NEW ROLES FOR VOLUNTEERS IN ACTION-RESEARCH SETTINGS

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Volunteers fulfill important service functions in a variety of community agencies but have rarely been utilized as research interviewers. Paid interviewers are generally preferred even when money is short.

Our experience in a rehabilitation hospital in using 17 volunteers as research interviewers suggests that such non-traditional use of volunteers can constitute a valuable resource. These volunteers successfully administered 825 patient interviews thus providing valuable data which otherwise could not have been collected.

We will examine the conditions favorable to the use of volunteer interviewers and the characteristics of the more successful volunteers.

The Burke Rehabilitation Center in White Plains, N.Y., is a 150 bed hospital for physical rehabilitation and convalescent patients. In January, 1966 the Center, with the support of the Public Health Service, launched an exploratory study into "Community Influences on the Patient Care Process."[1] With a limited budget, the Center's sociologist assembled a small staff for a new socio-medical research program.

One project aim was to obtain data on the social characteristics of the patients. With Medicare due to start in six months, we wanted urgently to collect baseline data on admissions before that event. Since Center staff were not available for interviewing patients, volunteers were our only hope. Fortunately, a strong volunteer program was responsible for operating many hospital services. With some misgivings, we established the Patient Interview Project in which volunteers would assume responsibility for interviewing all admissions, about 18 per week, for at least 5 months.

RECRUITMENT AND TRAINING

Fifteen women fitting our job description were recruited by the Chairman of Volunteers and others. The training was tightly organized and the importance of objectivity was emphasized. Those who felt uncomfortable were encouraged to withdraw. Accordingly, 4 of the 15 women did not return after the first session. Within two weeks, 11 trainees had completed an 8 hour training program of 3 sessions. These included

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discussions, demonstrations, written materials, role playing, and practice interviews.

Our first goal was to interview every admission from February through June of 1966. Ten of the eleven original interviewers completed the first 5 month period and then volunteered to continue through the summer. To meet contingencies we trained 4 more volunteers in May and 2 more in October. Thus reinforced, the group agreed to complete a full year.

The 17 women who stayed with the project for at least two months can be described as middle and upper middle class suburban women. Half were college graduates. Five had retired from long careers. Most were in their 40's and 50's. All were married, except for one widow and 3 single ladies. Thirteen had children—mostly of school age and older. All functioned as homemakers. Three-quarters of the group had been volunteers for at least 5 years and over half had given prior service to Burke.

The most difficult aspect of the training was the inculcation of basic principles of friendly neutrality, of standardizing questions, and of probing appropriately. Initial resistance to our early emphasis on neutrality and objectivity was partially counteracted by emphasizing friendly interest and personal rapport. Many trainees, however, continued to feel cross-pressured. While they desired to master this new, sometimes discomfitting skill and to accept the standards set for them, they also empathized with patients, and were frequently frustrated by their inability to help them.

The problem tended to be resolved in three ways: (1) the staff built in several procedures by which volunteers could help patients; (2) several volunteers integrated their research role with the more familiar helping role, with little conflict; and (3) for the substantial number who experienced role conflict, the staff moderated its expectations.

MAINTAINING MORALE

The volunteers displayed a generally high level of motivation and morale. This was confirmed by their answers to a questionnaire at the end of the project. Certain aspects of our approach appear to have contributed to the team's morale.

Our approach to volunteers can be described as respectful, appreciative and professional. (1) We tried to respect the needs and motives of the volunteers to help patients as well as to do research. (2) We made it clear to the volunteers that we were grateful for the contribution they were making to the success of our new research program. (3) We expected a great deal from our volunteers and set professional standards. We expected them to utilize our supervision constructively, maintain strict confidentiality, and deal professionally with patients and staff.

We anticipated the volunteers' need to serve a helping function by defining the interview as an important part of the hospital's welcoming process. The interviewers also derived satisfaction from knowing that the questionnaires were placed in the patient's chart for staff use. Finally, the interviewer was given an opportunity to suggest that a patient with a problem be referred for help. Some interviewers, however, were disappointed that immediate help was not always forthcoming. If the interviewers' desire to help patients was only partially met by the interview process, how was morale sustained? The answer apparently lies in the individual supervision and group support provided.

Each interviewer was closely supervised on an individual basis. Team spirit was fostered by three meetings which served (1) to keep the interviewers informed of the progress of data analysis; (2) to give them opportunity to exchange views about improving the questionnaire and (3) to obtain their suggestions for improving patient care.

VOLUNTEERS VIEW THEIR EXPERIENCE

Sixteen volunteers assessed their experience by means of a special questionnaire. They consistently rated their experience a good one. They described it as interesting, out-of-the-ordinary, informative, worthwhile, meaningful, and helpful. With one mild demurrer, the group felt the project fit their needs well.

The women emphasized satisfactions from helping and being in contact with patients. Fifteen cited these as their greatest satisfactions. Most felt that the interviews had been of immediate help to the patient aside from their research value.

One interviewer summed up the general sentiment succinctly:

> For many of the patients the interview is the only touch with the outside world. Many felt that they could tell us their troubles, hopes, etc., and they did. These people felt that the professional staff were too busy for such trivial talk. They were made happier by the visit of the interviewers.

Yet the interview was not helpful enough to satisfy most of the group. Just over half reported their greatest frustration was in feeling constrained by impersonal aspects of the research role or in not being able to help patients more. Difficulties cited most often among a list were "finding time to give to the project" and "giving the project priority over other commitments." About a third found it somewhat difficult to be in contact with so many chronically ill and disabled patients.

Typical was the following comment:

> I had never seen chronically ill and disabled persons before and I found it depressing. I felt that sometimes I was able

> to bring them a little cheer but underneath and afterward I felt sad and depressed to think of the poor outlook of so many of these persons . . .

Four-fifths of the group reported one or more difficulties. We believe that more ladies would have dropped out if it weren't for their capacity to respond to the professional way in which they were treated, and to handle their frustrations accordingly.

The volunteers were generally challenged by the high standards and professional climate sustained by staff. Most surmounted frustrations by deriving immediate gratifications, not only from the feeling that the interview itself helped, but also from the process of personal growth.

One woman, who responded to supervision to improve her early interviews, said:

> I find working with and under the supervision of serious minded people tends to make me more serious about the job I am doing—this, in turn, tends to make me do a better job than I ordinarily might do and if I think I'm doing a good job, I am self-rewarded . . .

Most of the volunteers rated professional aspects of the project, such as supervision of their work and participation in research as at least fairly important gratifications. Another aspect of personal growth cited by most was the development of greater insight into the problems of older, sick and disabled persons. Nearly half saw implications for their own lives.

One lady spoke for at least half the group stating that:

> This was an infinitely more professionally-oriented kind of experience than any other volunteer job I've ever done. I felt that the professional staff set good standards for us, trained us adequately, and had respect for us as volunteers. I really felt that I was part of a team and that what I did was important to the overall project. There was none of the "Lady Bountiful" aspect to this project.

VALUE OF VOLUNTEER INTERVIEWERS

From our point of view, profits from the volunteer project clearly outweighed losses. Of 935 patients interviewed, volunteers interviewed 82%. Staff interviewed the rest. The data suffer somewhat from the lack of sophisticated probing for complete, clear and relevant answers. While these data would not meet standards for an experimental test of specific hypotheses, the data was very adequate for our exploratory purposes.

Our volunteers were at least as dependable over a long period of time as

paid interviewers would have been. Nine women stayed with the project to the very end. The average duration for all 17 women was 7.7 months. They contributed an average of 46 interviews per person.

Several dividends were unexpected. Cheating was not a problem as it can be with paid interviewers. Then, at the end of the project, a group of our ladies helped conduct 100 special pre-discharge interviews. Another dividend was the assignment of vocational workshop trainees to our program as coders and statistical clerks.

Using volunteers provided invaluable pre-Medicare baseline data which could not have otherwise been collected. The $2500 it would have cost was not available. A more fundamental value was the impetus the project provided for establishing the research program as a continuing unit. Data collected by the volunteers was utilized in preparing two grant applications, one of which was funded.

The institution also benefitted. The presence of volunteer interviewers provided a free welcoming service for patients. Their non-judgemental posture may have served to reinforce the professional ideals of treatment. One effect of our project remains—a face sheet routinely used by social service. We believe that the efforts of the Director of Volunteers to expand the areas in which modern "special volunteers" can make a meaningful contribution has been enhanced.

FACTORS CONDUCIVE TO SUCCESS

The need to obtain research data before financing can be arranged is the basic circumstance calling for volunteer interviewers. Other necessary conditions include one or more staff persons available for supervision, a reservoir of volunteers, and a cooperative administration.

Other circumstances can help insure success. The availability of our secretary to interview when no volunteer was present was important. Screening can discourage volunteers ill-suited for interviewing. Team spirit and group loyalty can help sustain the morale of women with diverse interests.

Only 2 interviewers failed to make a significant contribution. While the quality of interviewing varied, it was not a major problem among those who stayed. A more practical measure of performance was dependability—how long did the volunteer stay with us and what was her monthly rate of interviews? By comparing the most dependable with the least dependable we can identify characteristics of volunteers which appear related to high performance.

While 16 volunteers is a small number on which to base conclusions, the differences between the high and low dependability groups seem to hang together consistently. The findings suggest the influence of three factors: availability of time, perseverance and organizational loyalty,

and the ability to gain satisfactions from an action-research role in spite of frustrations. These conclusions are supported by 3 sets of findings.

First, the women who delivered the most over the longest period of time were more likely than the less dependable group: to be over 55; to be single or widowed; to have no children under 14; to have retired rather recently; and to experience little difficulty in finding time for the project even though they were more likely to be volunteering elsewhere. In short, the more dependable women seemed more likely to have fewer homemaker responsibilities, and to be able to give what time they had more easily.

Second, the more dependable were more likely: to have had careers; to have volunteered at Burke before; to consider it important that their volunteering was credited to the civic organization they represented; and to have been part of the original group of 11 trainees. The more dependable group appeared more likely to have developed habits of perseverance and loyalty either in lifetime careers or in their organizational ties including those to Burke and to the project.

Third, the more dependable women were more likely: to mention that doing research was satisfying; to consider a research project at least as desirable as an action project; and to experience less difficulty handling the research role and less frustration over not being able to help patients more.

The more dependable group was also more likely to consider work with older patients at least as desirable as work with younger patients, even though they were more likely to report negative reactions to so many chronically ill and disabled patients. They were more likely to feel that helping patients was the most important thing they gained from the project. They were apparently better able to combine the satisfactions of helping with the satisfactions of research.

Strongly suggestive of this group's dual definition of their role as a helping researcher is the following: while the more dependable group was most likely to cite research as satisfying, they felt that the patients saw them not as a researcher but as a social worker or friendly visitor. In contrast, virtually all of the less dependable group, which preferred an action role to the frustrations of research, felt patients saw them as a researcher.

Our experience has, nevertheless, shown the value of forming a somewhat heterogeneous group. While they varied in background, in preferring research or action, and in their dependability and capability, all were interested in meaningful work, and almost all made a contribution. Busy, enthusiastic mothers with young children and talented women considering a return to school or work, are assets even though they may leave the project sooner.

SUMMARY

We have learned that volunteers can successfully complete a long term research mission in a sensitive action setting. Our experience indicates that selected volunteers can also serve as adequate coders. Community agencies with research or demonstration components can reap significant benefits from developing such innovative roles for modern volunteers.

Perhaps the greatest potential area for using volunteers in new action roles is that of meeting the social and emotional needs of patients and clients. Volunteers could assist overburdened social service staff and render crucial help to patients adjusting to institutionalization. Volunteers who bring the outside world into institutional life are especially helpful for the elderly, for those whose socio-economic resources are limited, and for those whose ties to community are tenuous.

The traditional role of friendly visitor can be broken down into several important functions which might better be served by specific new roles. These include admitting hostesses, supportive counseling aides, recreation aides, and information and referral aides. The need is for more volunteer specialists from all educational levels, whose sensitive interpersonal skills and specialized knowledge can be effectively utilized. These pre-professional roles for volunteers can be organized and supervised so as to select and prepare participants for possible return to professional training. Volunteers can help to develop models for new careers through participation in research and demonstration.

Such projects can attract volunteers to work with neglected groups like the chronically ill, institutionalized children, and the aged. Three of our volunteers were 65 and older themselves. The fact that all three were among the most dependable volunteers points up the potential of our untapped reservoir of healthy aging persons to make their experience count.

In summary, "Lady Bountiful" is fast disappearing. As the modern volunteer emerges into more meaningful activities, however, there remains a gap between the ideal of the responsible volunteer as member of the team and the resistance by staff and volunteer alike to breaking through the traditional barriers between them. To fill the gap we need to develop new creative roles in which more volunteers are trained, supervised, and trusted to do the specialized tasks which are vital for the continued humanizing of our bureaucratized institutions and agencies.