

https://dspace.org/

Volunteers As A Resource In Community Psychology

Brady, Lynette

2015-01-12
http://hdl.handle.net/10539/16417

Downloaded from a DSpace repository. https://dspace.org/

VOLUNTEERS AS A RESOURCE IN COMMUNITY PSYCHOLOGY

By Lynette Brady

A Dissertation presented to the Department of Psychology,
University of the Witwatersrand,
in partial fulfilment for the degree MA Clin Psych

I hereby declare that this dessertation is my unaided work and that I have given full acknowledgement to sources which I have used. Figures that appear in the text of this dissertation have been duly checked and are accurate.

ACKNOWLEDGEMENTS

I would like to thank the following people for the part they played in bringing this study to completion:

Mr Ian Shochet, my supervisor.
Prof Michael M. Saling, for his creativity, commitment and unflagging attention to detail in the final stages of the study.
Bo Lombard for his advice.
Mr Peter Fridjohn who assisted me so competently in the statistical analysis of the data.
Mr Vaughn Weber, for his permission to carry out the study in the 702 Crisis Centre, as well as for his understanding and support.
The volunteers at the 702 Crisis Centre who were implicated in the study, and without whose co-operation, it would not have been possible.
The M.R.C. for its grant towards the cost of this research.
Jessica Pistorius, whose interest and enthusiasm never waivered as typing this dissertation.
My family and friends for their support.
Greig.

TABLE OF CONTENTS

	PAGE
ABSTRACT	I
CHAPTER 1 : INTRODUCTION	3
CHAPTER 2 : HISTORY AND THEORETICAL PERSPECTIVES	6
A. The Evolution of Crisis Intervention	6
B. The History of the Development of the *Kid Crisis Centre*	10
a) The selection and training of the *volunteers*	12
b) The maintaining of morale within *the volunteer system*	15
CHAPTER 3 : RESEARCH DESIGN AND METHODOLOGY	16
A. The Crisis Intervention Model : Definitions and Assumptions of Relevance to the Research Design	16
B. Research Design and Methodology	20
a) The Hypotheses	20
b) The Design	20
c) Subjects	22
d) Research Instrument	22
e) Statistical Analysis of the Results	23
CHAPTER 4 : STATISTICAL ANALYSIS OF THE RESULTS	26
A. Introduction	26
B. The Results	29
C. Summary of the Findings	32
CHAPTER 5 : DISCUSSION OF THE RESULTS	37
A. Introduction	37
B. Discussion of the Results	40
a) Limitations of this Study	40
b) Recommendations : A Model of Motivational Strategies Designed to Reduce Burnout	41
C. Implications for Future Research and Recommendations	60

TABLE OF CONTENTS

	PAGE
ABSTRACT	1
CHAPTER 1 : INTRODUCTION	3
CHAPTER 2 : HISTORY AND THEORETICAL PERSPECTIVES	6
A. The Evolution of Crisis Intervention	6
B. The History of the Development of the 702 Crisis Centre	10
a) The selection and training of the volunteers	12
b) The maintaining of morale within the volunteer system	15
CHAPTER 3 : RESEARCH DESIGN AND METHODOLOGY	16
A. The Crisis Intervention Model : Definitions and Assumptions of Relevance to the Research Design	16
B. Research Design and Methodology	20
a) The Hypothesis	20
b) The Design	20
c) Subjects	22
d) Research Instrument	22
e) Statistical Analysis of the Results	23
CHAPTER 4 : STATISTICAL ANALYSIS OF THE RESULTS	26
A. Introduction	26
B. The Results	28
C. Summary of the Findings	32
CHAPTER 5 : DISCUSSION OF THE RESULTS	37
A. Introduction	37
B. Discussion of the Results	40
a) Limitations of this Study	40
b) Recommendations : A Model of Motivational Strategies Designed to Reduce Burnout	41
C. Implications for Future Research and Recommendations	60

APPENDIX ONE 65

NOTES 68

BIBLIOGRAPHY 74

APPENDIX ONE 65

NOTES 68

BIBLIOGRAPHY 74

ABSTRACT

The aim of the proposed study was to look into the issue of volunteers as a resource in community psychology.

Considerable concern has been expressed among mental health professionals working within a model of community psychology, at the high drop-out rate among volunteers. The reasons for their concern are not only fiscal, but in addition, the longevity of community mental health programmes are seriously jeopardised by the lack of continuity in the staff involved in the project.

Thus, the purpose of this study was to test a particular theoretical construct, which would enable the personnel of the crisis centre, via feedback, to possibly increase their understanding of the high drop-out rate among volunteers and to formulate counter measures. In addition, a model of motivational strategies was proposed, in order to develop a more comprehensive understanding of the phenomenon of burn-out.

The study was carried out in the 702 Crisis Centre in Hillbrow. The Procidano and Heller Social Support Scale, 1983, was utilised to test the hypothesis that a support system in the life of a volunteer improves the tenure of the volunteer within the community crisis centre as a counsellor.

The questionnaire was administered to 13 volunteers in the June 1985 training course and again to 13 volunteers in the April 1986 training course. The questionnaire was followed by a length of time which allowed the volunteers the opportunity to become more experienced and in turn to experience the demands made on them. A time period of six months was decided on. After this interval, the volunteers had self-divided retrospectively into two groups, namely on the one hand, counsellors in the experimental group (the "drop-out" volunteers) the other hand, those

counsellors in the control group (the "stayers").

The study was by its nature therefore predictive in that, on the basis of the information received from the questionnaire, various trends in social support from family and friends were examined in relation to the variable tenure, that is, Tenure = f (PSS Fa; PSS Fr).

The results of the nonparametic discriminant analysis indicated that the perceived social support from family and the perceived social support from friends were not significant in predicting drop-out rate. However, the matched pairs t-test indicated that the perceived social support from friends was statistically significant in relation to the perceived social support from family.

These results were interpreted and incorporated into a larger model of motivational strategies which would serve to slow down the process of burn-out.

CHAPTER 1 : INTRODUCTION

Considerable concern has been expressed among mental health professionals working within a model of community psychology, at the high drop-out rate among volunteers [1, 2, 3].

One of the greater advantages of the community mental health model is its economy, both fiscally and in terms of manpower. However, the high drop-out rate which is observed among volunteers, often serves to negate the advantage, causing concern among mental health professionals working within this model. A great deal of time and money is spent on the adequate training of volunteers in order that they may successfully fulfil their function as crisis counsellors.

In addition, the volunteers have a crucial responsibility within the community mental health model towards helping clients achieve the ideal of positive mental health and as such, given the lack of continuity and the high drop-out rate, may endanger the longevity of carefully developed community projects.

Universally, the most obvious questions concerning the management of a volunteer programme are those which receive most or all of the directors attention. Issues of recruitment, selection, training and scheduling of volunteers are so obviously important that most programmes have neglected to worry about maintenance strategies [4]. It is of great importance, not only to be prepared for such problems, but to have some idea of what causes them and how to alleviate them.

The aim of this study was to test a particular theoretical construct, namely whether or not the perceived social support from family and friends had any significant relationship to the counsellor's tenure at the centre.

It was envisaged that the purpose of this study would be two-fold. Firstly, it would have a theory building function in that the results of the study could be utilized as part of the development of a model proposing a number of strategies to prevent burn-out.

Secondly, it was envisaged that the results of this study would enable the director of the crisis centre, via feedback, to increase his understanding of the possible relationship which the theoretical construct has to the drop-out rate among the volunteers. It was envisaged that in the event of a significant relationship, strategies to increase perceived social support from friends and family would need to be developed, in order to help increase the tenure of volunteers of the centre.

The 26 volunteers were selected by the personnel of the crisis centre and are for the purposes of this study, a random population. The selection procedure consisted of answering a questionnaire and then attending a selection interview hosted by the three permanent staff members of the 702 Crisis Centre. The volunteers were all asked to complete the Procidano and Heller Social Support Scale 1983, in the initial week of the training course. They were then expected to self-divide, retrospectively, over a six month period of time into two groups, namely on the one hand counsellors in the experimental group (the "drop-out" volunteers), and on the other hand, those counsellors in the control group (the "stayers").

Thus, on the basis of the discrete variable, tenure, (that is "drop-out" versus "stayers"), a statistical analysis was utilized to underline the various trends in social support from family and friends, relating to the above mentioned variable. Additional information on the nature of the perceived social support from family and friends was gained through the calculation of the Fisher's exact probabilities test, and a

matched pairs t-test. Based on these findings, as well as a literature review on the phenomenon of burn-out, a theoretical model of motivational strategies was developed. The model was intended to serve as a theoretical framework of motivational strategies, from which to view the burn-out syndrome. Recommendations for the experimental testing of this model were also included.

CHAPTER 2 : HISTORY AND THEORETICAL PERSPECTIVES

A. THE EVOLUTION OF CRISIS INTERVENTION

Crisis intervention has adapted to constantly changing demands placed upon it by conditions in various communities.

During the 1950's and 1960's, ego psychologists such as Allport, Maslow and Erikson did much to lay the philosophical base for crisis theory [5, 6, 7]. They stressed the persons ability to learn and grow psychologically throughout life. Their views are based on the study of normal, rather than disturbed individuals. Decades earlier, Freud made pioneering contributions to the study of human behaviour and the treatment of emotional conflict. He laid the foundation for the view of people as complex beings capable of self-discovery and change. Through extensive case studies, he demonstrated the profound effect that early life experiences can have on our later development and happiness. He also found that people can resolve conflicts stemming from traumatic events of childhood and thereby live fuller, happier lives. His conclusions, however, are based largely on the study of disturbed, rather than normal individuals [8]. Psychoanalysis, the treatment method he developed from his theory, is costly, lengthly, available to few and not really applicable to the person in crisis. Certain psychoanalytic techniques, however, such as listening and "catharsis" - the expression of feelings around a traumatic event - are useful in all psychological helping processes, including brief psychotherapy and crisis intervention [9].

Much of what is practised in crisis centres today would seem alien to the early theorists in the field, as it is

the result of development that began with psychiatrists' experiences during World War II and has evolved through recent critical evaluations of long-term therapies [10, 11, 12]. During World War II (1939 - 1945), and the Korean War (1950 - 1953), members of the United States Army who were suffering the effects of post-traumatic stress disorder, were treated at the front lines, rather than being sent back home to psychiatric hospitals. Studies revealed that the majority of these men were able to return to combat duty rapidly, as a result of receiving help on the spot, that is, through crisis intervention [13, 14].

It was apparent from the afore mentioned studies that the soldier's knowledge that he had to return to combat, served to counter any regressive tendencies and prevented him from being labelled as a "psychiatric casualty" - a role which had much secondary gain. The factors outlined by Caldwell (1967) [15], such as locating treatment facilities advantageously, focussing on the immediate situational crisis and on an individual's feelings about what has happened to him, promotion of group support, social manipulation and a rapid return to combat duties in an effort to maintain self-confidence in his own ability to function, can all be applied to the treatment of patients in community based crisis centres. Thus, with minimum interference in a person's life routine, and with a commitment to keeping the person functioning in his own milieu, regression is undercut.

Erich Lindeman's (1944) [16] classical study of bereavement following the Coconut Grove fire in Boston, defined the grieving process people went through after the sudden death of a relative. His findings were later generalised and applied in working with anyone suffering a serious loss. For example, studies were done on the patterns of responses of people to, for example, a premature birth (Kaplan and

Mason, 1960) [17] *and the diagnosis of chronicity and* impending surgery (Janis, 1968) [18].

While studies such as Lindemann's (1944) deal with situations seldom encountered in either community or private psychiatric practice, they do provide a model for programmes of primary prevention based on the adaptive resolution of the crisis situation. Unfortunately, these models are not always appropriate for a crisis unit, where most of the treatment is of a secondary preventive nature.

Gerald Caplan (1961) [19] of the Harvard School of Public Health is another pioneer in the field of crisis intervention. He developed a theory of the person in crisis and emphasised a community-wide approach. Public education programmes and consultation with various caretakers such as teachers, police and public health nurses were found by him to be important ways in which to prevent the possibly destructive effects resulting from a *crisis.*

James Tyhurst (1957) [20] has helped mental health professionals understand people's rerponses to community crises such as natural disasters. During the 1940's and 1950's he studied transition states such as migration, parenthood and retirement. His work was thus focussed on the effects of social mobility and cultural change.

Another important historical influence on crisis intervention was the United States 1961 Report of the Joint Commission on Mental Illness and Health [21]. This report laid the foundation for the development of the community mental health movement in America. It documented through five years of study, the fact that the public was not getting the help it needed, when it needed it and where it needed it. The report revealed that (a) people in crisis

were tired of waiting lists, (b) professionals were becoming disillusioned with lengthly and expensive therapy that often did not help, (c) a significant proportion of people (42%) initially went to a physician or clergyman for any problem, (d) long years of training were not always necessary to learn how to help distressed people and (e) volunteers and community caretakers (for example, police, ministers and teachers) were a large untapped source for helping people in distress.

An important contribution to the development of crisis intervention as a method of helping people in mental health centres was made by Norris Hansell (1970) [22]. He refined many of the findings of Caplan (1961) and Tyhurst (1957), as well as other mental health studies into an entire system of response to the person's distress [15]. His work is especially important to volunteers in community mental health centres where many high risk groups of people come for help. Lastly, there is the important historical influence of the Suicide Prevention Movement. Richard MacGee (1974) [23] documented in detail the launching of the suicide prevention and crisis intervention movements in the United States.

An outcome of the increased knowledge on the patterns of response to life crises has been the attempt to develop a theoretical framework which would lead to a better understanding of the intrapsychic changes that correlate with the overt responses to a crisis [24, 25, 26]. A theory of acute emotional disorder, as noted by Kaplan and Mason (1960) [27], has been developed from understanding the so-called traumatic neuroses (Freud, 1925 [28]; Fenichel, 1945 [29]) and from an understanding of acute infectious diseases (Halliday, 1943) [30]. The course of such a disorder is thought to be limited usually to four to six weeks with a median of about four weeks (Jacobson, 1965) [31]. While not

denying that the underlying intrapsychic organisation may make some people more susceptible to disintegration (for example, through the early loss of a parent, one may have an increased vulnerability to the stress of the loss of a later love object), the crisis intervention model generally emphasises the extrapsychic realities which may in fact be overtaxing a well-balanced person. The emotional discord and unhappiness experienced by individuals at times of stress, such as for example divorce or separation, rather than being viewed as indicants of psychopathology, are viewed by the crisis clinician as responses that can be understood and treated if indicated, without referring to early psychogenetic experiences [32]. These situations can be seen in much the same perspective as Erikson's (1950) [33] concept of "developmental crisis as a time for growth". Thus, emphasis is placed on the recruitment of community and other social supports which may complement intrapsychic ego function at a time when the equilibrium between external reality factors and intrapsychic organisation is disturbed.

B. THE HISTORY OF THE DEVELOPMENT OF THE 702 CRISIS CENTRE

The crisis intervention movement has also been firmly established in the Republic of South Africa. All data for this study was obtained from the volunteers undergoing training at the 702 Crisis Centre in Hillbrow. It is therefore necessary to look briefly at the establishment and subsequent development of this specific centre, in order to contextualise the data presented in Chapter 4. Brief mention will also be made in relation to the selection and training of the volunteers at the 702 Crisis Centre.

In the early 1970's the then Department of Social Welfare and Pensions established a crisis centre in Hillbrow. It

was known as the Hillbrow Crisis Centre and was an independent offshoot of the department. It was run according to a classic crisis intervention model. That is, it was community centred and offered a walk-in, confidential after hours service, when other clinics were closed and most professionals were unavailable.

At the end of the decade, the Department of Social Welfare and Pensions decided to shift the focus of the centre for a number of reasons and it became more closely affiliated to their own "intake" division and it was henceforth primarily an assessment and referral centre.

However, some of the staff who were invloved initially in the Hillbrow Crisis Centre perceived the ongoing need for a specialised crisis intervention service, where treatment could be provided. The Waverley Crisis Centre was established to meet the need. Geographically though, the Waverley Crisis Centre was not equipped to meet the needs of all the people in the Pretoria-Witwatersrand-Vereeniging area.

It was then that the director of the Mental Health Society, as well as the chairperson of that society spearheaded a movement to establish a preventative and community based service within the Hillbrow area, which would once again provide the public with an after-hours, walk-in, confidential counselling service.

At the same time, a local independent radio station, Radio 702 had set up a helpline service for listeners offering them a telephone counselling service during office hours. In addition, through the development of their "talk-back" show (a one hour a week "live on air" opportunity for listeners to consult a mental health professional about their personal problems), they had been increasing the

awareness of their listeners in relation to psychological and social welfare concepts. In the light of their obvious commitment to their community, they were approached by the Mental Health Society and a joint project to establish a Hillbrow Crisis Centre, was proposed.

Three mental health professionals were appointed in 1984 as permanent staff members at the 702 Crisis Centre and were given a mandate to advertise for, select and train a group of 35-40 volunteers, who would be responsible for running the centre. In addition, they had to acquire premises from which to operate. The 702 Crisis Centre opened in August 1984 in van der Merwe Street in Hillbrow.

The centre has clearly met a need in the community and statistics indicate that since its inception, there has been a gradual, but steady increase in the number of people treated. Currently, approximately 500 people are treated monthly. The 702 Crisis Centre offers a specialised crisis intervention service, but it also serves as a referral centre for those who need long-term psychotherapy.

The selection and training of the volunteers

There are no racist, sexist or age criteria for selection. While experience in community or mental health is obviously not a requirement, most of the volunteers have had some experience, either theoretical (for example, doing a social science degree) or having worked for other organisations that offer counselling. The centre is also a recognised training institution for students doing an internship in a BA Social Work degree from the University of the Witwatersrand or the University of South Africa.

Once they have been selected, the volunteers are asked for a commitment of at least one year. However, they are not

required to sign any written agreement to this effect. The commitment consists of being available for one evening a week from 5pm to 11pm, during which time they work as volunteer-counsellors at the centre. In addition, they are expected to attend the ongoing training for two hours every two weeks. Supervision consists of ongoing individual supervision of approximately one hour a week for each volunteer. Volunteers are also encouraged to ask for immediate supervision, if a problem arises in a session with a client and whenever they feel they need help.

The first group of volunteers was recruited through advertising. Approximately 120 people applied and each person was interviewed for 30 minutes by the three permanent staff members. On the strength of that interview, 60 people were selected. Training was done initially over a weekend and the volunteers were then divided into four groups to undergo a ten-week experimentally based training.

The selection procedure has gradually evolved and for the last three training courses no advertisement has been necessary. Application has been through word of mouth. There were 80, 100 and 110 applicants respectively for the last three courses. Selection is now based on the strength of a questionnaire, giving the staff members the biographical details of the applicant. Successful applicants are then interviewed. The interview is therefore still the most important part of the selection process and always involves at least three trained mental health professionals.

The first question to be addressed in the interview is why the volunteer has decided to join a crisis centre and what he hopes to gain from the experience.

required to sign any written agreement to this effect. The commitment consists of being available for one evening a week from 5pm to 11pm, during which time they work as volunteer counsellors at the centre. In addition, they are expected to attend the ongoing training for two hours every two weeks. Supervision consists of ongoing individual supervision of approximately one hour a week for each volunteer. Volunteers are also encouraged to ask for immediate supervision, if a problem arises in a session with a client and whenever they feel they need help.

The first group of volunteers was recruited through advertising. Approximately 120 people applied and each person was interviewed for 30 minutes by the three permanent staff members. On the strength of that interview, 60 people were selected. Training was done initially over a weekend and the volunteers were then divided into four groups to undergo a ten-week experimentally based training.

The selection procedure has gradually evolved and for the last three training courses no advertisement has been necessary. Application has been through word of mouth. There were 80, 100 and 110 applicants respectively for the last three courses. Selection is now based on the strength of a questionnaire, giving the staff members the biographical details of the applicant. Successful applicants are then interviewed. The interview is therefore still the most important part of the selection process and always involves at least three trained mental health professionals.

The first question to be addressed in the interview is why the volunteer has decided to join a crisis centre and what he hopes to gain from the experience.

In addition, the following characteristics are important selection criteria, namely :

a) a sense of responsibility,
b) an average level of intelligence,
c) a genuine concern for others and an ability to empathise,
d) an awareness of one's own vulnerability without being too self-absorbed,
e) an internal capacity to contain one's own anxiety as well as that of others
f) an intellectual and emotional flexibility that allows one to be accepting, but at the same time to be firm and, lastly,
g) the extent of the volunteer's support network and whether or not they have the encouragement of their support system in their decision to join the centre.

Now that the centre has been established and the training course has been built into a training programme, a limited number of volunteers are selected and the training course then runs over a 16-week period. The course includes counselling skills and techniques. Areas such as the importance of the counselling relationship, assessment (according to traditional American diagnostic scheme for example through the use of the Benjamin Rush Assessment sheet), crisis theory and various techniques of crisis intervention are addressed. The course is a mixture of theoretical and experimental training.

Once the initial training period has been completed, the volunteers sit in on sessions with more experienced counsellors, for a period of time, before they are expected to start work on their own. During this initial peri d they are closely supervised and they are also required to fill in the obligatory administrative reports, relating to

their crisis intervention sessions. Once the 15-week training course has been completed, they join the ongoing training programme which covers more specialised issues, such as developmental theory, drug abuse, marital therapy, unemployment and telephone counselling.

The Maintaining of morale within the volunteer system

The question of role relationship between volunteers and paid staff appears to be one of primary importance in the maintenance of volunteer morale [34]. At least two professional staff members are available at the 702 Crisis Centre every evening, to provide ongoing, as well as immediate supervision for difficult cases. In addition, the centre encourages volunteers to work on a specific night each week, so that they become familiar with their colleagues and so that a team-spirit develops in each group. This helps foster the feeling of a commitment both towards the centre and towards the work they do.

While there is no guarantee that the volunteers will fulfil their commitment, the best way to ensure the development and maintenance of adequate commitment is to build in rewards and recognitions for it. Supervision, as well as the ongoing training programme which has been described, fulfil an important function in that they help the volunteers to feel supported and rewarded for their efforts, primarily through a team approach.

CHAPTER 3

A. THE CRISIS INTERVENTION MODEL : DEFINITIONS AND ASSUMPTIONS OF RELEVANCE TO THE RESEARCH DESIGN

The mental health model has its roots in the community mental health centre movement. The community is conceptualised primarily as a geographical area in which the model is focussed on the process of mental health and illness in individuals. The centre serves as a "catchment area" and the model conceptualises a strategy to influence human behaviour, largely within the setting of the centre, in an attempt to provide greater coverage and impact of mental health services to a given area [35].

The crisis intervention model assumes that problems are the result of both the susceptibility of the individual, as well as the stressful or noxious factors in the environment [36].

"Crisis" has been defined by Lindemann (1944) and Erikson (1953) as a demanding problem-solving situation, which may arise out of disruptive experiences in people's lives, or which may occur in normal development as changing demands are encountered.

Caplan (1974) postulates that crises are not emotional illnesses, but that the latter are usually preceded by some period of crisis that changes the individual's equilibrium in the direction of ill health. During this period, feelings of tension, emotional upheaval and disorganised problem-solving behaviour prevail. The goal of the model is the resolution of the crisis towards growth and positive development, that is, an increased level of functioning that improves the individual's ability to cope with

subsequent crisis situations. Furthermore, it is assumed that the individual is particularly amenable to change during this period, since the individual is experiencing a state of disequilibrium.

Key significance is assigned to the role of the volunteer, who works as a counsellor in the community centre. Caplan (1974) [37] pinpoints the role of the volunteers as being that of a "support system", instrumental in resolving crises in the direction of growth. Thus, the recognition of the importance of the volunteer and the co-ordinate relationship between volunteers and consultants is emphasised within this model.

The mental health professional functions as a consultant and attempts to influence intermediaries, that is, the volunteers, to intervene directly, in order to resolve the problems with which the client is faced. The model developed in Chapter 5, namely the contingency approach to improving volunteer motivation is based on assumptions of the community mental health model.

This community mental health model [38] assumes some global values which are likely to be shared by the community, namely that it is better to be out of hospital than in and that is is better to be well than ill. In addition, Caplan (1974) [39] pinpointed the following assumptions as underlying the model :

a) <u>That the control of mental health problems is primarily by means of prevention</u> :

Primary prevention refers to the effort to decrease the number of cases of a specific mental health problem. This takes place through education, consultation and crisis intervention. There are several means of doing

this, for example, eliminating or modifying the hazardous situation by reducing or limiting the person's exposure to such a situation. Also by reducing the person's vulnerability by helping him or her increase his or her coping ability. The success of the preventative measures depends largely on the person's openness to learning, previous problem-solving success and general social supports.

Secondary prevention refers to the early identification or problems and their treatment, in order to reduce the severity of the individual's problem. The term "secondary prevention" implies that some form of mental disability has already occurred, because of the absence of primary prevention activities or because of the person's inability to profit from these activites. The aim of secondary prevention is to shorten the period of time a person is mentally disabled. A major means of doing this is to provide easily accessible crisis intervention services. This helps prevent hospitalisation in many instances and therefore avoids the disabling effects of institutionalisation.

Tertiary prevention refers to the prevention of relapses of those individuals who have recovered through rehabilitation and reintegration into the community. The goal of this level of prevention is to reduce long-term disabling effects for those who have recovered from a mental disorder. Crisis intervention is also important at this level, for the same reasons noted in the discussion of secondary prevention. Hopefully, the recovery process includes learning new ways of coping with stress.

b) The conception of positive mental health

this, for example, eliminating or modifying the hazardous situation by reducing or limiting the person's exposure to such a situation. Also by reducing the person's vulnerability by helping him or her increase his or her coping ability. The success of the preventative measures depends largely on the person's openness to learning, previous problem-solving success and general social supports.

Secondary prevention refers to the early identification or problems and their treatment, in order to reduce the severity of the individual's problem. The term "secondary prevention" implies that some form of mental disability has already occurred, because of the absence of primary prevention activities or because of the person's inability to profit from these activites. The aim of secondary prevention is to shorten the period of time a person is mentally disabled. A major means of doing this is to provide easily accessible crisis intervention services. This helps prevent hospitalisation in many instances and therefore avoids the disabling effects of institutionalisation.

Tertiary prevention refers to the prevention of relapses of those individuals who have recovered through rehabilitation and reintegration into the community. The goal of this level of prevention is to reduce long-term disabling effects for those who have recovered from a mental disorder. Crisis intervention is also important at this level, for the same reasons noted in the discussion of secondary prevention. Hopefully, the recovery process includes learning new ways of coping with stress.

b) The conception of positive mental health

Jahoda's (1958) [40] definition of mental health is that of "autonomy, integration, growth and self-actualisation, consisting of positive attitudes towards the self and environmental mastery".

c) The salience of the social-environmental context

The attention to the social-environmental context emphasises that mental health and mental health problems are a product of the relationship between the individual and the environment. This does not reduce the role of personality, but rather it increases the role of the salience of the social factors.

The 702 Crisis Centre, in which this study was operationalised, is based conceptually on the framework of the community mental health model. One of the most crucial elements on which this model depends, is the recruitment of volunteer workers who are responsible for maintaining the treatment programmes which have been developed by the consultant mental health professionals. While there has been fairly comprehensive research on various aspects of the community mental health model [40, 41, 42, 43], the literature on the non-professional volunteer crisis worker seems sparse [44]. It is particularly the issue of maintaining morale and preventing the high drop-out rate which is of concern [45]. Universally, the most obvious questions concerning the management of a volunteer programme are those which receive most or all of the director's attention. Issues of recruitment, selection, training and scheduling of volunteers are so obviously important that most programmes have neglected to isolate more covert maintenance strategies, for example, the role of perceived social support from friends and family. It is obviously of importance to any crisis centre to investigate as many factors as possible which may have an influence on

Jahoda's (1958) [40] definition of mental health is that of "autonomy, integration, growth and self-actualisation, consisting of positive attitudes towards the self and environmental mastery".

c) The salience of the social-environmental context

The attention to the social-environmental context emphasises that mental health and mental health problems are a product of the relationship between the individual and the environment. This does not reduce the role of personality, but rather it increases the role of the salience of the social factors.

The 702 Crisis Centre, in which this study was operationalised, is based conceptually on the framework of *the community mental health model.* One of the most crucial elements on which this model depends, is the recruitment of volunteer workers who are responsible for maintaining the treatment programmes which have been developed by the consultant mental health professionals. While there has been fairly comprehe sive research on various aspects of the community mental health model [40, 41, 42, 43], the literature on the non-professional volunteer crisis worker seems sparse [44]. It is particularly the issue of maintaining morale and preventing the high drop-out rate which is of concern [45]. Universally, the most obvious questions concerning the management of a volunteer programme are those which receive most or all of the director's attention. Issues of recruitment, selection, training and scheduling of volunteers are so obviously important that most programmes have neglected to isolate more covert maintenance strategies, for example, the role of perceived social support from friends and family. It is obviously of importance to any crisis centre to investigate *as many factors as possible which may* have an influence on

the tenure of volunteers [46].

The aim of this study was twofold. The initial part of this study was aimed at testing a particular hypothesis so that the staff at the crisis centre could, via feedback, increase their understanding of the role of support systems in the life of volunteers. Secondly, the study was to serve a theory-building function in that a model focussing on improving volunteer motivation and preventing burn-out was proposed.

B. RESEARCH DESIGN AND METHODOLOGY

a) The hypothesis

The hypothesis tested the following assumption, namely that a support system in the life of a volunteer improves the tenure of the volunteer within the community crisis centre as a counsellor.

The Procidano and Heller Social Support Scale 1983 [47] (see Appendix One) was utilised to test the above hypothesis. The Social Support Scale measures :
perceived social support from the family (PSS-Fa) and perceived social support from friends (PSS-Fr).

b) The Design

The study was carried out in the 702 Crisis Centre in Hillbrow.
Permission was obtained to use the data from two volunteer groups in the initial stages of training. The first group did their training in June 1985 and the second group did their training in April 1986. The Procidano and Heller Social Support Scale (see Appendix One) was administered to each group during their first

week in the training course after selection. While the volunteers were aware of the fact that the questionnaire formed part of the research for a thesis, in order to fulfil the requirements for a Master of Arts degree in Psychology, they were told that the study was not attempting to make a differentiation between "good" and "bad" crisis counsellors, but rather that the study was an attempt to examine the type of person who volunteers for crisis counselling.

The volunteers were each handed a questionnaire during one of their training sessions and asked to fill it in and return it at the end of the evening. This ensured that each volunteer completed a questionnaire.

Once the questionnaires were completed, a time period of six months was set aside to allow the trainee volunteers to become more experienced and in turn, to experience the demands made on them. After this interval of time, the subjects had self-divided retrospectively into two groups, namely on the one hand, the counsellors in the experimental group (the "drop-out" volunteers) and on the other hand, those counsellors in the control group (the "stayers").

The data gleaned from the Procidano and Heller Social Support Scale, 1983, was then analysed in terms of whether or not the perceived social support from family (PSS-Fa) and from friends (PSS-Fr) affected the tenure of those counsellors in the community mental health programme.

The study was by its nature predictive, in that, on the basis of the information received from the questionnaire, various trends in perceived social support from family and friends could be analysed, in

relation to the variable, tenure, that is, Tenure = F (PSS-Fa; PSS-Fr).

In addition, as a result of the fact that the scale construction is such that the two scale-constructs are valid, yet separate, individuals evidenced differences in their perceived social support from family and from friends. The relative importance of these differences was examined by means of statistical analysis.

c) Subjects

As already stated, permission was obtained to use two volunteer groups, who were receiving their training at the 702 Crisis Centre as the subject-pool. The same questionnaire was administered to each group.

There were 13 volunteers in the first group and 13 volunteers in the second group. Five volunteers dropped out of group one, and two volunteers dropped out of group two. Thus, on average, the drop-out rate was 26%. Previous experience indicated that the expected drop-out rate was around 30%.

d) Research Instrument

The Procidano and Heller Social Support Scale (1982) [48] was utilised to test the perceived social support from family and the perceived social support from friends.

The authors, Procidano and Heller [49], note that the impetus to develop methods to adequately tap various dimensions of social relationships arose in large part from the investigation of the detrimental effects of stressful life events on physical and psychological health. Furthermore they advanced the hypothesis that

social support might play a significant role in mediating these stressful life events. Procidano and Heller (1983) go on to describe three studies in which measures of perceived social support from friends and family were developed and validated. The measures were found to be internally consistent and to measure valid constructs that were separate from each other.

The Procidano and He ler Social Support Scale was selected as the measu ing instrument of choice in this study, due to the fact that it offered a well-standardised measuring instrument, with high reliability and validity. In addition, it was well-suited to the theoretical framework underlying the community mental health model.

Volunteers were asked to complete this paper and pencil-type test during their initial week of training. A six month period of time was then allowed to elapse, in order to allow the volunteers the opportunity to work as crisis centre counsellors and to experience the demands made on them. After this duration, the drop-out rate of the volunteers in each of the two sample groups was recorded. The two separate scores for each construct, namely perceived social support from family and perceived social support from friends, was then utilised, in order to seek a significant relationship with drop-out rate.

e) *The statistical analysis of the results*

The following statistical techniques were employed :

(a) a chi-square test and a Fisher's exact probabilities test and
(b) a matched pairs t-test.

A nonparametric technique was selected after consideration of the fact that "tenure" is a discrete variable, rather than a continuous one. There were two discrete groups into which the subjects self-divided, namely (a) the "drop-outs" and (b) the "stayers".

The Procidano and Heller Social Support Scale consists of two separate constructs, namely perceived social support from family (PSS-Fa) and perceived social support from friends (PSS-Fr). PSS-Fa and PSS-Fr were used as a measurement of the predictive validity of tenure.

The technique of discriminant analysis was utilised for the classification and interpretation of the data obtained from the Procidano and Heller Social Support Scale (1982). A discriminant function is a regression equation with a dependent variable that represents group membership. The function maximally discriminates between the members of the group. The discriminant function gives the best prediction of the correct group membership of each member of the sample. From the scores on the two measures, the least squares "best" composite score is calculated (Kerlinger 1973) [50]. The Neighbor option of the BMDS discriminant analysis package was chosen to analyse the data.

Due to the fact that the data did not fulfil one of the criteria for a discriminant analysis (that is, both groups did not have a multivariate, normal distribution), an additional chi-square test and Fisher's exact probabilities test was calculated to confirm the results of the discriminant analysis. The Fisher's exact probabilities test is more accurate for small sample sizes.

Finally, a matched pairs t-test was calculated in order to ascertain whether or not there was a statistically significant difference between the perceived social support from families, compared to the perceived social support from friends, as measured on the Procidano and Heller Social Support Scale (1983).

CHAPTER 4 : RESULTS

A. INTRODUCTION

The hypothesis tested the following assumption, namely that a support system in the life of a volunteer improves his or her tenure within the community crisis centre as a counsellor.

The following statistical techniques were utilised to investigate the hypothesis, namely :

a) The Neighbor option of the SAS discriminant analysis package.
b) A chi-squared and Fisher's exact probabilities test, and,
c) A matched pairs t-test.

The technique of discriminant analysis was utilised for the interpretation and classification of the data. In short, the rules of this analysis obtain estimates of the density function for groups one (the "drop-outs") and two (the "stayers"), at the point to be classified, and form the ratio of the density estimates.

The discriminant function is the assignment rule when the following assumptions are satisfied, namely :

a) no variable is a linear combination of other discriminant variables,
b) the population covariances are equal for each group, and,
c) each group has a multivariate normal distribution.

The two groups in this study, however, did not have a

normal distribution. Lachenbruch (1978) [51] has indicated that discriminant analysis is a robust technique which can tolerate some deviation from these assumptions.

However, the normality assumption is important for classification, based on the probability of group membership. These probabilities are calculated from the chi-square distribution. In addition to the chi-square calculation, a Fisher's exact probabilities test was also computed. The Fisher's exact probabilities test is more accurate than the chi-square and is used in two-by-two classification tables in small sample sizes and does not need five observations per cell.

Due to the fact that the distribution of the two groups was unspecified, a non-parametric method of discriminant analysis was employed.

Certain assumptions are associated with non-parametric-statistical tests, namely :

a) the observations are independent,
b) probability statements obtained from non-parametric statistical methods are exact probabilities, regardless of the shape of the distribution from which the random sample is drawn, and
c) if the sample size is too small, there is no alternative to using non-parametric methods, unless the nature of the population distribution is known.

To date, few methods of non-parametric discriminant analysis are widely available (Klecka, 1980) [52] and therefore, the problems involving the selection of variables have not yet been studied fully.

B. THE RESULTS

Table 1 : The results of a discriminant analysis performed on the drop-outs and stayers, using perceived social support as the discriminant function.

Observations			Results of Statistical Analysis		
Perceived Social Support from Family	Perceived Social Support from Friends	Observation: Dropout versus Stayers	Predicted Result	Probability of Dropout	Probability of Staying
14	19	S	No Significance	0.5	0.5
11	5	D	No Significance	0.5	0.5
17	13	S	Stayer	0	1
15	1	D	No Significance	0.5	0.5
14	9	D	Dropout	1	0
12	9	S	Stayer	0	1
15	20	D	No Significance	0.5	0.5
12	14	D	No Significance	0.5	0.5
18	14	S	Stayer	0	1
15	14	S	Stayer	0	1
13	16	S	Stayer	0	1
15	19	S	No Significance	0.5	0.5
6	2	S	No Significance	0.5	0.5
19	7	S	Stayer	0	1
15	17	S	Stayer	0	1
15	12	S	Stayer	0	1
13	18	S	Stayer	0	1
14	5	S	No Significance	0.5	0.5
12	6	S	Stayer	0	1
19	19	S	Stayer	0	1
16	19	S	Stayer	0	1
12	8	S	Stayer	0	1
17	8	S	No Significance	0.5	0.5
15	8	D	Dropout	1	0
18	1	D	No Significance	0.5	0.5
13	11	S	Stayer	0	1

Table 2 : The percentage number of correct predictions, compared to the percentage number of cases where no significant prediction could be made, based on the data from Table 1.

		Observations	Results of Statistical Analysis	
		Total Number of Volunteers	Number of Correct Predictions	Number of Cases Where No Significant prediction could be made
Dropouts	Number	7	2	5
	Percentage	100%	29%	71%
Stayers	Number	19	14	5
	Percentage	100%	74%	26%
TOTAL	Number	26	16	10
	Percentage	100%	62%	38%

From the data presented here, the null hypothesis was not rejected. This suggests that :

a) the perceived social support from family is not significant in predicting the tenure of volunteers at the crisis centre,
b) the perceived social support from friends is not significant in predicting the variable tenure.

As the underlying assumptions of the chi-square test have not been met, only Fisher's test results will be used. The computations of the Fisher's exact probabilities test are also given below.

Table 3 : Cross classification of "Dropouts" and "Stayers" by perceived social support from family (PSS-Fa) and perceived social support from friends (PSS-Fr).

	Groups		
	Dropouts	Stayers	Total
PSS-Fa 0	6	12	18
PSS-Fa 1	1	7	8
Total	7	19	26

Fisher's exact probability = 0,274 (1 Tail)

This supports the results of the non-parametric discriminant analysis, indicating that perceived social support from family and perceived social support from friends are not statistically significant in predicting drop-out rate.

The matched pairs t-test, yielded a t-value of 2,70, significant at the 5% level and suggests that the perceived social support from friends was statistically significant, in relation to perceived social support from family.

C. SUMMARY

Both the non-parametric discriminant analysis, as well as the Fisher's exact probabilities test, suggests that the null hypothesis was not rejected. That is, neither the perceived social support from friends, nor the perceived social support from family differed significantly in predicting the variable tenure, at the centre. A summary of the results presented in Table 4, confirms this.

Due to the fact that the null hypothesis was not rejected, it was felt that a further analysis of the differences and similarities of the responses of the drop-outs and stayers to each individual question, may yield a significant result. Table 4 illustrates these differences and similarities between the responses of the drop-outs and stayers to each of the individual questions posed in the Procidano and Heller Social Support Scale, 1983. Table 4(a) represents their response to the twenty questions posed to them in the questionnaire pertaining to Perceived Social Support from Friends, while Table 4(b) represents their responses to the twenty questions posed to them in the questionnaire pertaining to Perceived Social Support from Family.

Because the design of the study by its nature is primarily predictive, in that on the basis of the information received from the questionnaire, various trends in perceived social support from family and friends could be analysed. Table 4 also indicates which questions were statistically significant in predicting tenure.

Table 4 consists of the following data :
Column 1 indicates the question number of the questionnaire
Column 2 indicates the corresponding number of stayers and dropouts who answered yes or no to the questions indicated

in the column.
Column 3 indicates the percentage of stayers or dropouts who answered yes or no to the questions indicated in column 1.
Column 4 indicates the total number of volunteers who answered yes or no to the respective questions represented in column 1.

Table 4 : Differences and Similarities Between the Raw Scores of Dropouts and Stayers to Perceived Social Support from Friends (a) and Family (b).

(a)	PERCEIVED SOCIAL SUPPORT FROM FRIENDS									
Quest. no.	Stayers		Dropouts		S D		S D		Population	
	Yes	No	Yes	No	Yes		No		Yes FR	No FR
1	14	5	6	1	70	30	83	17	20	6
2	12	7	5	2	71	29	78	22	17	9
3	18	1	6	1	75	25	50	50	24	2
4	18	1	6	1	75	25	50	50	24	2
5	1	18	6	1	14	86	95	5	7	19
6	14	5	7	0	67	33	100	0	21	5
7	14	5	6	1	70	30	83	17	20	6
8	17	2	7	0	71	29	100	0	24	2
9	19	0	6	1	76	24	0	100	25	1
10	10	9	6	1	63	38	90	10	16	10
11	16	3	7	0	70	30	100	0	23	3
12	6	13	3	4	67	33	76	24	9	17
13	15	4	6	1	71	29	80	20	21	5
14	11	8	1	6	92	8	57	43	12	14
15	16	3	5	2	76	24	60	40	21	5
16	15	4	6	1	71	29	80	20	21	5
17	15	4	3	4	83	17	50	50	18	8
18	10	9	7	0	59	41	100	0	17	9
19	9	10	1	6	90	10	63	38	10	16
20	14	5	6	1	70	30	83	17	20	6

(b)	PERCEIVED SOCIAL SUPPORT FROM FAMILY									
Quest. no.	Stayers		Dropouts		S D		S D		Population	
	Yes	No	Yes	No	Yes		No		Yes FA	No FA
1	1	18	6	1	14	86	95	5	7	19
2	7	12	3	4	70	30	75	25	10	16
3	10	8	1	6	91	9	57	43	11	14
4	10	9	4	3	71	29	75	25	14	12
5	16	3	4	3	80	20	50	50	20	6
6	10	9	1	6	91	9	60	40	11	15
7	15	4	6	1	71	29	80	20	21	5
8	7	12	3	4	70	30	75	25	10	16
9	11	8	4	3	73	27	73	27	15	11
10	13	6	3	4	81	19	60	40	16	10
11	9	10	2	5	82	18	67	33	11	15
12	16	3	5	2	76	24	60	40	21	5
13	8	11	2	5	80	20	69	31	10	16
14	8	11	2	5	80	20	69	31	10	16
15	10	9	4	3	71	29	75	25	14	12
16	9	10	5	2	64	36	83	17	14	12
17	13	7	4	3	75	25	70	30	16	10
18	14	5	5	2	74	26	71	29	19	7
19	11	8	3	4	79	21	67	33	14	12
20	12	7	2	5	86	14	58	42	14	12

The following procedure was utilized to ascertain which questions were statistically significant as predictors of the independent variable, tenure :
There were two conditions which had to be met, in order for a question to have predictive validity, namely :

(a) a sample size of no less than 15 was required. Jahoda (1958) [53] notes that a sample size of 15 or more is required to ensure stability of the sample, in order to protect it from too much variation of the standard deviation.

(b) There had to be a significant difference between the answers of the stayers and the dropouts to a given question. A significance of greater than 95% or less than 5% was selected as the measure of significant difference.

By examining the data presented in Table 4, the following questions were seen to yield significant results :
Question 5 of the Perceived Social Support Scale for Friends, indicated that the 95 % of the stayers who answered no to the question, "I rely on my friends for emotional support" stayed. This result indicates that the volunteers who are successfully maintaining their work responsibility by staying, do not rely on their peer-group, outside the crisis centre, for support.
In addition, question 1 of the Perceived Social Scoport Scale for Family yielded a significant result. There were 95% of the stayers who answered no to question 1, namely "I rely on my family for emotional support". Again, this result indicates that a high percentage (73%) of the volunteers who stay, do not rely on their family for support.

It appears from the volunteers answers to these two questions as if those volunteers who are not dependent on their family or friends for support are more likely to stay. It is important to note, however, that the Procidano and Heller Social Support

Scale 1983, was administered during the first week of training. Therefore, it is a measure of the volunteers support network outside of the crisis centre. It does not yield information on the support from the staff, and peer group within the crisis centre. The hypothesis that the perceived social support from the staff and peer group within the crisis centre may be a *significant factor in preventing burn-out, has* not yet been tested. It is beyond the scope of this thesis to do so. However, in Chapter 5, a model of motivational strategies is proposed which focusses on the possible strategies for support emanating from the crisis centre *itself, and suggests, in* addition, what the next stage of research in this area would appear to be.

CHAPTER 5 : DISCUSSION OF THE RESULTS

A. INTRODUCTION

As the crisis intervention movement grows and more clinics adopt crisis intervention as a primary treatment modality, the danger of burn-out increases, since more time each day is spent in this type of work.

The effects of continued intense involvement with clients with acute distress are cumulative on the volunteer and become a significant liability if measures are not taken by the professional staff members to prevent burn-out in their volunteers. As Larson, Gilbertson and Powell (1978) [54] so aptly state in this regard, "the mental health environment..., as currently structured, facilitates burn-out. In fact, the present attitude seems to be one of not respecting, in terms of themselves, those same principles of mental health that volunteers espouse for patients : the need to set limits on the demands of others, the need to balance work and social needs, the need to foster self-respect, and the need to reject the notion of being all things to all people."

The burn-out syndrome as a psychological phenomenon has only recently been recognised. Freudenberger (1974, 1975) [55] first conceptualised burn-out when he recognised it among the staff of alternate services and free clinics in the late sixties. In those services, he noticed that volunteers tended to leave after about one year, because they had "burned-out" as a result of intense involvement with clients and the need to give constantly to clients experiencing acute distress.

More recently Maslach (1978(a)) [56] and others have

recognised that burn-out seems particularly endemic among those in the social service and health professions because of the often emotionally charged nature of helping in this type of work (Pines and Maslach, 1978) [57]. In these professions, staff members are required to respond to clients experiencing acute crises, as a major aspect of their responsibility. Because of this, burn-out becomes a very real and powerful vulnerability if not anticipated and f preventive measures are not taken.

. and Maslach (1978) [58] define burn-out as "a syndrome . physical and emotional exhaustion, involving the d lopment of a negative self-concept, negative job attitudes, and loss of concern and feeling for clients". This description is very similar to Freudenberger's (1974) [59] earlier observations of the reactions of volunteer staff members in alternate services.

Shubin (1978) [60] cautions that the first signs of burn-out may be so subtle that they are easily dismissed. As the symptoms intensify with time, they may be blamed on other (usually external) factors, rather than on personal burn-out. In the first stage of burn-out (Maslach, 1976) [61], there is experienced characteristic physical tiredness and emotional exhaustion. This is often accompanied by somatic symptoms of stress such as headaches, gastric intestinal distress, or other aches and pains. There may be increased susceptibility to physical illness, and absenteeism may increase. Often experienced as well is insomnia and the inability to truly relax.

Slowly this phase evolves into a second stage in which the volunteer "loses all concern, all emotional feeling for the persons they work with and come to treat them in detached or even dehumanized ways" (Maslach, 1976) [62]. In turn, this devalues the volunteer as an important and functional

member of the crisis team. While the volunteers self-esteem is often lowered as a result of his negative feelings about patients, there is often also a concurrent physical and emotional withdrawal from clients. A minimum of effort and energy is put into work with clients and the individual burning out becomes orientated towards "just getting through" another shift.

Up to this point, burn-out can be controlled, and can be reversed, if an effective set of strategies are utilized. Section 6 of this discussion suggests a contingency approach to improving volunteer motivation and consists of a set of strategies and a recommended framework which can be utilized to develop a preventative programme.

However, in at least some individuals, where the "burn-out" syndrome was not recognised, it can progress to a third and probably irreversible phase. This is the stage of terminal burn-out (Maslach 1978b) [63]. It is characterized by deep cynicism about people in general and patients in particular, accompanied by a feeling of total disgust with the work that has created burn-out. While most of the volunteers who reach this terminal stage will discontinue their services at the centre, others stay on to continue working in the same or similar positions, to the detriment of their patients and themselves.

At the present level of knowledge about burn-out it is not known whether this syndrome can be completely prevented (Burgess and Baldwin, 1981) [64]. However, with foreknowledge and preventive measures instituted, its progression can be significantly slowed.

B. DISCUSSION OF THE RESULTS

a) Limitations of this study

This study was aimed at testing a particular theoretical construct, in order to examine its significance in relation to the variable, tenure. The hypothesis tested the assumption that a support system in the life of a volunteer improves the tenure of the volunteer within the community crisis centre as a counsellor. The null hypothesis was not rejected and this suggests that neither the perceived social support from family, nor the perceived social support from friends, were significant in predicting the variable tenure. However, the results of the matched pairs t-test indicated a statistically significant difference between the perceived social support from friends, in relation to the perceived social support from family, in favour of the former.

It is important to note that the Procidano and Heller Social Support Scale 1983, was administered during the first week of training, before significant peer-group relationships were built up among the volunteers themselves. Therefore, the perceived social support score from friends (that is PSS-Fr) was indicative of the support network outside of the crisis centre.

Thus, the hypothesis that the support from the peergroup within the crisis centre may be a significant factor in predicting tenure, needs further consideration. However, by implication, this may be of importance to the training staff of the crisis centre, since it suggests that volunteers will be more productive with a firm structure of team support and supervision. In fact, Hoff (1978) [65] noted that people

who do crisis work need the support of a clearly defined staffing arrangement. Crisis workers must know who their teammates are and who to call for consultation or other assistance.

Sensitivity of the organisation to burn-out and to its prevention among volunteers is helpful not only to extend the effectiveness of the volunteers engaged in this important work, but also to provide quality care to patients seeking help from the service.

Thus, while the results of this study suggest that neither the perceived social support from family, nor the perceived social support from friends were significant in predicting the variable tenure, the hypothesis that the perceived social support from the peergroup, within the crisis centre may be a significant factor, has not yet been tested. To test this hypothesis is beyond the scope of the present study. However, a model of motivational strategies is proposed, which focusses on the possible strategies for support emanating from the crisis centre itself.

b) Recommendations : A model of motivational strategies designed to reduce burn-out.

"The contingency approach to improving volunteer motivation" consists of a set of assumptions regarding employee behaviour, a set of strategies for increasing motivation, and a recommended framework or set of steps a director can follow when attempting to improve volunteer motivation. It is a preventative programme which attempts to structure a safety net of strategies which can be employed once a volunteer has been identified as suffering from "burn-out".

i) Basic principles :

1) No single approach for increasing volunteer motivation will be effective under all conditions.
2) Most approaches currently available will be effective under certain conditions and
3) Under certain conditions two or more approaches to improving motivation will be just as effective.

Let us consider each of these briefly :

No single approach is always effective

For years a basic and powerful strategy to solve all motivational performance has been sought.

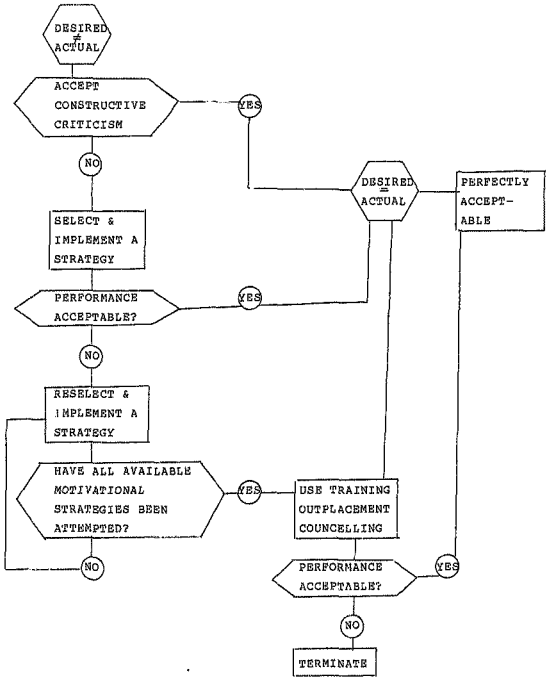
Many approaches are effective

Over the years research has suggested a number of different motivational strategies. Each of these typically begins with an analysis of why previous approaches have been unsuccessful and why the new approach will work effectively. Is one to conclude that all these approaches should be discarded as ineffective? Certainly not. One should surmise that each of these approaches will probably be successful under certain conditions. The critical questions then are not whether a given strategy will be effective, but under what conditions it will be successful and how successful it will be.

Some approaches work equally well

The contingency approach suggests that under certain conditions two or more approaches will be equally effective.

ii) Specific steps in the contingency approach



iii) Actual behaviour versus desired behaviour

The Contingency Approach begins with the assumption that the volunteer's job behaviour is not equal to that desired by the director. In order to determine what a volunteer is actually doing on the job, a *director must* be able to recognize, conceptualize or identify the behaviour of the people within his organisation.

iv) Keeping volunteers informed
Accepting constructive criticism

Are of the easiest interventions the supervisor/*director can perform whenever a volunteers* actual behaviour is not the same as the desired behaviour, is to inform the volunteer of the performance deficit. This strategy costs nothing and can have very rapid results. Far more frequently than is often expected, volunteers are not performing the tasks desired by the supervisor, simply because they do not know either what the desired behaviour is or that a *discrepancy exists* between what they are doing and what is wanted. Therefore, the director/supervisor is always wise to check immediately to see whether or not the volunteers are informed *about the discrepancy* between the actual behaviour and the desired behaviour. However, it is clearly necessary that the director be able to specify the desired behaviour before this approach will work.

If it is found that the desired behaviour can be obtained by simply informing the volunteer, then the *director need only proceed* to the final step, the monitoring of future behaviour. If, however, the phenomenon of burn-out has developed further and constructive criticism does not produce the desired

behaviour, the director has to select and implement one or more of the available motivational strategies.

v) Selecting and implementing a volunteer motivational strategy

In this step, the director must decide whether to utilize one of the available motivational strategies or to refer the problem to others by outplacement counselling. If the problem he is facing is one of motivation, i.e. burn-out, then he can proceed to step 5 and select an appropriate strategy. If, however, personal or emotional problems seem to be interfering with motivation, a counselling referral outside of the crisis centre has to be considered. Only if he can conceive of no way to continue working with this volunteer should the director consider terminating the volunteer's services.

The selection and implementation stage requires that the director decide which strategy should be implemented in order to improve the volunteers motivation. In order to do this the director has to be aware of the different strategies that could be used to improve motivation. Thus in addition to being able to identify and understand a volunteer's actions, a successful director must also know the actions that can be taken to improve the volunteer's motivation.

By way of preview, it is necessary to mention that a similar format is followed in presenting each strategy. A basic diagram will again be provided to illustrate the various strategies for improving volunteer motivation. The strategy will be discussed, by pointing out which decisions need to be made, the information necessary for making each decision, the

problems to expect, the consequences to consider at each stage of the implementation.

Determining the success of the strategy

Performance acceptable?

After having implemented a given strategy, the next procedure is to determine whether or not the strategy was successful. This step entails evaluating the volunteer's job performance and comparing actual performance to desired performance.

Trying an alternative strategy

Attempt alternative strategy

Infallibility in selecting a strategy for improving volunteer motivation is unrealistic. It is critical to adopt a strategy analogous to the medical model, i.e. by use of a trial and error process, the doctor will evaluate the symptoms, prescribe a medication and evaluate its effectiveness. On some occasions, however, the doctor may realize that patient's problem falls outside the scope of his work and he will then refer him to seek consultation with an appropriate specialist. On other occasions, the doctor may realize the patient's illness is truly incurable and nothing can be done.

Thus one role of the supervisor is that of being a volunteer diagnostician. While the supervisor cannot be expected to have a comprehensive or completely accurate grasp of the volunteer's difficulties, nonetheless the supervisor must prescribe a strategy which is likely to be effective. A supervisor may also

problems to expect, the consequences to consider at each stage of the implementation.

Determining the success of the strategy

Performance acceptable?

After having implemented a given strategy, the next procedure is to determine whether or not the strategy was successful. This step entails evaluating the volunteer's job performance and comparing actual performance to desired performance.

Trying an alternative strategy

Attempt alternative strategy

Infallibility in selecting a strategy for improving volunteer motivation is unrealistic. It is critical to adopt a strategy analogous to the medical model, i.e. by use of a trial and error process, the doctor will evaluate the symptoms, prescribe a medication and evaluate its effectiveness. On some occasions, however, the doctor may realize that patient's problem falls outside the scope of his work and he will then refer him to seek consultation with an appropriate specialist. On other occasions, the doctor may realize the patient's illness is truly incurable and nothing can be done.

Thus one role of the supervisor is that of being a volunteer diagnostician. While the supervisor cannot be expected to have a comprehensive or completely accurate grasp of the volunteer's difficulties, nonetheless the supervisor must prescribe a strategy which is likely to be effective. A supervisor may also

need the advice and support of his direct superior (usually the director of the crisis centre), in solving volunteer motivation problems.

vi) Using training or outplacement counselling

Finally, in some cases, a volunteer's burn-out may be terminal. That is, there does not seem to be a workable solution to the volunteer's motivational problem. McGee (1974) notes that while the overinvolved volunteer is initially a great asset to the centre, he is potentially an even greater liability. It becomes necessary for the supervisors and ultimately for the director to monitor cautiously the degree of involvement of all the workers. The overinvolved volunteer must be assisted to set explicit limits on his performance at the centre in order to prevent him from experiencing the burn-out phenomenon 66.

On the other hand, a volunteer may be experiencing long term personal stress which makes him dysfunctional. Under these circumstances an open system of communication is essential in helping volunteers communicate with their respective problems. If morale problems are accepted by the staff and volunteers as a given fact in the type of anxiety producing work, and if morale problems are understood as a natural aspect of the programme, no one need to be too discouraged or to react with panic when it becomes impossible to deny a sense of "burn-out" any longer. The development of an educational-awareness programme detailing the symptoms of burn-out, will help increase volunteers' self awareness, making early diagnosis of the problem possible.

vii) Monitoring future volunteer performance
Performance acceptable?

Monitor future performance. Once this step has been reached, the volunteer motivation problem has been remedied - for the moment. However, since both the conditions in the crisis centre, as well as the personal lives of volunteers change, nothing can be expected to work forever. Therefore, it is always desirable for staff of the crisis centre to devise *methods of monitoring future volunteer motivation* and performance. This may be accomplished by using a volunteer maintained feedback system when a volunteer's performance becomes unsatisfactory in the future, it is once again time to consider the behaviours that are desired versus the actual behaviours, consult the procedures recommended and begin again.

The most important feature of the contingency approach is that it prescribes a framework or set of steps for improving volunteer motivation and productivity.

In the following section, the basic strategies to enhance motivation are presented. However, success in the implementation of any of the strategies depends, not only on the specific nature of each strategy, but also on the attributes of the director, as well as the personality traits of the volunteer. The director needs to examine the interrelationship of these factors before selecting a strategy. *While the contingency approach may suggest* an apparently ideal strategy for the director to follow, the practical realities of the centre as well as the directors individual skills and the volunteer's personality traits, *may prevent the use of the* ideal strategy. A compromise strategy must then be used instead.

Amitas Etzioni (1961) [67] made an important contribution to the field of leadership by pointing out the importance of a leaders power in taking organizational action. If the director is to change the motivation of the volunteers, he must have sufficient power to do so. Etzioni (1961) [68] observed that a leader can potentially have two somewhat different types of power : position power and personal power.

Position power refers to the director's ability to motivate volunteers as a result of his own position within the crisis centre. Authority per se, however, is only a part of what constitutes position power. Clearly the amount and type of rewards, together with the severity of the discipline over which the director has authority affects the amount of position power he has. It is also important to note that a director's position power is not fixed. Rather, this attribute changes over time, with changing circumstances.

Personal power refers to a directors ability to motivate a volunteer, because the volunteer likes, trusts or wants to be accepted as a valuable member of the team. A volunteer's motivation to continue working optimally is not always in direct proportion to the amount of organizational rewards received. It is not necessary that a friendship exist between the director/supervisor and the volunteer. A relationship resulting in personal power may be based on respect and a reputation for fairness just as easily. But, since personal power is built upon a personal relationship, its magnitude is dependent upon the quality of the relationship between the leader and the subordinate. The magnitude of the leaders personal power depends on mutual consent and commitment.

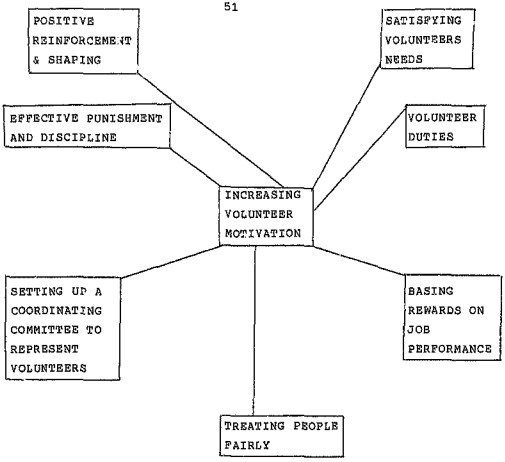
There remains one final observation. If the director is to increase volunteer motivation, he needs either position power or personal power. Without either, he will be helpless. While the director/supervisor can be somewhat effective with either position or personal power, to be maximally effective, he needs both and the more of each, the better.

Thus the leader's personal and position power will affect the likelihood of success for each of the motivational *strategies. However,* the success of a motivational strategy is also dependent on the leader's ability to effectively implement a given strategy. While some *skills, like communication,* have utility across all strategies, some critical skills required differ significantly from one strategy to another. Before implementing any *strategy every* director needs to assess his own skills and to compare them to those required for the strategy.

While in the above discussion, attention has been given to the necessary attributes of a *successful director,* it is also important to consider the characteristic attributes of volunteers, which are relevant in choosing a strategy.

The volunteers are all individuals, who differ in terms of their personalities; they differ in terms of their values *and goals;* they differ in their innate abilities and their developed skills. They also differ in terms of how they respond to a leader's personal and *position power.* All of these factors will influence a volunteers performance and the likelihood that a motivational strategy will be successful. Because *of individual differences,* no approach to motivation can possibly take into account all, or even most of the differences.

In the following section, each of the strategies is presented separately. The following diagram *illustrates the* different strategies which can be utilized in order to improve volunteer motivation:



1) Positive reinforcement and shaping

This strategy typically requires both position power and personal power. The extent to which each of these is required depends on the reinforcement used. Praise, one of the most typical reinforcers, requires personal power if it is to be effective. On the other hand, position power is needed if organisational rewards (for e.g. promotions, recognition rewards) are being utilized. The best way to ensure the development and maintenance of adequate morale

is to build in rewards and recognitions for it. Nothing will replace the director who is sensitive and aware of the volunteer and who gives him public praise for a job well done.

Since praise is low cost and often a highly effective reinforcer, the supervisor must develop the competency to give it effectively. Almost all volunteers will respond favourably to receiving praise. It is an exceedingly effective tool in the crisis centre, since the volunteers often get little, if any feedback, from the job itself. The effectiveness of other rewards in improving a volunteer's motivation are often situation-specific and have to be assessed as appropriate by the staff members of the crisis centre.

This strategy is most obviously not appropriate for volunteers whose job performance requires immediate change; such as those who have already been identified as risks of the "burn-out" syndrome. More immediate help has to be offered there.

2) Effective discipline and punishment

While the supervisor may use personal power in conjunction with this strategy, it is specifically not recommended. An expression of personal displeasure is both appropriate and effective, but it must refer to a volunteer's behaviour, not to his personality. Primary weight is given to the use of position power when using discipline and punishment. From the power position alone, the supervisor can impersonally administer the negative organisational sanctions which this strategy may require.
"However, just because the staff maintain the directorate role, there is no reason for them to give up being understanding, sensitive and concerned. Similarly, just

because a volunteer is giving time freely, there is no reason to assume that he gives up his need for structure direction and limit-setting. A perpetual morale problem among *volunteers may in fact* result from the unclear role relationship and role expectations between staff and volunteers." [68] (MacGee, 1974).

Volunteers who value their association with the crisis centre are likely to respond *better to discipline and* punishment than those who are dissatisfied, or nearly ready to terminate. Unhappily, these volunteers are more often at risk of burn-out and in need of the controls discipline imposes, than their colleagues. The threat that personal needs may be thwarted must be felt for this strategy to work.

3) Treating employees fairly

When a volunteer feels unfairly treated, the director may deal effectively with this problem by using position power to eliminate actual inequities. *Some personal qualities* and skills of the director are basic to deal successfully with a volunteer who feels unfairly treated. Chief among these are an empathic ability to sense the nature and the depth of the volunteer's felt inequity. The director has to employ his listening skills and empathise with the volunteer. Sometimes, it is necessary to persuade the *volunteer that the perceived inequity* does not exist, or is not as great as the volunteer feels it to be.

This strategy will be effective with volunteers who feel unfairly treated, but who also perceive their complaints to be "heard" and who see some changes *in the organisation in* consequence of their suggestions. The coordinating committee is an important tool in helping volunteers feel a part of the autonomous decision making process. This will

be further discussed in section (5). It will also work if the volunteer is rational and amenable to legitimate persuasion. The strategy is not workable however, with those volunteers who have an odd sense of what is fair. Those volunteers who always feel unfairly treated, no matter what, and those who refuse to accept a rational explanation.

4) Satisfying volunteer's needs

It must be remembered that volunteer crisis workers earn their living in a number of diverse occupations. In addition, they volunteer to work several hours per week as crisis centre counsellors. They are not paid for this and therefore do not rely on this work as a means of supporting themselves. Those who volunteer their time as crisis counsellors do so because of their dedication and interest in this work, as their chosen way of helping others (Hoff, 1978) [70]. Most volunteers claim that the experience is personally growth producing as well [71]. The work itself therefore, is an important means towards satisfaction for volunteers. However, volunteers needs can rarely be satisfied by the organization alone. In all helping situations, there are many circumstances beyond the helper's control. Volunteers are exposed almost exclusively to the negative sides of the people they work with. Patients do not come for counselling to talk about the positive parts of their lives. Rewards for the work as a volunteer are often few and not highly visible. "The volunteer probably entered the job with visions of a supportive institution, peopled with wise supervisors and cooperative patients. He may even have contemplated results and tangible proof of his ability to create a difference in people's lives ... If the volunteer has been looking for the kind of personal fulfillment he should be finding elsewhere, he will quickly begin to burn-out"

(Freudenberg, 1980) [72].

However, the combined position power and personal power of the director are of *substantial utility in this strategy*. The director needs position power to satisfy those needs of the volunteer which can only be satisfied using appropriate organizational resources. He also needs personal power to satisfy other needs of the volunteers, such as, recognition, praise, respect and approval from the leader.

Since this strategy in its simplest sense, consists of identifying the needs of the volunteer and then satisfying them, it follows that the ability to identify the volunteers' needs is the primary organizational skill involved. No substitute, in this context, exists for interpersonal *sensitivity and the ability to both identify*, and identify with, the needs of the volunteer.

This strategy works effectively whenever the needs of the volunteer and the need satisfiers which are available within the organization mesh together.

5) Setting up a coordinating committee to represent volunteers

McGee (1974) [73] notes that the primary issue which affects volunteer morale, is the question of role relationship between volunteers and paid staff. *The staff members* generally tend to feel that they run the centre service programme. Their greater familiarity with the individual cases, and with problems arising between the centre and other resources in the community makes it natural for the staff to see the need for changes in policy and procedures, or for the staff to feel more knowledgable about specific cases. *The staff* is clearly in a decision making role where administrative matters are concerned. It is very

easy to slip into the habit of making decisions which affect the lives of volunteers while they are in the office, without consulting the volunteers first. Volunteers tend to resent this, they feel that they should make some of the decisions about their role in the programme [74].

McGee (1974) goes on to note that the volunteers need a "representative body", [75] that is, a coordinating body, which can function as a labour union, to negotiate with the staff for anything which would make the volunteer's time in the centre more pleasant. In its ideal state, the coordinating committee would become a channel of communication serving to create a forum for the staff to explore and explain issues for organizational changes. When the committee fully understands the rationale behind the changes, they could carry the message to the rest of the volunteers and interpret them for everyone's understanding. Of course, this would have to be a two-way process, and messages or requests from the volunteers to the staff would be interpreted similarly to the staff. The committee would therefore be both a channel and a method for including volunteers in the decision making process within the centre.

The only solution to the continuing dilemma over control over the centre is to make very certain that the staff runs the programme, but that the workers have a continuously functioning vehicle for adding their input to decision making.

The director must have the ability to utilize both personal and position power to develop an organizational strategy. This strategy should allow volunteers a forum for decision making, while also providing a place where questions can be raised, feelings can be expressed, anxieties and

ambiguities can be reduced and the staff can reveal that they are truly interested in the volunteers who are performing a *service*. *The director has* to facilitate integrative employee goal setting, and the translation of these goals into objectives and plans. A final attribute necessary is the ability to evaluate the progress of programmes and to facilitate remedial action when objectives are not met.

For the coordinating committee to be successful, volunteers *must feel that they have* a certain amount of autonomy in the decision making process. Those volunteers who are unwilling to see the service they render as a part of a larger organizational context, *are particularly at risk in* this strategy.

6) Rotating duties

Successful implementation of this strategy requires sufficient position power to make meaningful changes in the structure of volunteers jobs. While personal power is not *absolutely essential* to the success of this strategy, directors who lack personal power are likely to meet initial resistance when they suggest that jobs be redesigned. They will be suspected of *expanding work*, rather than enriching it. For example, if a number of preventative programmes are being established (i.e. researched) and implemented simultaneously, volunteers can be given an opportunity to rotate their duties, and in turn to experience the challenge of esta lishing new programmes, as well as contributing through counselling on already established programmes. A roster of rotation can be *developed by the coordinating committee*. In addition, the roster should allow for a specific number of days per year vacation. Freudenberger (1980) notes that the patient population seen by volunteers "require continual giving and

assume an endless supply on the part of the volunteer. Unless the [volunteer] worker remains aware of *his* limitations as a human being, he will begin to burn-out. And once he does, the conditions of the job will speed him on his way" [76].

The primary skill required by the director for successfully *implementing this strategy* is the ability to creatively determine how a job can be restructured in a way that truly enriches it.

This strategy is usually effective when the volunteers involved in the job rotation effort have high needs for esteem and self-realization, meaning they want to grow in their jobs, and develop their potential to the fullest. Volunteers who are content working in their present counselling positions, who do not trust the coordinating committee and who see the attempt at job rotation as an attempt at job enlargement will respond least favourably to this strategy.

7) Basing rewards on job performance

Due to the fact that the crisis centre workers volunteer to work at the centre several hours a week and are not paid for the task, this strategy requires that a director have sufficient positional power to give institutional rewards to volunteers who perform well and to withold rewards from those volunteers whose job performance is unsatisfactory. Personal power is also involved here, since it is the promise of reward (expectation), not the reward itself which precedes performance. The volunteer must trust that the system of rewards for performance will be implemented, and this trust is attached to the director.

Three organizational skills are necessary for this

strategy. First, the director must be aware of the job performance of all the volunteers, via the supervisory body. Secondly, he must adopt at giving rewards in a way that *encourages* all volunteers to improve their performance, or to maintain a high level of performance. Finally, the director must have the ability to accomplish these tasks while preserving the feeling among volunteers that they are all being treated fairly.

Again, the primacy skill required by the director for successfully implementing this strategy, is the ability to creatively determine which rewards will be meaningful for his volunteer workers. Examples of such rewards could be promotion to a supervisory position, the chance to serve on the coordinating committee as a volunteer-representative, *or even the chance* to head the volunteer workers on a new educational or preventative programme being planned.

Clearly, the volunteers in the organization who are high achievers and goal orientated will benefit most from this strategy. In addition, *this strategy will be successful* with those volunteers of medium and even low levels of skill who are capable of improving their performance and who want to attain the rewards given to high performers.

Selecting the strategy and summary

The contingency approach to improving volunteer motivation often needs to compromise in selecting a motivational strategy. The theoretically ideal approach may in fact be practically undesirable or impossible. More specifically, the approach states that the success of a strategy is contingent upon three major factors:

1) The particular properties of each of the motivational skills,

2) The leaders power (personal and positional) and critical skills.

3) The personality characteristics of subordinates. When choosing a motivational strategy, the director will want to consider each of the above carefully. Often, a director may be wise to use a combination of the different strategies; major aspects of many strategies can be combined quite easily and often quite effectively. To illustrate, parts of the strategy, (treating people fairly) can be readily combined with all of the other six approaches. In fact, doing so typically enhances the effectiveness of the other strategies. In summary, parts of each of the strategies can and should be used in combination with parts of all the other strategies.

C. IMPLICATIONS FOR FURTHER RESEARCH AND RECOMMENDATIONS

As has already been noted, the results of the present study indicated that neither the perceived social support from family, nor the perceived social support from friends were significant in predicting the variable, tenure. Therefore, a model of motivational strategies was proposed which places the major source of support, or alternatively the major source of burn-out, within the crisis centre itself. The next stage of research in this area would appear to be the testing of the model proposed in section B.

In order to test this model a specific type of experimental methodology is required. Christensen (1980) [77] suggests a form of evaluation specifically designed to examine the validity of social or human service programmes, namely "evaluation research". Evaluation research is defined as "an attempt to employ [the] basic scientific methodology in the assessment of social programmes, so as to provide an empirical basis for the utility of these programmes. (Christensen, 1980, p.273) [78]. Freeman (1977) [79] described

evaluation research as consisting of process evaluation and impact or summative evaluation. An examination of the specific nature of these two types of evaluation research follow.

a) Process evaluation

The primary issue of concern in process evaluation is whether or not the model was *implemented in the manner* dictated in its stated guidelines. Process evaluation may *precede or run concurrently* with any subsequent evaluation activity.

Freeman (1977) [80] states that the model can be most effectively evaluated if the specific aspects of the model are operationally defined. Thus, each of the strategies has to be transformed into a research question. The research question has to address the task of determining whether or not the goal of increasing motivation was met. To illustrate, a single strategy, namely, the setting up of a coordinating committee to represent volunteers will be utilized to offer a suggestion of the process of the evaluation procedure. The hypothesis *suggests that setting up a* coordinating committee to represent volunteers will *significantly increase motivation, as* it will serve to increase the feeling of support the volunteers *experience from the staff* members.

There are typically two methods by which process data is collected for the initial phase of evaluation (Freeman, 1977) [81]. The first procedure is observational and entails keeping a record of the manner in which the strategy has been implemented. The researcher has to note the structure of the coordinating committee, that is the number, as well as

the functions of each of its members. In addition, the process by which volunteers are selected or elected to serve on this body have to be noted. The second procedure entails interviewing all the volunteers who participated in the programme, as well as the staff who implemented the programme, to obtain their accounts of the function and utility of the coordinating committee, if any.

The most important issue in process evaluation is deciding whether or not the programme represented a sufficient realization of the theoretical model, even though it was modified to meet the unique needs of the specific crisis centre. In addition, the observations and interviews serve an important exploratory function. Pertinent statements and referents are recorded for later use.

b) Impact or summative evaluation

Impact or summative evaluation has as its goal the determination of whether or not the implemented programme had the desired and predicted effect. Impact or summative evaluation rests on the assumption that there is a prespecified goal (namely, the implementation of a coordinating committee to increase the support within the crisis centre), and that there is a criterion of success or impact, that the programme attempts to achieve, (namely the reduction of the burn-out rate among the volunteers). The impact evaluation will of necessity be an ex post facto research design. The main weaknesses being the fact that direct control is not possible. Neither experimental manipulation of the independent variable nor random assignment can be used by the researcher. Since the volunteers are all working at a crisis centre

where the motivational strategy under study is part of a broader model of operation, it is not possible to assign the volunteers to groups, at random, or to assign treatments to groups at random. The volunteers have already "self-selected" on the basis of their working at the specific crisis centre where the model is being operationalised.

However, although there are dangers in the erroneous interpretation of the data in ex post facto designs, the conclusion that these designs are inferior to experimental designs is unwarranted [82]. Thus, despite the weaknesses of ex post facto designs, controlled inquiry is still possible, even if true experimentation is not. The value of these designs lie i· their appropriateness for studyi..g the impact of a strategy in a lifelike setting.

To return to the example, namely the development of a coordinating committee as a strategy to increase motivation, a field experiment by Coch and French [83] can be utilized as an example of a similar ex post facto design. The broad hypothesis tested was that the independent variable, participation in planning, had an effect on the dependent variable, resignations. Factory workers from two different factories were compared, where the experimental group participated in discussion and decision making procedures by means of a representative body, whereas the control group did not have any participation in the decision making process. Similarly, while the volunteers had all by necessity been part of a strategy, similar to that of the experimental group in the Coch and French experiment [84], a control group of volunteers could be tested from another crisis centre. While it may not be possible to match each volunteer in the experimental group, with a

similar volunteer in the control group, it would be quite possible to match the experimental crisis centre and the control crisis centre on such factors as catchment area and the more basic organizational strategies (that is the community mental health model on which the centre operations are based).

It is important to note that the testing of each of the individual motivational strategies will have to be done individually, simultaneously to the implementation of the programme. Each strategy will have to be implemented and then tested for its effectiveness, before the next stage of implementation and testing of the next strategy can be commenced. In this way, the relative significance of each strategy can be assessed, without the interference of the other strategies as possible extraneous variables.

Once the programme has progressed through this developmental stage and has acquired some stability in terms of the way it is run, the focus can be directed at a global assessment of the goal of the theoretical model, namely, the increase of motivation and subsequent decrease in burn-out among the volunteers. This will necessitate the development of a further evaluation research procedure, which could possibly compare and rank in order of importance, strategies which were identified as being significant in the development stage of the research.

APPENDIX A

PSS-Fr and PSS-Pa Scales

Directions : The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with friends. For each statement there are three possible answers : Yes, No, Don't know. Please circle the answer you choose for each item.

Yes	No	Don't know	1.	My friends give me the moral support I need.
Yes	No	Don't know	2.	Most other people are closer to their friends than I am.
Yes	No	Don't know	3.	My friends enjoy hearing about what I think.
Yes	No	Don't know	4.	Certain friends come to me when they have problems or need advice.
Yes	No	Don't know	5.	I rely on my friends for emotional support.
Yes	No	Don't know	6.	If I felt that one or more of my friends were upset with me, I'd just keep it to myself.
Yes	No	Don't know	7.	I feel that I'm on the fringe in my circle of friends.
Yes	No	Don't know	8.	There is a friend I could go to if I were just feeling down, without feeling funny about it later.
Yes	No	Don't know	9.	My friends and I are very open about what we think about things.
Yes	No	Don't know	10.	My friends are sensitive to my personal needs.
Yes	No	Don't know	11.	My friends come to me for emotional support.
Yes	No	Don't know	12.	My friends are good at helping me solve problems.

Yes No Don't know 13. I have a deep sharing relationship with a number of friends.

Yes No Don't know 14. My friends get good ideas about how to *do things or make things from me.*

Yes No Don't know 15. When I confide in friends, it makes me feel uncomfortable.

Yes No Don't know 16. My friends seek me out for companionship.

Yes No Don't know 17. I think that my friends feel that I'm good at helping them solve problems.

Yes No Don't know 18. I don't have a relationship with a friend that is as intimate as other people's relationships with friends.

Yes No Don't know 19. I've recently gotten a good idea about how to do something from a friend.

Yes No Don't know 20. I wish my friends were much different.

Directions : The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with their families. For each statement there are three possible answers : Yes, No, Don't know. Please circle the answer you choose for each item.

Yes No Don't know 1. My family give me the moral support I need.

Yes No Don't know 2. I get good ideas about how to do things or make things from my family.

Yes No Don't know 3. Most other people are closer to their family than I am.

Yes No Don't know 4. When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.

Yes No Don't know 5. My family enjoys hearing about what I think.

Yes No Don't know 6. Members of my family share many of my *interests.*

Yes No Don't know 7. Certain members of my family come to me when they have problems or need advice.

Yes No Don't know 8. I rely on my family for emotional support.

Yes No Don't know 9. There is a member of my family I could go to if I were just feeling down, without feeling funny about it.

Yes No Don't know 10. My family and I are very open about what we think about things.

Yes No Don't know 11. My family is sensitive to my personal needs.

Yes No Don't know 12. Members of my family come to me for emotional support.

Yes No Don't know 13. Members of my family are good at helping me solve problems.

Yes No Don't know 14. I have a deep sharing relationship with a number of members of my family.

Yes No Don't know 15. Members of my family get good ideas about how to do or make things from me.

Yes No Don't know 16. When I confide in members of my family, it makes me uncomfortable.

Yes No Don't know 17. Members of my family seek me out for companionship.

Yes No Don't know 18. I think that my family feels that I'm good at helping them solve problems.

Yes No Don't know 19. I don't have a relationship with a member of my family that is as close as other people's relationships with family members.

Yes No Don't know 20. I wish my family were different.

NOTES

1. Caplan, G. An Approach to Community Mental Health, New York : Grune and Stratton, 1961.

2. Parad, H.J. ed. Crisis Intervention : Selected Readings, New York : Family Service Association of America, 1965.

3. Thomas, G.S. and Weisman, G.K. "Emergency Planning : The Practical and Theoretical Backdrop to an Emergency Unit". Int J Soc Psychiatry, 16 : 283-287, 1970.

4. MacGee, R. Crisis Intervention in the Community, Baltimore, Md : University Park Press, 1974.

5. Allport, G.W. Pattern and Growth in Personality, 2nd Edition, New York : Holt, Rhinehart and Wissenshaw, 1961.

6. Maslow, A. Motivation and Personality, 2nd Edition, New York : Harper and Row, 1970.

7. Erikson, E. Childhood and Society, 2nd Edition, New York : W.W. Norton and Company Inc, 1963.

8. Freud, S. "Mourning and Melancholia" in Collected Papers, IV, London : Hogarth Press, 1925.

9. Hoff, L.A. People in Crisis - Understanding and Helping, Addison Wesley Publishing Co, 1978, p. 8.

10. Small, L. The Briefer Psychotherapies, New York : Brunner and Mazel Publishers, 1971.

11. Jacobson, G.F., Strickler, M. and Morley, W. "Generic and Individual Approaches to Crisis Intervention", Am J of Public Health, 58 : 338-343, 1968.

12. Caplan, G. and Grunebaum, H. "Perspectives on Primary Prevention, A Review", Arch of Gen Psych, 17 : 331-346, 1960.

13. Caldwell, J.M. "Military Psychiatry" in *Comprehensive Textbook of Psychiatry* (A.M. Freedman, H.I. Kaplan, H.S. Kaplan, eds), Baltimore : William and Wilkins, 1967.

14. Glass, A.J. "Psychotherapy in the Combat Zone", Am J of Psychiatry, 110 : 725-731,1954.

15. Caldwell, J.M. "Military Psychiatry" in Comprehensive Textbook of Psychiatry (A.M. Freedman, H.I. Kaplan, H.S. Kaplan, eds), Baltimore : William and Wilkins, 1967.

16. Lindemann, E. "Symptomatology and Management of Acute Grief", Am J of Psychiatry, 101 : 141-148, 1944.

17. Kaplan, D.M. and Mason, E.A. "Maternal Reactions to Premature Birth Viewed as an Acute Emotional Disorder", Am J of Orthopsychiatry, 30, 1960.

18. Janis, I.L. Psychological Stress; Psychoanalytical and Behaviour Studies of Surgical Patients, New York, Wiley, 1958.

19. Caplan, G. An Approach to Community Mental Health, New York : Grune and Stratten, 1961.

20. Tyhurst, J.S. "The Role of Transition States - Including Disasters - in Mental Illness", Symposium on Preventive and Social Psychiatry, Walter Reed Army Institute of Research and The National Research Council, Washington D.C.

21. Evaluation Criteria for the Certification of Suicide Prevention and Crisis Intervention Programmes, Prepared by the Committee on Certification, The American Association of Suicidology, 1961.

22. Tyhurst, J.S. "The Role of Transition States - Including Disasters - in Mental Illness", Symposium on Preventive and Social Psychiatry, Walter Reed Army Institute of Research and The National Research Council, Washington D.C., 1957.

23. MacGee, K. Crisis Intervention in the Community, Baltimore : University Park Press, 1974.

24. "Criteria for Defining Community Mental Health Centers' *Emergency Services*", *Bulletin of Suicidology*, National Institute of Mental Health, 1971.

25. Evaluation Criteria for the Certification of Suicide Prevention and Crisis Intervention Programs. Prepared by Committee on Certification, The American Association of Suicidology, 1976.

26. Motto, J., Brooks, R., Ross, C. and Allen, N. Standards for Suicide Prevention and Crisis Centers, New York : Behavioural Publications, 1974.

27. Kaplan, D.M. and Mason, E.A. "Maternal Reactions to Premature Birth Viewed as an Acute Emotional Disorder", Am J of Orthopsychiatry, 30, 1960.

28. Freud, S. "Mourning and Melancholia" in Collected Papers IV, London : Hogarth Press, 1925.

29. *Fenichel*, O. The Psychoanalytic Theory of Neurosis, New York : W.W. Norton Co., 1945.

30. Halliday, J.L. "Principles of Aetiology", Brit J of Med Psychol, 19, 1943.

31. Jacobson, G.F. "Crisis Theory and Treatment Strategy : Some Sociocultural and Psychodynamic Considerations", Journal of Nerv Mental Dis, 141, 1965.

32. Lieb, J. A History of Crisis Intervention" in The Crisis Team : A Handbook for the Mental Health Professional, New York : Harper and Rav, 1980, p.5.

33. Erikson, E. Childhood and Society, New York : W.W. Norton and Co, 1950.

34. MacGee, R. Crisis Intervention in the Community, Baltimore : University Park Press, 1974, p. 212.

35. Caplan, G. An Approach to Community Mental Health, New York : Grune and Stratton, 1961.

36. Ibid.

37. Caplan, G. Support Systems and Mutual Help, New York : Grune and Stratton, 1974.

38. Ibid.

39. Caplan, G. Principles of Preventive Psychiatry, New York : Basic Books, 1964.

40. Jahoda, M. Research Methods in Social Relations, New York : Dryden, 1958, p. 7.

41. Jacobson, G., Strickler, M. and Morley E. "Generic and Individual Approaches to Crisis Intervention", Am J of Public Health, 58 : 339-342, 1968.

42. Barbonne, A. "Crisis : A Review of Theory, Practice and Research", Int J of Psychiatry, 6 : 371-379, 1968.

43. Lieb, J. The Crisis Team : A Handbook for the Mental Health Professional, New York : Harper and Row, 1980.

44. MacGee, R. "The Non-professional Volunteer Crisis Worker" in Crisis Intervention in the Community, Baltimore : University Park Press, 1974.

45. Ibid., p. 227.

46. Ibidem., p. 228.

47. Different groups of subjects (sample groups of 70, 80 and 90 respectively), served as the final "scale construction" sample. From an original pool of 94 items, generated by the authors to reflect instances of provision of support,

information or feedback, as well as some instances of support reciprocity, an intermediate pool of 35 items was selected according to the magnitude of the correlations between the item and the scale total (minus that item). This set of 35 items constituted a preliminary version of a Perceived Social Support Measure and was found to possess both high test-retest reliability (r + 83 over a one-month interval) and internal consistency (Cronback x = .90). Each of the 35 items was duplicated to refer to friends and family. Then both the PSS-Fa and PSS-Fr scales were reduced to 20 items each, again according to the magnitude of the item correlation. Separate factor analysis with orthogonal factor rotation indicated that each scale was composed of a single factor, as would be expected from the method of final item selection and internal consistency.

48. Procidano, M.E. and Heller, K. Measures of Perceived Social Support from Friends and from Family. Three Validation Studies, America, J of Community Psychology, Vol. 11, No. 1, 1983.

49. Ibid., p. 2.

50. Kerlinger, F.N. Foundations of Behavioural Research, New York : Hdt, Rhinehart and Winston Inc, 1973, p. 279.

51. Lachenbruch, P. Discriminant Analysis, New York : Hafner, 1978, p. 27.

52. Klecka, W.R. Discriminant Analysis, Beverley Hills : Sage, 1980, p. 37.

53. Jahoda, M. Research Methods in Social Relations, New York : Dryden, 1958, p. 69.

54. Larson, C.G., Gilbertson, D.L. and Powell, J.A., "Therapeutic Burn-out : Perspectives on a critical issue", Social Casework, 59 (1978) p. 563-565.

55. Freudenberger, H.J. "The staff burn-out syndrome in alternative institutions", Psychotherapy : Theory, Research and Practice, 12, (1975), 73-82.

56. Maslach, C., "The Client Role in Staff Burn-out", Journal of Social Issues, 34, 1978, p. 111-124.

57. Pines, A. and Maslach, C., "Characteristics of Staff Burn-out in Mental Health Settings", Hospital and Community Psychiatry, 29, 1978, p. 233-237.

58. Ibid., p. 233.

59. Freudenberger, H.J. "Staff Burn-out", Journal of Social Issues, 30, 1974, p. 159-165.

60. Shubin, S. "Burn-out : The Professional Hazard You Face in Nursing", Nursing, 1978, 8, No. 7, p. 22-27.

61. Maslach, C. "Burned-Out", Human Behaviour, 5, no. 9, (1976) p. 16-22.

62. Ibid., p. 16.

63. Maslach, C. "Job Burn-out : How People Cope", Public Welfare, 36, no. 2 (1978) p. 56-58.

64. Burgess, A.W. and Baldwin, B.A. Crisis Intervention in Theory and Practice, Prentice Hall Inc., 1981, p. 15-19.

65. Hoff, L.A. People in Crisis : Understanding and Helping, Addison Wesley Publ. Co. 1978 p. 253.

66. McGee, R. "The Non Professional Volunteer Crisis Worker" in Crisis Intervention in the Community, Baltimore University Park Press, 1974, p. 230.

67. McGee, B. and Poffenberger, W. Productivity Strategies, New Jersey : Prentice Hall Inc., 1982, p. 219.

68. Ibid. p. 220.

69. McGee, R. "The Non Professional Volunteer Crisis Worker" in Crisis Intervention in the Community, Baltimore : University Park Press, 1974, p. 231.

70. Hoff, L.A. People in Crisis : Understanding and Helping Addison Wesley Publ. Co., 1978, p. 256.

71. Ibid., p. 256.

72. Freudenberger, H. Burn-out, London : Arrow Books, 1980, p. 153.

73. McGee, R. "The Non Professional Volunteer Crisis Worker" in Crisis Intervention in the Community, Baltimore : University Park Press, 1974, p. 227.

74. Ibid., p. 227-228.

75. Ibid., p. 228.

76. Freudenberger, H. Burn-out, London : Arrow Books, 1980, p. 159.

77. Christensen, L.B. Experimental Methodology, Boston, Allyn and Co. Inc. 1980, p. 273.

78. Ibid., p. 273.

79. Freeman, H.E. "The Present Status of Evaluation Research", in Evaluation Studies Annual Review, edited by M. Guttenberg. Beverley Hills : Sage Publications, 1970, p. 63.

80. Ibid., p. 63.

81. Ibid., p. 64.

82. Kerlinger, F.N. Foundations of Behavioural Research, New York : Holt, Rhinehart and Winston Inc., 1973, p. 390.

83. Coch, L. and French, J. "Overcoming Resistance to Change" Human Relations, I, (1948) p. 512-532.

84. Ibid., p. 512-532.

BIBLIOGRAPHY

Allport, G.W. — *Pattern and Growth in Personality*, 2nd Ed, New York : Hart, Rhinehart and Winston, 1961.

Burgess, A.W. and Baldwin, B.A. — Crisis Intervention in Theory and Practice, Prentice Hall Inc., 1981 p. 15-19.

Caldwell, J.M. — Military Psychiatry in Comprehensive Textbook of Psychiatry (A.M. Freedman, H.I. Kaplan, H.S. Kaplan, eds), Baltimore : Williams and Williams, 1967.

Caplan, G. — An Approach to Community Mental Health, New York : Grune and Stratton, 1961.

Caplan, G. — Principles of Preventive Psychiatry, New York : Basic Books, 1964.

Caplan, G. and Grunebaum, H. — *Perspective on Primary Prevention* : A Review, Arch of Gen Psych, 17, 1967.

Caplan, G. — Support Systems and Mutual Help, New York : Grune and Stratton, 1974.

Coch, L. and *French, J.* — "Overcoming Resistance to Change" Human Relations, I, 1948.

Christensen, L.B. — Experimental Methodology, Boston : Allyn and Bacon Inc., 1980, p. 273.

"Criteria for Defining Community Mental Health Centres' Emergency Services" in Bulletin of Sociology, National Institute of Mental Health, 1971.

Darbonne, A. — Crisis : A Review of Theory, Practice and Research, Int J of Psychiatry, 1968.

Erikson, E. — Childhood and Society, New York : W.W. Norton Co., 1950.

"Evaluation Criteria for the Certification of Suicide Prevention and Crisis Intervention Programmes", Prepared by the Committee on Certification, The American Association of Suicidology, 1961.

Farberow, N. — The selection and training of non-professional personnel for the therapeutic role *in suicide prevention.* Presented at the meeting of the South Eastern Psychological Association, New Orleans, 1966.

Fenichel, O. — The Psychoanalytic Theory of Neurosis, New York : W.W. Norton Co., 1945.

Freeman, H.E. — The Present Status of Evaluation Research. In Evaluation Studies Annual Review, edited by M. Guttenberg, Beverley Hills : Sage Publications, 1977.

Freud, S. — "Mourning and Melancholia" in Collected Papers IV, London : Hogarch Press, 1925.

Freudenberger, H.J. — "The Staff Burn-out" Journal of Social Issues, 30, 1974, p. 159-165.

Freudenberger, H.J. — "The Staff Burn-out Syndrome in Alternative Institutions" Psychotherapy : Theory, Research and Practice, 12, (1975), 73-82.

Freudenberger, H.J. — Burn-out, London : Arrow Books, 1980.

Glass, A.J. — "Psychotherapy in the Combat Zone", Am J of Psychiatry, 110, 1954.

Halliday, J.L. — "Principles of Aetiology", Brit J Med Psychol, 19, 1943.

Heilig, S.M. — "Manpower Utilization of Non-Professional crisis workers". In R.K. McGee (ed.), Planning Emergency Services for Comprehensive Community Mental Health Centres, University of Florida, Dept of Clinical Psychology, Gainesville, Florida, 1967.

Hoff, L.A. — People in Crisis : Understanding and Helping, Addison Wesley Publishing Co., 1978.

Jacobson, G.F. — "Crisis Theory and Treatment Strategy. Some Sociocultural and Psychodynamic considerations", J Nerv Mental Dis, 141, 1965.

Jacobson, G., Strickler, M., Morley, E. — "Generic and Individual Approaches to Crisis Intervention", American Journal of Public Health, 58, 1968.

Jahoda, M. — Research Methods in Social Relations, New York : Dryden, 1958.

Janis, I.L. — Psychological Stress : Psychoanalytic and Behavioural Studies of Surgical Patients, New York : Wiley, 1958.

Kaplan, D.M. and Mason, E.A. "Maternal Reactions to Premature Birth Viewed as an Acute Disorder", Am J of Orthopsychiatry, 30, 1960.

Kerlinger, F.N. Foundations of Behavioural Research, New York : Holt, Rhinehart and Winston Inc. 1973.

Klecka, W.R. Discriminant Analysis, Beverley Hills : Sage, 1980.

Lachenbruch, P. Discriminant Analysis, New York : Hafner, 1978.

Larson, C.G., Gilbertson, D.L., Powell, J.A. "Therapeutic Burn-out. Perspectives on a critical issue", Social Casework, 59, (1978) p. 563-565.

Lieb, J. The Crisis Team, New York : Harper and Row, 1973.

McGee, B., Poffenberger, W. Productivity Strategies, New Jersey : Prentice Hall Inc, 1982.

MacGee, R.K. Crisis Intervention in the Community, Baltimore : University Park Press, 1974.

Maslach, C. "Burned-Out" Human Behaviour, 5, no. 9, (1976) p. 16-22.

Maslach, C. "The Client Role in Staff Burn-out" Journal of Social Issues, 34, 1978a, p.111-124.

Maslach, C. "Job Burn-out. How People Cope", Public Welfare, 36, no.2 (1978b) p. 56-58.

Maslow, A. Motivation and Personality, 2nd Edition, New York : Harper and Row, 1970.

Motto, I., Brooks, R., Ross, C. and Allen, N. Standards for Suicide Prevention and Crisis Centres, New York : Behavioural Publications, 1974.

Parad, H.J. (ed.) Crisis Intervention - Selected Readings, New York : Family Services Associations, 1965.

Pines, A. Maslach, C. "Characteristics of Staff Burnout in Mental Health Settings" Hospital and Community Psychiatry, 29, 1978, p. 233-237.

Siegel, S. Nonparametric Statistics.

Small, L. — The Briefer Psychotherapies, New York : Brunner and Mazel Publishers, 1971.

Thomas, C.S. and Weisman, G.K. — "Emergency Planning : The Practical and Theoretical Backdrop to an Emergency Treatment Unit", Int J Soc Psych, 16, 1970.

Tyhurst, J.S. — "The Role of Transition States - Including Disasters - in Mental Illness". Symposium on Preventive and Social Psychiatry, Walter Reed Army Institute of Research and the National Research Council, Washington D.C., 1957.

Hoff, L.A. — People in Crisis : Understanding and Helping, Addison Wesley Publishing Co., 1978.

Jacobson, G.F. — "Crisis Theory and Treatment Strategy. Some Sociocultural and psychodynamic considerations", J Nerv Mental Dis, 141, 1965.

Jacobson, G., Strickler, M., Morley, E. — "Generic and Individual Approaches to Crisis Intervention", American Journal of Public Health, 58, 1968.

Jahoda, M. — Research Methods in Social Relations, New York : Dryden, 1958.

Janis, I.L. — Psychological Stress : Psychoanalytic and Behavioural Studies of Surgical Patients New York : Wiley, 1958.

Kaplan, D.M. and Mason, E.A. — "Maternal Reactions to Premature Birth Viewed as an Acute Emotional Disorder", Am J of Orthopsychiatry, 30, 1960.

Kerlinger, F.N. — Foundations of Behavioural Research, New York : Holt, Rhinehart and Winston Inc., 1973.

Klecka, W.R. — Discriminant Analysis. Beverley Hills : Sage, 1980.

Lachenbruch, P. — Discriminant Analysis, New York : Hafner, 1978.

Lieb, J. — The Crisis Team, New York : Harper and Row, 1973.

MacGee, R.K. — Crisis Intervention in the Community, Baltimore : University Park Press, 1974.

Maslow, A. — Motivation and Personality, 2nd Edition, New York : Harper and Row, 1970.

Motto, I., Brooks, R., Ross, C. and Allen, N. — Standards for Suicide Prevention and Crisis Centres, New York : Behavioural Publications, 1974.

Parad, H.J. (ed.) — Crisis Intervention - Selected Readings, New York : Family Services Associations, 1965.

Shubin, S. — "Burn-out : The Professional Hazard You Face in Nursing", Nursing, 1978, 8, no.7, p.22-27.

Siegel, S. — Nonparametric Statistics.

Small, L. — The Briefer Psychotherapies, New York : Brunner and Mazel Publishers, 1971.

Thomas, C.S. and Weisman, G.K. — "Emergency Planning : The Practical and Theoretical Backdrop to an Emergency Treatment Unit", Intl J Soc Pscyh, 16, 1970.

Tyhurst, J.S. — "The Role of Transition States - Including Disasters - in Mental Illness". Symposium on Preventive and Social Psychiatry, Walter Reed Army Institute of Research and the National Research Council, Washington D.C., 1957.



Author Brady Lynette
Name of thesis Volunteers As A Resource In Community Psychology. 0

PUBLISHER:
University of the Witwatersrand, Johannesburg
©2013

LEGAL NOTICES:

Copyright Notice: All materials on the University of the Witwatersrand, Johannesburg Library website are protected by South African copyright law and may not be distributed, transmitted, displayed, or otherwise published in any format, without the prior written permission of the copyright owner.

Disclaimer and Terms of Use: Provided that you maintain all copyright and other notices contained therein, you may download material (one machine readable copy and one print copy per page) for your personal and/or educational non-commercial use only.

The University of the Witwatersrand, Johannesburg, is not responsible for any errors or omissions and excludes any and all liability for any errors in or omissions from the information on the Library website.