the attendants resent this from women.

Volunteer: In the mental hospital here the attendants are practically the same as the nursing personnel in other hospitals, and they’re with the patients so much of the time.
Volunteer: The attendants are in a class by themselves and ought to have medals. I think they’re wonderful people in this institution and I didn’t think so when I first came in. The ones I’ve seen know more about the patients than any other people in the hospital. The nurses are busy but the attendants take time to understand the patients and take care of them more.

Because of the reputation of the hospital as a teaching and research hospital and also because of the status tendered the attendant, it is not unusual to see students of both social science and medicine working as attendants as a learning opportunity. Student volunteers often return to the hospital to work as attendants. This applies principally to the male attendant:

Attendant: I’m very grateful that I have a chance to sit in on something like staff meetings and also be able to hear the patients and doctors in conversations between them and see how the doctors will treat such a case. I see it more as a good learning experience for myself, and it’s also very practical to do this because we spend a great deal of time with the patients. It works both ways here: the doctors want to know what we think about the patients and they ask all the attendants; then they decide what is best to be done.

Added to the above factors of prestige and learning opportunities, the fact that the attendant spends more time with the patients than do any of the other staff personnel provides for him an advantage over the others. Even the non-student attendant who comes to the hospital with the institutionalized role image of both the doctor and the attendant comes to see himself as almost equal to the doctor in some instances:
Attendant: Of course the doctor is the sine qua non of anybody getting cured; I appreciate that personally. When you're having a rough-and-tumble on the ward, the doctor is the one that the patient calls for and feels is his friend. That condition also applies to the attendant under certain conditions.

In some instances the attendant even feels that he is able to do something that the doctor cannot do. The volunteer shares this accomplishment with him: "But an attendant may be able to establish the relationship with the patient that the doctor can't. This also goes for the volunteer."

Most of the contacts between volunteers and attendants occur on the wards where attendants spend most of their time. Occasionally, attendants accompany patients to occupational therapy or in the yard where they may also come into contact with volunteers. However, when volunteer and attendant do meet, it is usually the volunteer who takes the initiative to communicate with the attendant. Thus, the attendant may seemingly ignore the volunteer, especially the new volunteer, but at the same time he accepts her on the therapy team. He does this for three main reasons: First, he finds that he himself lacks the time to spend with individual patients and perceives keenly the shortage of personnel.

Attendant: I like the open-door policy here; it taxes the personnel, but it could be corrected with more personnel. We could use more volunteers.

Attendant: Volunteers are a necessity in this hospital. A volunteer can take some small area that an attendant just can't sit down and work at because of lack of time. Volunteers can fill in those areas that can't be covered by the attendants.
Secondly, the attendant who is himself a student feels a
kinship with the student volunteer:

Attendant: Now as an attendant I feel that these
people coming in from the outside can come up to me,
and it's the feeling that both have for each other -
attendant and student.

Thirdly, the attendant who finds it difficult to accept his
own role as defined for him by the hospital, and especially
when he must accept the authority of the nurses in all phases
of his work, much of which is of a menial nature in the ward,
feels the greatest support to his ego when he can assert his
superiority over someone else. He can afford to be generous
to the volunteer: with his training against the volunteer's
complete lack of training and experience, he can feel superior
to someone. An attendant who was formerly a volunteer himself
presents the viewpoint of both volunteer and attendant:

Attendant: If I hadn't been a volunteer myself and
had been one of the attendants here, I wouldn't know
this. When a volunteer comes, the attendant can say,
"Here's someone who is a little better than me and
I'm at the bottom, but here's a chance for me to pull
rank." The attendants love to show off their knowledge;
they're very eager to explain things to all newcomers
and to volunteers in particular; such things as what
the nature of electric shock is, etc. They really don't
pay too much attention to the volunteer except that it's
a chance to pull rank. "Here's someone at last that is
lower on the scale than I am." The attendant more or
less ignores the volunteer otherwise.

The superiority which the attendant feels for the volunteer,
however, is not in terms of exerting authority and pressure
on her, since he also is extremely cognizant of the social
status of the older volunteers. He ignores the volunteer on
the one hand because of his recognition of her status in the community, but he accepts what she can do and does not object to seeing volunteers in his ward. "I think attendants think a great deal of volunteers," says one attendant who had been at the Psycho for many years. "Of course volunteers should go to staff meetings," says another who feels that the volunteer has a part in the hospital activities.

When the attendant becomes acquainted with the volunteer, he finds communication easier: "The volunteer will ask at different times how the patient is doing. I don't object to discussing things with volunteers about patients." A female attendant who had been at the Psycho for fifteen years and had watched volunteers work with very sick patients on her ward says,

I can appreciate what volunteers do for its own sake and not just because the hospital says I should. Some volunteers put themselves out for patients: "Can I go downstairs and get you a cup of coffee? Is there anything I can do for you?" Volunteers aren't here to do things like this. The patient realizes it. The attendant thus accepts the volunteer on her own merits.

Although the attendant may feel himself superior to the volunteer because of his training and experience, he nevertheless does not feel that he is competing with the volunteer. As a non-professional himself he does not feel the intrusion of the non-professional that the other staff members feel. He may realize that his job is at stake if he steps on the toes of a volunteer, but he knows that the volunteer will
not take over his job. The female attendant may be more reluctant to see volunteers on her ward than the male attendant and may feel some envy for this person who does not have to work for a living. On the other hand, the attendant may express admiration for the volunteer who prefers to spend her time in a mental hospital talking to very sick patients when she could very well be doing something else:

Attendant: The quality of volunteers here is of a high level, and it does indicate that these people have a certain amount of intelligence. They're usually college people. I look up to volunteers because it's an indication of character for them to come in on their own time and come in religiously. That's a yardstick of character.

Especially for the attendant who spends most of his hospital time in the acute wards, the volunteer presents a change of atmosphere for him, as well as for the patient. But the volunteer brings something else from the outside besides a breath of fresh air:

Attendant: Here volunteers are quite free to express ideas. I wish we could have had them twenty years ago instead of now. We become fossilized after awhile. The volunteer doesn't have those frustrations to fall back on so he may be able to get something accomplished, and these days there is a more receptive attitude toward new ideas. And when the situation gets stagnant, you can get the volunteers to take a crack at some of the new ideas.

The attendant also identifies the volunteer with the community:

Attendant: From what I've seen of volunteers, they're very much a part of the hospital, and I think that they have responsibility here. I had a feeling when I came here that patients don't want to mingle with other patients and would rather chum around with someone that
is not mentally ill. That's why they might go after
volunteers rather than with patients when they first
come.

The volunteer herself feels accepted by the attendants.
"Some of the attendants who are with the patients could be
pretty nasty to the patients but not to the volunteers." One
volunteer went so far as to suggest at a staff meeting that
the "student nurses be told that the attendants are the
backbone of the hospital and a superior bunch of highly
trained, skilled workers."

The attendant also sees the volunteer as contributing
to patient therapy, besides being able to establish a
relationship with a patient:

Attendant: Volunteers can help by listening to
patients' problems and the very intimate details of
their lives. I think that all relationships do help
in making a patient well. Take a patient who is
really out of contact; he can't even find the doctor.
You can't get to him in psychotherapy, but shock and
insulin forces him on the highways, and when he has
that contact with that highway, then you can take him
and lead him.

Attendant: Patients appreciate the volunteer if she
is sincere and not just a curiosity seeker. She does
have a part in making a patient well. If I were a
patient, I'd be happy to have an outsider come in.
Patients put a different evaluation on a person who
is a staff member and one who is a volunteer.

Attendant: A volunteer does a lot in making a patient
well. In some things the volunteer can do more than
the attendant - in getting things for patients that the
attendant can't get. I also think the volunteer is
more useful in talking to a patient rather than making
beds. Volunteers go out of their way to help a patient,
whereas somebody else couldn't handle all the patients
at one time.
The resistance felt by the attendant for the volunteer occurs mostly when the volunteer undertakes to do something on her own initiative without consulting someone else. In this respect the attendant is keenly conscious of the person with influence;

Attendant: Once in a while I've heard it talked that there are a few volunteers that want to come in and take over. "Who is he?" "He's a volunteer." Immediately you think that it's one of these people who are going to build the hospital over again. Volunteers shouldn't decide to change policies on their own initiative; this should be done on the executive level rather than having volunteers do it for themselves. A volunteer can stir things up, but here we're stirred up all the time.

Attendant: A line should be drawn between volunteers and paid personnel where they should not consider themselves in the capacity of making decisions for the patient such as when the patient asks, "When do I go home?" and the volunteer says, "Oh, perhaps in a couple of weeks." The volunteer should ask the doctor and should make no outside contacts for patients without permission or mail letters for them on the outside, or anything like that.

The attendant thus defines the volunteer role in terms of helping out with patients in the wards where the attendant is too busy with his own work to spend the time with the patients. The stress is not on the housekeeping tasks but in such things as serving meals to patients and giving a hand to the attendant when a patient is difficult to handle. "Every volunteer can do something here. I don't prefer any certain type; they can all do a certain thing." But the volunteer can also contribute to a relationship with a patient in a unique way because the volunteer comes
from outside the hospital. "Patients respond to volunteers very much." "I've heard women patients say that Mrs. H is wonderful because she's a person of infinite patience with those who are very sick." "Volunteers are good to have because I have to go to work, but a volunteer has to be more dedicated than that." Finally, the volunteer must define her own role to a point beyond which the attendant has had to do at the Psycho:

Attendant: No attempt is made for the volunteer to be fitted into the hospital picture. If the volunteer doesn't take the initiative, there's no one who will take it for her. You can be welcomed into the hospital, but the staff people have their own jobs to do. It's up to the volunteer.

G. Summary

Because no organized volunteer group exists at the Psycho, there is little contact between volunteers who are not members of the ladies' auxiliary. But where a volunteer is also a member of the auxiliary, certain problems arise: first, for individual members who must divide their loyalties and time between volunteer activities and auxiliary activities; and, second, among individual members who are attempting to raise their status both inside the hospital and outside it.

The volunteer's relationships with the various staff
members on the therapy team varies with the different roles and is dependent mainly on the effect of the hospital goals on both the volunteer and staff roles, any similarities in task functions between the volunteer role and the various staff roles, and the definition which the various staff roles give to the volunteer role.

The hospital goals reflect most strongly on the relationship between the volunteer and the doctor. The institutionalized role patterns of the doctor are broken down at the Psycho, and the doctor, especially the new resident, feels himself least necessary to the hospital organization. As an "equal" member of the hospital team in the therapy of patients, he competes not only with all the staff members, but with the volunteer as well. He accepts the volunteer insofar as there is an economic need for her services and because she provides a social experience for the patient. It is the volunteer's contribution to therapy which is the source of greatest strain to the doctor. Thus, it is not possible to separate the doctor's relationship with the volunteer from his central role function of therapy. This relationship with the volunteer is discussed further in the following chapter.

The nurse's relationship with the volunteer is based partly on hospital goals and their effect on her institutionalized role patterns, and partly on volunteer status. The
head nurse who is accustomed to authoritarian patterns resists the freedom given to volunteers. She competes with the volunteer in her friendship role to the patient in that she lacks the time to socialize with patients, but she does not feel threatened by the kind of relationship which the volunteer makes with the patient because she does not look upon her role as that of therapist. The nurse is insecure in the presence of certain volunteers who she feels might have influence in the hospital; but she accepts the volunteer as a necessary friend to the patient and as someone who makes a unique contribution to both the hospital and the patient.

The volunteer feels most accepted by the staff members of the occupational therapy department where most volunteers spend the greatest amount of their time. The occupational therapist puts the need for the volunteer and the unique contribution she makes to the hospital and to the patient above any competition she may feel for the volunteer's social status, her creative ability, or her constant presence in the department. The occupational therapist also defines the role of the volunteer in terms of a satisfying experience for the volunteer, as well as for the patient.

The volunteer has fewer contacts with the social workers than with any of the other staff members in the hospital and feels least accepted by them. The reluctance to utilize volunteers on the part of the social workers is due to the
insecurity they feel in their own profession and the fact that the volunteer competes with them directly in both social work practices and in establishing therapeutic relationships with patients. Where the volunteer is utilized, careful screening and supervision are advocated.

The institutionalized patterns of the attendant's role break down completely at the Psychot because of the high status and learning opportunities tendered him. This reflects on his relationship with volunteers insofar as he considers himself superior to the volunteer in training and experience, although he recognizes the higher social status of the volunteer. However, he feels no competition with the volunteer in the relationship with the patient and both recognizes and accepts her as an economic necessity and as a unique contributor to patient rehabilitation.

The strains between the staff roles and the volunteer role occur, first, when staff members are reluctant to accept hospital goals for volunteers; second, when the pattern of expectations which staff members have for the volunteer role differs from the pattern which the volunteer has for her own role; third, when the volunteer assumes or disregards those role functions which staff members look upon as central to their own roles; and, fourth, when staff members observe the volunteer role in non-occupational terms, e.g., as women rather than as nurses or occupational therapists.
CHAPTER VIII

THE MARGINAL ROLE OF THE VOLUNTEER

In Chapter IV the volunteer saw her role at the Psycho, among other things, as contributing to the therapy of the patients. She was told by the hospital when she first came that she was on the hospital "psychiatric" or "therapeutic" team, along with doctors, nurses, social workers, occupational therapists, and attendants, all of whom would work together toward the common goal of helping patients achieve enough psychological and sociological efficiency to enable them to resume their former roles in the community. In the definition of her own role and in the definition which the regular staff personnel and the patients gave to her role, she was able to feel that she was helping to make patients well. In this respect she was a "therapist," in a sense similar to the other staff members. In other words, she was performing a professional function in the hospital: she was helping to "cure" sick people. Whether or not she looked upon this function of her role as merely supplementary to that of the doctor, she had unmistakably entered the undisputed domain of the doctor's institutionalized role:

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a therapist-patient relationship formed for the purpose of making the patient well.

But merely to be a member of a team with others who are professionals, even when the same goal is sought, does not make a volunteer a doctor or a nurse or an occupational therapist. As a professional the person must act in a certain way; he is expected to act in this way. The professional adopts group norms which are completely those of professionalization.

The role of the professional is institutionalized both within and without the subsystem. His status in the total system is a status based chiefly on his specific function in the subgroup. It is an achieved status in the subsystem and an ascribed status in the larger system. To be a professional means to have an achieved status in the subsystem through indoctrination in a graduate school and some recognition of technical competence from this school such as a degree or legal license or both; and to be a professional means to have an ascribed status in the larger system based on the status which has been achieved in the subsystem. Because the role of the professional is institutionalized in both groups, his actions are predictable and he is thus not a problem to the society.

On the other hand, the volunteer is not a professional.
The function of volunteering is to intend or not to intend to act in a system. The non-professional group norms of the volunteer are to be found not in the subsystem where the professional norms lie, but in the total system.

The chief status of the volunteer lies in the total system. This status is based not on any specific function which the volunteer must perform in the subgroup, but rather on his status in the larger system. This status is ascribed to him in the subgroup by a status which is either ascribed or achieved within the larger system. He cannot achieve the role of the volunteer within the subgroup because technical competency is not a part of the role requisite.

The role of the volunteer is thus peripheral or marginal to the professional roles in the subsystem. Furthermore, because the role of the volunteer is not institutionalized in the subsystem, the volunteer's actions will be less predictable, and he may become a problem to the subgroup.

But although the volunteer is not institutionally expected to be a professional, he may nevertheless perform a professional function in the technical organization. At this point the element of voluntariness drops out; it does not matter too much whether the person is voluntary or not. He may now be considered from the point of view of being marginal to the professional roles in the technical organization.
to which he has volunteered. In this study this concept has been called marginal professionalization.

The psycho presents an opportunity to view a situation in which the non-professional volunteer performs some of the professional functions in the organization. The volunteer at this hospital is not required to have any technical training whatsoever when she enters the hospital; furthermore, no training is provided to her such as is given to the attendant who may also enter the hospital without any previous training.

In the present chapter the professional function which will be surveyed is that of therapy. This has been selected because the therapeutic function has always been attributed to the doctor as his central function, and it is around this function that his role is institutionalized. The doctor also represents a profession which enjoys the highest prestige both among the other staff members in the hospital and with other professions in the outside community. The focus in this chapter will be on the kind of relationship which both doctor and volunteer have with the patient and the extent to which this therapeutic relationship reflects on their relationships with each other. In this respect the present chapter is a continuation of the volunteer-doctor role relationships which was discussed in Chapter VII.
A. Friendship Therapy

The relationship which the volunteer has for the patient is central to her role image. This was brought out in the volunteer's definition of her role in Chapter IV. The volunteer sees her relationship to the patient in particularistic terms: "All that I am and all that any volunteer should be is simply a friend." The same role image is indicated by the other staff members in the hospital with varying degrees of stress (see Chapter VII). The patients, both the very sick ones and those well on their way to recovery also look upon the volunteer in the light of this friendship. This was presented in the chapter on the volunteer's performance of her role (Chapter VI). The term which has been adopted in mental hospitals because of this central role function of the volunteer is "friendship therapy."

1. The volunteer as therapist. The volunteer thus relates herself to the patient as a friend. Her success or failure in the mental hospital depends mainly on her being able to establish this relationship of friendship with patients. As in any friendship relationship, each volunteer interprets and carries out this friendship function in her own individual way: one may be a close friend, a good friend, a casual acquaintance, or just plain friendly. Friendship is known to lead to stronger attachments.
The central problem of the volunteer as a therapist is revealed when one asks two questions: First, does friendship in and of itself make patients well, i.e., is friendship therapy? Secondly, does the volunteer offer something to the patient in friendship therapy that the doctor is not able to offer in psychotherapy, i.e., in his institutionalized role function? Both these questions will be considered in the following discussion.

In the first place, the fact that the administration tells volunteers that they help in the therapy of patients indicates that friendship plays at least a part in the patient's recovery, since the ability to offer friendship is the one skill which all volunteers are asked to provide as volunteers. Partly because of the emphasis by the hospital that volunteers help make patients well and partly because volunteers come to feel this for themselves as they relate more and more with patients, most volunteers soon come to see themselves as therapists in the friendship function in varying degrees. The contribution which they feel that they provide in their friendship relationship ranges all the way from a very small amount to a point where it is equivalent to that of the staff people.
Those volunteers who feel that they contribute very little to patient therapy are those who have not changed their role image of the doctor. The new student volunteer says, "It shows more when a doctor treats the patient. The doctor can cure the patient without the aid of a volunteer, but a volunteer can't cure the patient without the aid of a doctor." Another volunteer who had come to the hospital on a doctor's recommendation says, "The doctors are the most important here. There just wouldn't be any psychiatric care without them. They contribute the most in making the patient well." The coffee shop volunteer who is the wife of a doctor in the hospital says, "We don't do anything about a patient taking cash from the register except refer it to the therapist because we feel that it requires a great deal more professional insight than we have." But most of the volunteers feel that theirs is a genuine contribution to therapy:

Volunteer: It is a different role that the volunteer has from the doctor, but still it is trying to help the patient get well. I think they're both needed.

Volunteer: Training is important but I wouldn't say only trained people can do the most; I think it takes a great deal of insight and sensitivity to the patients themselves.

Volunteer: I feel that I can get a patient well just by keeping him occupied at times; it takes his mind off his troubles. It's just as much the volunteer's work and the occupational therapist's work to make patients well as the doctor's and the nurse's.
Volunteer: I feel that I'm doing as much as the paid workers in getting a patient well in the rehabilitation program. I can get a patient out of the hospital quicker. I've seen a patient sitting out in the lobby trying to get up courage to go out the door, and I'll take him by the hand and take him out and buy him a tie or something and help him get going.

The staff also views the volunteer's contribution as a friend and as a necessary part of making the patient well:

Nurse: Volunteers contribute to making a patient well. It doesn't take very much to make a relationship with a patient if you have got anything on the ball — just put a smile on your face and be friendly. Patients respond to you if you're just walking through the wards. It's amazing how just a little thing like that will bring a response from patients.

Nurse: I think a volunteer plays a great part in making a patient well. Mrs. S has certain patients, puts herself out every time she's in here to say hello to them, and they look forward to it. It makes patients feel that they're wanted.

Social worker: So many patients are isolated in their social relationships and their need for friends is great. It is nice to be reached out to once in a while. A volunteer can contribute to a relationship with a patient.

Attendant: I think a volunteer helps a lot in making a patient well. I think she's more useful talking to patients rather than making beds. They go out of their way to help a patient.

Even the doctor recognizes the friendship function of the volunteer as something unique which he cannot provide himself: "It's a unique contribution when they can contribute a social experience for patients who are neglected and out of practice." "The great value of these volunteers is because of these natural things and the fact that they are seen by the patients as just people."
Finally, the patient himself emphasizes more than any of the staff the need for this friendship:

Patient: Some of these volunteers get right in your heart. Because they feel right in with you. They don't look down on you. A patient likes to have a volunteer interested in them, to be their friend. After we talk to volunteers we get a lot off our chests. It makes us feel good.

The stress by both volunteers and staff members, however, is that the friendship which the volunteer offers is a particular kind of friendship which the staff cannot provide because it comes from outside the hospital:

Volunteer: I don't think that the volunteer's contribution is anywhere as near as great as the professional worker's, but it is necessary. Every professional team needs the non-professional because it's something that they can't supply, and the fact that it's non-professional makes it of value.

Volunteer: I think that trained people can get patients on the way to being better, but I think it is very beneficial for a patient to talk to someone who doesn't know what the matter is and discuss other things rather than their problems.

Attendant: If I were a patient I'd be happy to have an outsider come in. Patients put a different evaluation on a person who is a staff member and a volunteer.

Nurse: There are many patients who shy away from the uniform, and a volunteer comes in from the street and the patient feels that he can knock elbows with the volunteer and tell her things they wouldn't tell the doctors.

The volunteer who was a patient herself tells why she turned to the volunteer instead of the doctor when she was ill in the hospital.
Volunteer: If you're there when you're needed, you can do something the doctor can't do. You can be with them. Of course the doctor would be the one to help them, but the person that they instinctively trust and will go to isn't always the doctor. I felt that Miss K could help me more than my doctor. I turned to her. There was something about her that I felt could be of more help to me. No money can repay the things that someone can do when they're needed. There has to be a feeling of empathy.

In summary, it may be observed that friendship plays a significant enough part in the volunteer's role that it is recognized as not only essential in creating a social relationship with patients but as unique in that it is offered by someone who comes from the outside community and is extended to people who have in most instances felt its lack in their own lives. Where friendship is not accepted by the patient, it is usually because the volunteer shows uneasiness with patients or because the patient's illness leads him to suspect everyone with ulterior motives. For example, one patient said about volunteers in general that she liked them but that it depended on who it was that was trying to be friendly. "If a person is too friendly, there is something abnormal about it."

A partial answer may thus be provided to the question, is friendship therapy? Because a person who is in the mental hospital as a patient is often there because of having been rejected by the society and has failed to receive the support he needs from others, the friendship which he receives from
someone in the hospital may provide this support and very often does. This is one reason that patients who come to the Psycho express unhappiness at the thought of having to leave it: all their friends are in the hospital. Because at the Psycho the friendship role is also that of the staff other than the volunteer and the students, patients may feel this group support as coming mainly from nurses or occupational therapists or doctors or attendants. This is as true of the social worker who is assigned to the patient and is referred to as "my social worker" as it is to the doctor who is referred to as "my doctor." The pattern which applies to the volunteer-patient relationship carries over to the entire mental hospital situation, and universalistic elements appear for all the staff-patient relationships in the friendship function. The mental patient needs friendship for his therapy as much as he needs medicine or authority; in some instances it may be friendship alone that is needed. The staff member must add friendship to his role requisites even if this means a breakdown in his institutionalized role.

Nevertheless, when a volunteer enters to become the patient's friend, the support that a patient feels comes from someone who is not paid to be friendly, and this support that the patient feels is thus likely to be greater. Also, because the volunteer represents the normal community to which the patient may return, the friendship which the
patient feels for the volunteer may be even greater than that which he may feel for the staff member. This is evidenced by the frequent remarks of patients that they wish there were more volunteers. If volunteers can provide this link with the community for the patient which makes the patient feel that he belongs in that community more than he belongs in a mental hospital, the volunteer may have been instrumental in motivating the patient to make the return to the community. If individual drive is a factor in mental patient therapy, the volunteer provides something for that therapy in her symbolic role of representing the community: "Inasmuch as nobody knows what helps these patients, I don't think you know if you're doing the right thing," says the doctor. The volunteer adds, "It's hard to say what makes a patient well except his own drive to get well, and I might be the one that could make him well," and "It's up to the patient if you do anything for that patient. The patient can get as much as he wants to out of it," and "I might possibly be one of the missing links that makes a patient get well." It is the nature of mental illness that thus assigns to the volunteer the possibility that it might be she and not another person who will help the patient the most.

On the other hand, friendship cannot be said to be therapy in and of itself when a patient's illness is such that none can reach him. The sickest patients who are in
this stage of their illness when they first enter the mental hospital often respond to none, and it is for these patients that the doctor provides insulin and shock therapy. Friendship can be offered only after the patient reaches a point where he recognizes social reality. Thus, in respect to this consideration, the therapy of friendship which a volunteer can offer is only a part of the complete rehabilitation of the patient, and it is for this reason that most of the volunteers, along with the staff, can say that they have a part in the therapy and that volunteers help to make a patient well. It is one thing to administer the medicine and another to engage in friendship conversation. Thus, in the case where drugs or other physical treatment are considered necessary, the doctor may carry out the first part of the therapy; what he does in psychotherapy and what the volunteer does in friendship therapy follow:

Attendant: I think that all relationships do help in making the patient well. Take a patient who is really out of contact; can't even find the doctor. You can't get to him in psychotherapy, but shock and insulin forces him on the highways and when he has contact with that highway, then you can take him and lead him; Volunteers help by listening to patients' problems and the very intimate details of their lives.

But treatment for the mentally ill has no definite pattern, and this tends to confuse the issue: identical treatment for all patients is not possible in the majority of cases. The friendship which the patient receives may be offered simultaneously while the patient is receiving
the drug or shock treatment, so that it is not possible to consider a volunteer’s relationship with a patient only after all the medication has been taken. When a patient says to a volunteer (and this was indicated more than once by volunteers), "I didn’t think I’d get well if it weren’t for you," the patient is referring only to that part of the therapy of which she was conscious of being a social being relating to another social being and which might have occurred at any time after the patient entered the hospital.

Consequently, it is not the drugs that the doctor administers which stand in direct competition with the friendship therapy that the volunteer offers. The competition between the doctor and the volunteer lies in the kind of relationship which each has with the patient. For the doctor this is called psychotherapy. These two types of therapy — psychotherapy and friendship therapy — will be discussed at a later point in the chapter.

2. Strains in friendship therapy. In her friendship function the volunteer undergoes certain strains which are brought about by the nature of mental illness and the attachments which develop between volunteers and patients.

(a) The nature of mental illness. With certain types of mental illness or in certain stages of the illness, it is possible that the patient may form a friendship with a
volunteer for the sole purpose of attempting to manipulate her:

Social worker: The volunteer gets manipulated. A manic-depressive patient and the kind of problems he has makes him want to be like that. He calls the volunteer and says, "Would you do this and would you do that?" That's the kind of thing that the volunteer is ripe for. Everybody agrees that the manic-depressive should be sent out to a custodial hospital because this is a permissive place with plenty of eager people around. A volunteer can get hurt in a place like this. I know of a patient who was a manipulator; the volunteer and the patient had a terrible fight, and the volunteer wasn't protected as I was.

Doctor: There was one time when a volunteer got involved with a hostile and manipulative patient, and she was really going to bat for him. Patients manipulate volunteers, but volunteers feel that this is the way of doing things for patients.

Attendant: When patients tell things to volunteers instead of to their doctors, they may be trying to manipulate the volunteers.

At times the volunteer herself can sense that she is being manipulated. In this respect she sees the patient less as a sick person and more as someone she might meet anywhere outside the hospital. One volunteer says, "If you give them too much, you get side-tracked." One student volunteer relates how she was very much aware of the patient's intentions:

One fellow used to latch on to me every few days or so, and I don't know if he used to give this same line to everyone. But I heard that they really didn't know just how sick he might be. After that I had sort of a jaundiced eye to everything he said to me because I didn't know whether he was really pulling my leg or something.
(b) Attachments between volunteers and patients.

(1) Male-female attachments: The friendship which forms among young people, both students and non-students, may also present a problem to the volunteer and to the hospital. With the young students the number of males is occasionally proportional to the number of females; at times there are more volunteers of one sex, usually female, present at a time in the hospital than the other. Often the young patients form stronger attachments with the young volunteers (or vice versa) than is felt to be necessary or therapeutic by the personnel who observe them. The student volunteers may thus sometimes find themselves in a situation where their relationship with the patients has gone beyond the point of friendship, and they may find themselves becoming deeply "involved" with patients. The student volunteer thus places his original objective in coming to the hospital to be useful in whatever capacity the hospital wants him to be second to his attachment to the patient. This is not only a source of strain for staff personnel in the hospital, but it is the situation which brings about the strongest criticism from the staff:

Occupational therapist: I find that most students want to get something comparing their textbook knowledge—learning but also in giving to the patients in the process. There are some that get overly involved, and we have to point out what they're doing with the patient. This takes skill because they think they're doing big things for the patient. Sticky relationships must be handled by workers who handle the patients in the department, talked about, and treated on a mature level.
Nurse: This winter we had two girls from some school who wanted to come over and work as volunteers; they were graduate health nurses. They got real involved with patients; they thought it was a good place to get chummy with male patients.

Doctor: A psychology student got involved with female patients and then dropped them. It was a burden to these patients, especially a suicidal one. The volunteer's reaction to this particular patient was that he had to get helped by her—something that she could say to him would make him feel better. This is a great danger in contacts of very deprived people. This fellow also wanted to know if he should see this patient outside the hospital; he really wasn't aware of his real needs to make a date.

The student volunteer who does not get any orientation concerning the dangers of strong attachments is thus likely to find herself (or himself) involved in a relationship from which it is difficult to be released. For this reason all staff people who point out these dangers suggest in the next breath that student volunteers should be advised of these dangers beforehand in some kind of orientation program.

Doctor: I think the training could be more adequate toward helping them to realize how much involved they might get before they start. This is a danger point and it might be threatening.

Social worker: What bothers me is that I have seen students go way over their heads. Some of us knew how hard it is to control them. I would like to have volunteers under the aura of a profession.

Doctor: Volunteers should know the types of patients and how one may get involved, what things are common pitfalls and what to look out for, then discuss the actualities that come up. The best thing is the group.

One social worker who herself could see danger in a close volunteer-patient relationship, points out the opposite
view shared by some of the hospital personnel and the administra-

There were patients under deep therapy with doctors, and the students were getting chummy with patients and were leaving. There were so many free diagnoses being handed out. But others have thought that this chance relationship with volunteers might be good for patients.

The point which is made by such staff personnel who do not disapprove of any strong attachments which might develop between volunteer and patient is that patients might very well form such strong attachments outside the hospital as well as inside it; and if such an attachment happens inside the hospital, at least it can be observed and handled by those personnel who are most concerned with it before the patient leaves the hospital.

(2) Female-female attachments. Strong attachments between volunteers and patients are not restricted to the younger volunteers, however, although it is to the younger ones that the male-female problems are usually attributed. The older volunteers also establish intense relationships with patients. Patients becoming attached to some volunteers "to the point of telephoning when they get out," as one volunteer indicates, "I seem to get involved with the neurotics most." But the same volunteer does not encourage such relationships to continue beyond this initial point:
Volunteer: Mrs. D will get much more involved than I; she takes patients down town and out; she gets more involved with the families of the patients; she gets emotionally involved. She'll have them out for Thanksgiving dinner. I don't think that's particularly therapeutic, and I think it puts patients under a great deal of strain because their backgrounds might be different. She gets interested in certain people; she'll have pets. If you're too friendly with one patient, it's apt to bring up some resentment and jealousy with other patients. You have to be very tactful.

That over-friendly attachments may be dysfunctional to the patient is also pointed out by another volunteer:

Mrs. K gives an awful lot to patients; but she makes pets and other patients resent it in the ward. It does a lot more harm than good. If you carry that too far, they begin to follow you at home, and patients shouldn't be too demanding.

In summary, the strain which comes from the relationship which volunteer and patient have for each other lies in the degree of friendship between the two. Beyond a certain point the relationship becomes particularistic and is not considered to be a therapeutic one by most of the staff personnel. In other words, it is not friendship therapy when a volunteer becomes overly involved with a patient; instead it is considered dysfunctional for the patient and prevents him from forming friendships with other people in what is considered as a mere "normal" relationship of friendship.

B. Psychotherapy and the Role of the Psychiatrist

As has been previously noted briefly in Chapter II,
psychotherapy is a relationship between the patient and the doctor, or therapist. During the time that the relationship persists, the therapist attempts to achieve certain objectives. The patient undergoes certain changes in his own self-image and in his concept of reality. Specifically, the therapist attempts to bring to the patient's consciousness the repressed feelings which may be the source of his conflict. As the patient releases his tense, repressed emotions, catharsis takes place in the process, and he "talks out" his problems with the therapist. Eventually, the patient is expected to receive "insight" into his problems, i.e., he comes to understand his conflicts and makes the effort to solve his problems himself. Somewhere along the way he re-enters the "real" world and again observes the social and non-social objects of his life according to the accepted norms of the society.

One aspect of the psychotherapeutic relationship between the patient and the therapist is called "transference," in which the patient views and acts toward his therapist as someone occupying a familiar role to him. Counter-transference occurs when the therapist acts back toward the patient in this familiar role. The goal of psychotherapy is considered reached when, in the opinion of the therapist, the patient is considered capable of being able to cope with his surroundings and is once more able to resume activity in
the community without being either a menace or a burden to himself or to others.

Psychotherapy in its adapted form involves certain steps in a relationship between therapist and patient taking place in a controlled situation. Merely talking out problems is not psychotherapy: there must be an attempt on the part of the therapist to bring to the patient's or client's consciousness the repressed feelings which may be the source of his trouble, to bring about a complete catharsis, to receive insight, and to move along to the patient's solution of his own problems. In its adapted form such as that presented by Carl Rogers and others, psychotherapy does not include the steps of transference and counter-transference. The patient may never come to see his therapist as someone having a role familiar to him. However, the steps of transference are not felt to be necessary in order to get the client to resolve his own problem. It is here that the psychiatrist may claim that the success or failure of the therapeutic session rests and that the greatest amount of skill is required on the therapist's part. The therapist must be able to control any turn which the psychotherapeutic session may take.

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The practice of psychotherapy is no longer the undisputed domain of the psychiatrist as it was at the time it was first accepted as a psychoanalytic technique. It may also be one of the functions of a practicing psychologist, and it is with the psychologist that the psychiatrist feels his keenest competition for the psychotherapeutic relationship. "Psychologists haven't found their place yet and the psychologists are trying to do therapy; they take the shorter course," says one of the doctors at the Psycho. This feeling for the psychologists is transferred to the young student volunteers who are psychology students, especially those who intend to pursue their work in psychology after graduation from college:

Doctor: The young student volunteers think all their psychology training means something and it doesn't mean a damn thing. The psychiatrists are criticized for not knowing what to do, but even if you have read all the works of Freud, you still aren't able to handle everything. The psychology students are very hostile to hospital doctors and they have all dressed up in fancy terms what they want to do; and some of them get all emotionally involved in what they're supposed to do. Some of them come in with the look of a licensed physician.

But psychotherapy is also a function, usually in its adapted form, of an increasingly growing number of other professional people such as the marriage counselor, the school guidance counselor, the minister, some of whom may even accept fees for their services. But because psychotherapy is central to his role and distinguishes him from other specialists in the medical field, the psychiatrist guards his exclusive
possession to it. It is his chief source of strain as a psychiatrist and basic to the relationship which he has with the volunteer.

6. Friendship Therapy Versus Psychotherapy

The doctor's exclusive right to the psychotherapeutic relationship sets the doctor in direct competition with everyone on the staff at the Psycho; not merely the volunteer:

Volunteer: The doctors don't like you to do it; That's their golden sphere; They've got to be essential somewhere in the business! I heard a doctor call up Mac and bawl him out for bringing about a cure.

The volunteer, even though she may be present in the hospital for only a few hours each week, is able to spend all this time with patients, whereas other staff personnel may be tied down to routine matters and meetings which command their attention before they can turn to the patients; Because of this advantage over other personnel, the volunteer presents a direct threat to the doctor who sees the patient for only one or two hours a week in psychotherapy.

The doctor admits readily that because of this advantage of time that the volunteer possesses, the patient will talk about his troubles to the volunteer and even discuss problems which may never reach his own ears in the private sessions conducted with that patient. "I'd respect it as a valid observation that a patient will tell a volunteer
things he won’t tell the doctors.” Volunteers, staff, and even patients, however, will give different reasons why the patient will tell some things to the volunteer and not to the doctor:

Volunteer: The volunteer doesn’t know, as far as the patient is concerned, anything about psychiatry; that’s why the patient will talk to a volunteer rather than to her doctor. It’s the same reason that anyone will tell a cab driver all his problems. But when it comes to going to someone for help in problems, he’ll go to a doctor.

Volunteer: Patients are very often afraid of talking to their doctor and are afraid they might be told to stay here in the hospital longer. They’re afraid to verbalize to their doctor. To the patient it doesn’t make much sense to spend the whole hour with the doctor talking about cigarettes, but they’ll tell me about how much they miss their mother. Eventually these things might come out in therapy, but they will tell me many things that they won’t tell the doctor. They’ll give me letters to mail. One girl was writing letters that she was going to kill the governor. So when I see their doctors, I’ll tell them what the patients have told me. The patients are willing to talk about it more afterwards to the doctor if he already knows about it.

Attendant: Patients don’t feel it’s right to tell their doctors their troubles because they’re afraid they’ll communicate with other people, and they don’t want to have their troubles told. They undoubtedly don’t want people to know about them. They might realize they’re telling a volunteer intimate things, but they don’t think the volunteer will do anything about it. But they’ll clam up when they realize we’re making reports on them.

Patient: I can get more in talking to Mac for a few minutes than I do for a half hour with my doctor.

Patient: People who go into the field of human relations who are paid don’t give you the help you need. You go to a psychiatrist and talk things over up to a certain point, but after that you have to have someone with more experience help you.
Patient: When I first talked to my psychiatrist here I thought he was just testing my mind, and I didn’t feel like telling him my problems.

Patient: The day that people around this hospital start getting well is the day they say, "I’m sick," and they start talking to people about their illnesses. They would just as soon talk to volunteers about their problems. They feel like talking.

These quotations may be summed up by saying that patients do not always understand what the psychotherapeutic session means and what is to be accomplished. They are thus reluctant to talk to the doctor either because they are afraid they might have to remain in the hospital or because they find it easier to talk to people who will not do anything about their illness.\(^1\) Their role image of the doctor is such that they rely on him for physical treatment or someone to call on when things are not going well; but when it comes to making conversation, they would prefer to talk to other people about their problems:

Attendant: Just spending an hour with the doctor is psychotherapy; the patients recognize this as psychotherapy; but this is not having someone say hello to you. They recognize psychotherapy as being something formal, but it might be anyone who helps them with their problems.

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1. In this connection it is also interesting to note that people are sometimes more willing to talk to strangers about their problems than they are to their own families. This thought is expressed by the first volunteer quoted on p. 259, who refers to the cab driver. The same idea is to be found in Kurt H. Wolff, The Sociology of Georg Simmel, The Free Press, Glencoe, 1950, pp. 402–403: The stranger "often receives the most surprising openness - confidences which sometimes have the character of a confessional and which would be more carefully withheld from a more closely related person." See p. 404.
Thus, not only the factor of time but also the patient's practice of confiding intimate details of his life to volunteers rather than to doctors is a source of strain to the doctor in the hospital. He recognizes it as competition, but he stresses that it is the kind of competition which can only lead to harm for a patient:

Doctor: I think there is competition; it varies with the patients, but I think that there is. In my opinion it seems to come from the volunteer's being involved. There are points where they get into trouble and make it harder for patients and also for themselves. Volunteers also make it clear from their actions that they feel the competition. There's an example of a volunteer who persisted in visiting a patient even after the doctor told him that it wasn't the best thing for the patient. He also was making dynamic demands on the patients. It occurs more with the younger ones than the older ones.

Doctor: Patients aren't quite sure what the process is and that's why they don't talk to doctors. I think there's a lot of competition for patients as to who the doctor is and who isn't.

Doctor: What a patient tells the doctor depends on his perception of his relationship with the doctor. It is the nature of the difference that is significant. The volunteer is fulfilling a role which can't be fulfilled by the doctor. But whether there is competition; the patient may seize on this and build it up; but there's another factor - that the patient is deprived; he is not going to reject the favor of his doctor. You just don't know what's missing. A lot of patients do have preconceived notions as to what is going to be talked about. So they leave things out, and the doctor may not really know what is going on in the ward. The material that is gathered from other sources can be used, but to confront the patient with it is to leave other areas open.

The nurse and the social worker likewise see the therapeutic session as something that belongs to the doctor:
Nurse: Lots of times patients will tell other people some things that they won't tell their doctors, but just listening to somebody's problems is not being a therapist. If people are going to work intensively with patients, they need direction.

Social worker: If a doctor is having intensive therapy with a patient and the volunteer is coming to see the patient two or three times a week - this may be disastrous.

Finally, the volunteer herself may also see that she is competing with the doctor: "It's not just up to the nurses and the doctors; if they can do it, I can, too." "If there were more volunteers on the wards, they might be a threat. That's why it's hammered in us to supplement but not to supplant the paid workers." The volunteer who feels the competition the most with the doctor, however, is the one who has spent many months at the hospital. The new volunteer may be surprised that "doctors didn't seem very doctorish when she first came, but this does not mean that he does not make the patients well.

The doctor who will not admit of actual competition emphasises that it is a different kind of relationship between doctor and patient and between volunteer and patient; that in the control which he is able to exert over the patient, he is able to keep the relationship going at the crucial moment; whereas the volunteer, in not being able to exercise this control when it is needed, loses what ground might have been gained, and thus the relationship is not a therapeutic one: It may even be dysfunctional for the patient:
Doctor: Psychotherapy is a caricature of a normal relationship. It is a normal process put in a controlled setting with a person. Control comes in with the doctor understanding his own emotional responses in the treatment situation—that's where the control comes in. This is very important. As a trained person, the therapist is able to keep the relationship going; the process is learning.

Doctor: It is a free relationship, but the problem is by itself artificial—sort of being a paid companion in a sense, and it varies from being a therapeutic relationship. The patient ultimately feels this. It is not therapeutic in a long-term relationship. The patient's feelings for this volunteer are not discussed. Nothing is done in transference. In other words, the patient expresses a feeling with the volunteer, and this feeling is not discussed.

Doctor: The doctor is there to help the patient; he's the doctor; the patient sees him. So what does a patient do— he tells his troubles to everyone else, but it doesn't get him anywhere. "I want to find out about you," says the doctor; and the patient goes to another person; he likes the other person better. It is another part of the problem of the volunteer's resisting the relationship. A patient will tell a volunteer, "I'm going to commit suicide." This may happen ultimately—I doubt it—but this is the kind of thing the patient will tell a volunteer because of the nature of the relationship. The volunteer might be alarmed by this; this puts the volunteer on the spot. She feels committed to this patient; she feels she is the only one that can help him; she's resentful of the doctor and becomes more and more involved. That's why I see this as something to tell the doctors. This sudden being on the spot can be very threatening and can succeed. There should always be an open door to communication.

Doctor: The thing that takes training is the talking about problems; it takes training to deal with the relationship once it establishes. Relatively speaking, I think volunteers establish very deep feelings with patients.

The doctor points out further that the value of his professional training goes beyond being able to control this relationship in transference. This might be an argument against the nurse
therapist who says, "A volunteer might not understand transference but there's no reason that she can't learn to understand transference." "I am told I represent the mother figure by some of the doctors," says one volunteer who has been identified in this role by patients and who responds to them in this role. In his own words, the professional training which the doctor has also permits him to fill in gaps where the patient has either intentionally or unintentionally omitted things:

Doctor: The young resident might be offended that the patient isn't confiding in him and that he can't get the data from the patients. As a psychiatrist you have to watch the interviews more closely to see what the gaps should be; what is not mentioned is very important; after all, what is the training for? By virtue of the profession a psychiatrist can see the image and see what the information is. We do too little of it here; the nurses resent it; there is this cleavage. But there should not be this cleavage, and getting the person to understand himself is not a question of tabulating all the data which has been said.

The doctor is asserting his professional prerogative as the person who is the ultimate authority in curing the patient. It is not a matter of competition but the kind of relationship which makes the difference. The volunteer exercises a two-way relationship with the patient, but the psychiatrist doesn't tell about his own problems. The same doctor thus does not see that the relationship in friendship therapy is therapeutic, because the two-way relationship allows the volunteer to become involved with the patient.
But it is also pointed out that all the training in the world is worthless if the psychiatrist cannot establish this relationship with the patient:

Nurse therapist: If the volunteers know what they're doing and if they have some understanding of therapy, i.e., establish a good relationship with someone, they can have a therapeutic relationship. Anybody can establish a good relationship — the patient chooses you; the patient makes you what he wants to; you are what the patient sees you in his psychotic state. If the doctor can't reach the patient and the volunteer can, why not have someone supervise this relationship instead of cutting it off? I don't say that psychiatric training is unimportant, but all the training in the world is worthless if you can't establish this relationship. I had one patient who never saw me as a head nurse, and it wasn't until she got well that she knew I had been the head nurse.

The question may now be asked, does the volunteer offer something to the patient in friendship therapy that the doctor is not able to offer in psychotherapy? There is the doctor who would answer in the affirmative when he admits that psychotherapy does not always turn the trick for the patient:

Doctor: Actual psychotherapy is something that should be done with a trained person; but if the volunteer is talking with a patient, it is part of human relationships and learning from each other. Learning for the patient doesn't take place exclusively with the doctor. Talking over problems is essential for every human being, and the degree to which that is done and the things which are talked about and the level of intimacy is something that varies. With the doctor the talking has to become very intimate to become worthwhile.

Doctor: So much depends on the needs of the patient; some patients just aren't prepared to work with a psychiatrist. A few weeks ago I referred a patient to a pastor. I did it because I realized the patient was going to quit. It's a situation that is dictated to
the needs of the patient. It's in the area of team
effort. Any schizophrenic should benefit with psycho-
therapy, and then the nursing personnel would be able
to give the patient some sort of security. Psycho-
therapy would be impractical in such a situation.

Doctor: Psychotherapy is not the entire answer by any
means. It has to be limited in a hospital study to the
acute psychoses.

The needs for the particular patient may point in the volun-
teer's direction rather than the doctor's; on the other hand,
these needs may point in more than one direction at a time.

Nurse therapist: The psychotic needs someone around
all the time to share experiences and talk about dif-
ferent things with him. It's not too much use for him
to go through a group situation on the ward and not
see the doctor until three or four hours later. You
can't get him on a verbal level then; you need to get
to him now while he's still experiencing it and share
it with him. The psychotic wants to know you have a
personal interest in him. You have to be a feeling
person, a theoretical knowledge that becomes so much
a part of you that it operates with you.

Thus, the doctor who admits that psychotherapy can be im-
practical in certain situations is suggesting that it might
be the volunteer who might provide the therapy for some
patients where he cannot. He is expressing a willingness
to have someone else assume the function which is central
to his own role — making a patient well:

Doctor: Psychiatry isn't threatened by everyone doing
psychotherapy. We're only too glad to get all the
sources tapped. Most psychiatrists realize that they
can't dominate the field. Somehow we're only too
happy to force people into the volunteer role.

Doctor: After all, it's absurd that the doctor can
feel threatened because there are so many patients
and so few doctors.
Two additional things happen when the doctor professes that the volunteer is performing his central role function. One is that he is making the volunteer role less marginal to his own. At the same time, he is accepting the goals of the hospital. He is thus defining the volunteer role in terms of therapy. The volunteer, along with the other team members, thus contributes to the breakdown of the professional norms of the doctor within the hospital subsystem. But since the patient's rehabilitation is central to the entire team effort, the doctor has no alternative but to step aside. The volunteer thus also contributes to the marginality of the doctor in his own profession:

Doctor: Ideally, every human contact in the mental hospital should be a therapeutic one, giving the patient experience, a satisfying emotional relationship with every human being - doctor, volunteer, carpenter, or electrician.

Nurse: All this is helping a patient get well; it isn't just being a therapist. It's the interaction of all this that cures the patient, the total impact of the situation. The volunteer does have a part in the hospital and makes a contribution in getting the patients well.

Volunteer: I'm one of the small parts that make up the big important thing. The big important thing is the attitude of all of us in what we're going to do to make the patients well. I'm just one of the parts that come into it.

D. Summary

The relationship which the volunteer has to the doctor is based on the doctor's central role function of therapy.
The volunteer relates to the patient as a friend in "friendship therapy," but this particularistic relationship becomes universalistic in effect because in the mental hospital all staff members, as well as volunteers, are expected to relate to patients in the friendship function. But the doctor is reluctant to admit that the relationship of friendship between volunteer and patient is necessarily a therapeutic one. However, inasmuch as the doctor himself will admit that no one knows what makes a patient well, it is possible that the support tendered the patient by the volunteer may provide the incentive for the patient to get well, and in this respect friendship is therapy.

The strain for the doctor occurs not only because the institutionalized patterns of his own role behavior are broken down in the mental hospital (see preceding chapter), but also because the volunteer is sometimes able to establish a relationship with the patient in friendship therapy which he cannot do in psychotherapy; consequently, the patient may be more willing to discuss his problems with a volunteer than a doctor. The doctor views the relationship between volunteer and patient as dysfunctional for the patient because the volunteer is unable to control it at the crucial moment as he is able to do in psychotherapy.

On the other hand, the doctor, particularly the older resident, also admits that psychotherapy is impractical in
certain situations and recognizes the therapeutic function of the volunteer. The volunteer may be able to offer the support to the patient which he cannot do. The volunteer who is able to do this is assuming the central function of the institutionalized role of the doctor - making the patient well. The role of the volunteer thus becomes less marginal to that of the doctor; at the same time, the doctor must change his own role expectations, and the volunteer thus contributes to the marginality of the doctor in his own profession.
CHAPTER IX
THE INSTITUTIONALIZATION OF THE VOLUNTEER ROLE:
SUMMARY AND CONCLUSIONS

The reliance placed on volunteers in any society presents in itself a problem of sociological significance in that the volunteer temporarily assumes a role other than that which is usually ascribed to him by the society. The problem of the volunteer is also significant when the volunteer joins a task group to perform functions which are similar or supplementary to those who are paid for their services. Finally, the sociological problem of the volunteer can be observed in terms of the non-professional volunteer who joins the professional task group and assumes in part or in whole the functions of the professional role.

The first problem raised in the present study is, to what extent can the non-professional volunteer supplement the professional roles within the technical organization without creating a situation of strain? Or, can a person who is institutionally not expected to be a professional perform a professional function in the technical organization?
The second problem raised is, what is the relationship between the marginal person's role in the organization, or subsystem of the society, with his role outside the subsystem in the total society?

The first problem is that of marginal professionalization. The volunteer stands on the periphery of the social organization. In the present study the volunteer, or marginal person is defined in terms of his position both in the group where his chief source of status lies and whose norms he has fully adopted (i.e., the group in which he is in the center) and in the subgroup to which he is identifying himself and whose norms he has not fully adopted (i.e., the group to which he is peripheral or marginal). The extent to which he adopts the group norms of this subgroup determines his marginality to the group. The important consideration is that his chief source of status does not lie within this subsystem but elsewhere in the social system.

The problem of marginal professionalization does not occur only when the marginal person is a volunteer. A person is always marginal to the professional role when he assumes the task functions of the professional role but does not adopt the group norms of that role. At this point the voluntariness drops out: it does not matter whether or not the person is a volunteer. A case in point is the reserve army or navy officer.
The problem of marginal professionalization points to the second major problem investigated in this study, the institutionalization of the marginal role in both the subsystem of the society and in the total society, or the extent to which the marginal role is accepted by both the person who is in that role activity and by the rest of the society. A person who is marginal to the subsystem does have an institutionalized role in the total society. The relationship between the person's role in the total system to his marginal role in the organizational subsystem constitutes a duplicate problem of institutionalization.

The scope of the study was guided by three general propositions:

1. That a close relationship exists between a person's role in the total society and his marginal role in a subsystem of the society.

   a) A person may be in an institutionalized role either within the subsystem or outside it; he may be in an institutionalized role neither within the subsystem nor outside it; finally, he may be in an institutionalized role in both the subsystem and outside it.

   b) What happens to institutionalization outside the subsystem may have some effect on institutionalization inside; and, vice versa, what happens to institutionalization inside the subsystem may have some effect on institutionalization outside.
(2) that in the process of becoming institutionalized, the marginal role affects the institutionalization of the other roles in the subsystem.

(3) where a marginal person must perform a function which is similar to that of the task group and deals with human relationships, the strains can be minimized only insofar as the members of the task group re-define their roles within the organizational subsystem.

The role of the volunteer in the mental hospital was selected as the data for the research. In the mental hospital the non-professional, non-trained, non-paid volunteer is utilized within the hospital social system to perform functions similar to those of the professional staff members and to work toward the same common goals of the hospital organization.

The approach to this study was sociological within the framework of the theory of action. All action was viewed as behavior belonging to a system of communication. Within such a framework the central concept used was that of role. All aspects of human behavior relevant to the study such as the group, culture, personality, role, status, etc., were defined in terms of the sending and receiving of messages. The social group was defined as a system of communication in which action is viewed in terms of the individuals who send and receive the messages, the content of these messages, and the channels through which these messages are sent.
The empirical setting for the study was the Boston Psychopathic Hospital, a small mental hospital located in the city of Boston, which combines diagnosis, treatment, teaching, and research activities relating to the first care of the acutely mentally ill. Like other hospitals, both mental and general, it lacks the economic resources necessary to carry out its functions in a manner consistent with its goals and relies on volunteers to help relieve the financial and personnel pressures. In addition to the use of treatments such as somatic therapy and psychotherapy, the hospital employs a third method of treatment known as "milieu" therapy: the hospital atmosphere is made as permissive as possible and the entire social system of the hospital becomes a "therapeutic community" in which reliance is placed on all possible social interaction between the patient and the group. The hospital goals for the utilization of volunteers provide for the participation of the volunteer in milieu therapy on an "equal" basis with the other staff members of the hospital, both professional and non-professional. The volunteer is viewed as contributing to the therapy of the patient in that she brings the community into the hospital as the patient left it and as the patient will return to it. In this respect the volunteer's function of therapy is unique in that none of the paid members of the hospital can provide it. The hospital administration defines the volunteer's role in terms of
offering friendship and confidence to patients: beyond this point the volunteer is expected to seek her own orientation and to define her own role. The permissive character of therapy is thus observed to show a relationship to the permissive formal organization and to the flexible position of the volunteer role. But the use of a permissive approach rather than one based on authoritarian lines creates a functional clash between hospital and volunteer, since the administration favors an unstructured volunteer program with no definite job specifications and no rules and regulations for volunteers. For the hospital there is the further functional strain of no criteria of volunteer selection, and for the volunteer feelings of technical inadequacy and the limitations in matters of time spent at the hospital.

On first entering the mental hospital the volunteer has no clear image of her role, and role expectations are defined mainly in terms of the institutionalized volunteer role in the general hospital. These expectations change after the volunteer has accepted the hospital goals and acquires changing attitudes about mental illness. In the performance of her role the volunteer relates with the patient both inside the hospital and outside it in varying patterns of activity such as in skills and recreations, conversation, and patient follow-up. She also acts as emissary to the
hospital in that she communicates with the community outside
the hospital about what she sees and does in the hospital.
The volunteer now views her role as friend to the patient
and as someone who helps in therapy. She also sees the
symbolic nature of her role and consequently its uniqueness:
to the patient she represents the community to which he will
someday return. The role of the volunteer is thus extended
beyond the organizational social system into the larger
system of the community.

Because no organized volunteer group exists at the
Psycho, there is little contact between volunteers who are
not members of the ladies' auxiliary, and the problems
which arise between volunteers concern those who are also
members of the hospital auxiliary.

The volunteer's relationships with the other staff
members of the therapy team vary with the different roles
and are dependent mainly on the effect of the hospital
goals on both the volunteer and staff roles, any similari-
ties in task functions between the volunteer role and the
staff roles, and the definition which the staff roles give
to the volunteer role. The economic need for the volunteer
is recognized by all staff personnel as is also the volun-
teer’s symbolic significance of representing the community
and linking the community to the hospital and patients.
The strains which appear specifically between the volunteer
role and each staff role occur, first, when staff members are reluctant to accept hospital goals for volunteers; second, when the pattern of expectations which staff members have for the volunteer role differs from the pattern which the volunteer has for her own role; third, when the volunteer assumes or disregards these role functions which staff members look upon as central to their own roles; and, fourth, when staff members observe the volunteer role in non-occupational terms, e.g., as women rather than as nurses.

In addition, the pattern of expectations characterized by disinterest, functional specificity, affective neutrality, universalism, and performance-oriented achievement which constitute the staff roles in their relationship to the patient is in direct opposition to the pattern of expectations constituting the volunteer role in her relationship to the patient.

The volunteer has the most contacts with and feels most strongly accepted by the occupational therapist, the nurse, and the non-professional attendant. She has the fewest contacts and feels least accepted by the psychiatrist and social worker whose central task functions in medicine and social work are in direct competition with the volunteer who relates to the patient both inside and outside the hospital. The hospital goals reflect most strongly on the
relationship between the volunteer and the doctor. Not only are institutionalized role patterns of the doctor broken down at the Psycho, but the volunteer assumes the function of therapy which is central to the doctor's professional role. The volunteer relates to the patient as a friend in "friendship therapy," although the particularistic relationship becomes universalistic in effect because in the mental hospital all staff members, as well as volunteers, are expected to relate to patients in the friendship function. Not only does this become a source of strain to the staff members, but an additional strain is created for the doctor, particularly the new resident, because the relationship which the volunteer has with the patient in friendship therapy stands in direct competition with the formal approach which the doctor must use with the patient in psychotherapy. The doctor views the relationship between patient and volunteer as dysfunctional for the patient when the volunteer becomes "involved" with the patient or carries the relationship outside the hospital.

But the older resident also admits that psychotherapy is impractical in certain situations and that the volunteer may be able to offer the support to the patient which he cannot do. The volunteer who is able to do this is thus assuming the central role function of the doctor — making the patient well. The volunteer who is institutionally
not expected to be a professional is nevertheless performing a professional function in the technical organization. As more and more doctors accept the volunteer role in its therapeutic aspect, the volunteer role becomes less marginal to their own role. At the same time, because the doctor must change his own role expectations to include the volunteer as therapist, the volunteer is contributing to the breakdown of the institutionalized role of the doctor within the mental hospital subsystem and thence outside it. The volunteer thus also contributes to the marginality of the doctor in his own profession. When the social worker also begins to accept the volunteer's relationship with the patient in terms of her own central role functions, the role of the social worker, which is itself still in the process of becoming institutionalized, can be expected to undergo further changes in role definition.

The volunteer in the mental hospital thus presents a striking example of role emergence and role differentiation, not only because it is subject to a wide degree of flexibility according to existing hospital needs and varying volunteer and staff interpretation, but also because the volunteer performs her role in the capacity of "herself" in her relationships with both patients and staff and deals with the entire gamut of human behavior rather than with specific duties. The strain of role conflict is thus
eliminated for the volunteer who acts as "herself" but not for the staff member. The constant changes in role expectations by both volunteers and staff members emphasize the point that role is dynamic and constantly being defined.

The role of the volunteer in the mental hospital is not institutionalized as are the roles of the other staff members in the hospital. But the person who acts as a volunteer in the mental hospital does have an institutionalized role in the community where her chief source of status lies. The question may now be answered as to why the person is volunteering and why the institutionalized role is not sufficiently rewarding to keep the volunteer entirely in that role activity.

The person who volunteers to work with patients in a mental hospital, as distinguished from the person who joins the hospital auxiliary, does so not for reasons of family or social pressure or bereavement, as does the volunteer in a general hospital, but mainly for personal reasons such as to secure therapy for herself or from curiosity or insecurity because of mental illness in her family. The status of the person who volunteers in the mental hospital is threatened in the community because of the stigma attached to mental
illness. Altruism and the desire to raise one's social status become considerations only after the volunteer has entered the mental hospital.

There is thus a close relationship between the person's role in the total system and his marginal role in the organizational subsystem. A person volunteers in a mental hospital because her status is threatened in the community. She is thus not in the center of her own institutional system in the community because she does not have the security of her own group behind her. As a volunteer in the mental hospital she may re-structure herself by accepting her role within the framework of the hospital goals and make a valuable contribution to patient rehabilitation; or she may be a complete failure as a volunteer and create a strain for the hospital. This illustrates that what happens to institutionalization outside the subsystem may have some effect on institutionalization inside. The volunteer role can become institutionalized in the subsystem only insofar as the volunteer makes herself functionally necessary to the organization.

On the other hand, as the volunteer role becomes institutionalized in the mental hospital and more and more volunteers perform that aspect of their role which joins the community to the hospital, i.e., when attitudes about mental illness change and people begin to accept mental illness as an illness and not as a stigma, the role of the volunteer
also becomes institutionalized in the community. This illustrates that what happens to institutionalization inside the subsystem may have some effect on institutionalization outside.

The question may now be answered as to why we have volunteers or marginal people in our society. On first examination the volunteer may seem to solve the problem of the need for vast numbers of people to relieve personnel and financial difficulties. But the volunteer in the mental hospital is not used as a scrubwoman; one can hire enough scrubwomen to do the job. In a word, the volunteer cannot be explained merely in terms of supply and demand.

Because the volunteer's chief source of status lies in the community, the volunteer is able to alleviate one of the problems or limitations of specialization by weakening the ethnocentrism of the task group in the subsystem. In a social situation such as is presented in the mental hospital, it is desirable that the task group not be ethnocentric or separated from the community outside the hospital. The volunteer serves as a communication link between the subsystem and the total system. The function of the marginal person in a technically specialized organization is to weaken the ethnocentrism of the task group.
A parallel situation may be cited in the case of the volunteer in the army or the person who is drafted from civilian life to serve for a certain period of time. The draftee is a peripheral person, and he is in the army for economic reasons of supply and demand: there are simply not enough career people relative to the demand for masses of troops. But there is another reason for the utilization of the army draftee just as there is for the volunteer in the mental hospital. Even in a military technology where it would be possible to have all career people employed, there is still a social reason why it is better to have some civilians in the army. The civilian is able to weaken the separatedness of the task group and consequently eliminate the danger of having all career soldiers whose status in the community depended entirely on their membership in the task group. In this respect both the volunteer in the mental hospital and the volunteer or draftee in the army serve to illustrate why the marginal person is functionally necessary to the technical organization.

There is yet another reason why the volunteer in the mental hospital is functionally necessary to the technical organization. The volunteer operates in a task group where human problems are dealt with - human beings, not things. In dealing with the vast range of human behavior, whether it be the mentally ill person or the mentally well person, the
volunteer, whose chief source of status lies outside the hospital, provides something to the organization which the regular staff members of the organization cannot do. Also, because it is human beings that are dealt with and not things, the role of the volunteer in the mental hospital cannot be explicitly defined. When the task performance deals with such things as specific duties which do not involve a human relationship, the role can be more definitely defined and the strains will be fewer. Where the marginal person must perform a function which is similar to that of the task group and deals with human relationships, the strains can be minimized only insofar as the task group accepts the marginal role and the members of the task group redefine their own roles within the organizational subsystem, thus contributing to the institutionalization of the marginal role.

The above conclusions and generalizations logically follow from the evidence gathered for this research. The present study has been limited to a general and exploratory presentation of a role which is not only new in the society, but one which has significance both for the development of sociological theory and for the practical solution of a serious social problem. A more detailed investigation of the volunteer role in the mental hospital would lead to further generalizations in such sociological and psycho-
sociological areas as small group theory, patterns of communication relative to the marginal role, attitudinal behavior, organizational structure and role, status characteristics of marginal people, acceptance-rejection patterns of role behavior in relation to personality, permissive-authoritarian role conflicts, and therapeutic aspects of interaction processes.

The method used in gathering the data has indicated many facets of the volunteer role which would not have been as easily revealed by using another type of methodological approach. The particular frame of reference used in the study, which has explained all social behavior in terms of a system of communication, has made it possible to draw generalizations concerning the behavior of all marginal roles in the society according to their position in the social communication system.

The present study also points to the need for comparative studies of the volunteer role in the mental hospital. Such factors as size, location, and goals of the hospital, available economic resources, hospital social structure, attitudinal differences, and status characteristics of mental patients are variables which bear directly on the volunteer role, all of which have implications for both theoretical and practical considerations.
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THE ROLE OF THE VOLUNTEER IN THE MENTAL HOSPITAL

Abstract of a Dissertation

Submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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The sociological aspects of the role of the volunteer deal with the marginal person who joins an organization in which professionally trained people are also employed. The immediate problem raised is, to what extent can the non-professional volunteer supplement the professional roles within the organization without creating a situation of strain? Or, can a person who is institutionally not expected to be a professional perform a professional function in the technical organization? This is the problem of marginal professionalization: the volunteer stands on the periphery of the social organization because he has not fully adopted the norms of the professional task group.

The second major problem investigated in the present study is, what is the relationship between the marginal person's role in the organization with his role outside the organization in the community? This is the problem of the institutionalization of the marginal role in both the sub-system of the society and in the total society, or the extent to which the marginal role is accepted by both the person who is in that role activity and by the rest of the society.

The reliance placed on volunteers in our society makes a study of the volunteer not only sociologically significant because it deals with the marginal person, but such a study has several practical implications as well. The utilization
of volunteers to relieve financial and personnel pressures at a period in history when the amount of leisure time available to people is on the increase points to a great potential source of labor for all organizations whose economic resources are inadequate to carry on their functions with paid personnel alone. When the organization happens to be a mental hospital, a study of the volunteer assumes further significance because it touches upon one of the serious social problems of the day.

A total of forty-nine volunteers and staff members of the Boston Psychopathic Hospital were interviewed intensively, while approximately twenty patients were interviewed in groups; and these interviews were analyzed for their sociological relevance to the problems at hand. The conceptual schema used in this study is the theory of action, within which framework behavior is viewed as belonging to a system of communication. All aspects of human behavior are defined in terms of the sending and receiving of messages. The central concept is that of role.

At the Boston Psychopathic Hospital volunteers are utilized to enable the hospital to carry out its functions in a manner consistent with its goals. In an atmosphere which is made as permissive as possible for both personnel and patients, the volunteer is considered on an "equal" basis on the therapy team with all other staff members,
and her role is defined in terms of offering friendship and confidence to patients; beyond this point the volunteer is expected to seek her own orientation and define her own role.

On first entering the mental hospital, the volunteer's expectations of her role are defined in terms of the volunteer role in the general hospital, but these expectations change after the volunteer has accepted the hospital goals and acquires changing attitudes about mental illness. In the performance of her role the volunteer relates with the patient both inside the hospital and outside it in varying patterns of activity, including skills and recreation, conversation, and patient follow-up. In this respect she offers a satisfying experience to both the very sick patients and those who are about to be discharged. She also acts as emissary for the hospital in that she communicates with people outside the hospital about what she sees and does as a volunteer. The volunteer now perceives her role as friend and therapist to the patient. She also sees the symbolic nature of her role and consequently its uniqueness to the patient she represents the community to which he will someday return. The role of the volunteer is thus extended beyond the hospital social system into the larger system of the community.

Because no organized volunteer group exists at this particular hospital, there is little contact between volunteers
who are not members of the ladies' auxiliary; and the problems which arise between volunteers concern those who are also members of the auxiliary.

The volunteer's relationships with the other staff members of the therapy team vary with the different roles and are dependent mainly on the effect of the hospital goals on both the volunteer and staff roles, any similarities in task functions between the volunteer role and the staff roles, and the definition which the staff roles give to the volunteer role. The economic need for the volunteer is recognized by all staff personnel as is also the social experience which the volunteer provides for patients because she has the time to spend with them. The strains which appear specifically between the volunteer role and each staff role occur, first, when staff members are reluctant to accept hospital goals for volunteers; second, when the pattern of expectations which staff members have for the volunteer role differs from the pattern of expectations which the volunteer has for her own role; third, when the volunteer assumes or disregards those functions which the staff members look upon as central to their own roles; and, fourth, when staff members observe the volunteer role in non-occupational terms, e.g., as women rather than as nurses.

The volunteer has the most contacts with and feels
most strongly accepted by the occupational therapist, the nurse, and the non-professional attendant, all of whom do not look upon their central role function as therapists. She has the fewest contacts and feels least accepted by the doctor and social worker whose central role functions in psychotherapy and social work are in direct competition with the friendship function which the volunteer performs with the patient both inside and outside the hospital. The relationship between patient and volunteer is viewed as dysfunctional for the patient when the volunteer becomes affectively "involved" with the patient or carries the relationship beyond the hospital.

The significance of the volunteer's marginal role is most clearly shown in her relationship with the doctor. The older resident who admits that psychotherapy is impractical in certain situations and that the volunteer may be able to offer the support to the patient in "friendship therapy" which he cannot do in psychotherapy is also admitting that the volunteer is assuming his central role function of making the patient well and is performing a professional functional in the hospital organization. At the same time, because the doctor must change his own role expectations to include the volunteer as therapist, the volunteer is contributing to the breakdown of the institutionalized role of the doctor and thus to the marginality of the doctor within
his own medical profession.

The volunteer in the mental hospital presents a striking example of role emergence and role differentiation, not only because it is a new role and subject to a wide degree of flexibility according to existing hospital needs and varying volunteer and staff interpretation, but also because the volunteer performs her role as "herself" in her relationships with both patients and staff members and deals with the entire gamut of human behavior rather than with specific duties. The strain of role conflict is thus eliminated for the volunteer but not for the staff member. The constant changes in role expectations by both volunteers and staff members emphasize the point that role is dynamic and constantly being defined.

The role of the volunteer in the mental hospital is not institutionalized as are the roles of the other staff members. But the person who acts as a volunteer does have an institutionalized role in the community where her chief source of status lies. She volunteers to work with mental patients not for reasons of family or social pressure or because she is altruistically motivated, but mainly for personal reasons such as to secure therapy for herself or from curiosity or insecurity because of mental illness in her family. Her status is threatened in the community because of the stigma attached to mental illness. She is
not in the center of her own institutional system in the community because she does not have the security of her own group behind her. But as a volunteer she may re-structure herself in the hospital and make a valuable contribution to patient rehabilitation. There is thus a close relationship between the person's role in the total system and his marginal role in the organizational subsystem. What happens to institutionalization outside the subsystem may have some effect on institutionalization inside.

On the other hand, as the volunteer role becomes accepted in the mental hospital and more and more volunteers perform that aspect of their role which joins the community to the hospital, i.e., when attitudes about mental illness change, the role of the volunteer also becomes accepted in the community. This illustrates that what happens to institutionalization inside the subsystem may have some effect on institutionalization outside.

An explanation is now offered as to why we have volunteers or marginal people in our society. In a word, the volunteer cannot be explained merely in terms of supply and demand. Because the volunteer's chief source of status lies in the community, the volunteer is able to alleviate one of the limitations of specialisation by weakening the ethnocentrism of the taskgroup in the organization. In a social situation such as is presented in the mental hospital,
it is desirable that the task group not be separated from the community outside the hospital.

There is yet another reason why the volunteer in the mental hospital is functionally necessary to the technical organization. The volunteer operates in a task group where human problems are dealt with, not things. Again because the volunteer's chief source of status lies outside the hospital, the volunteer provides something to the organization which the regular staff members cannot do. Also, because it is human beings that are dealt with and not things, the role of the volunteer in the mental hospital cannot be explicitly defined. When the task performance deals with such things as specific duties which do not involve a human relationship, the role can be more definitely defined and the strains will be fewer. Where the marginal person must perform a function which is similar to that of the task group and deals with human relationships, the strains can be minimized only insofar as the members of the task group accept the marginal role and re-define their own roles within the organization.
AUTOBIOGRAPHICAL NOTE

The first years of my life were spent in Nashua, New Hampshire, where I was born on January 24, 1919, the second of three children of Michael and Mary Rentounis. The family moved to Salem, Massachusetts, when I was three years of age, and I have resided in Salem ever since.

My entire public school education was received in Salem and was continued after high school at the State Teachers College in Salem, where I majored in business education and received the degree of B.S. in Ed. in 1941. Following graduation, I taught at Appleton Academy in New Ipswich, New Hampshire, followed by Stetson High School in Randolph, Massachusetts. During the latter position I entered the U. S. Naval Reserve and served as a commissioned officer for three years before being discharged in 1946. The following year I resumed teaching at Weylister Junior College in Milford, Connecticut, then at Cazenovia Junior College in Cazenovia, New York.

I began graduate study at Boston University in 1949 and received the Ed.M. degree in 1950 and the A.M. degree in 1951.