

## Introduction

Mental illness as defined by the American Psychiatric Association is an "illness that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves, and interacts with other people" and affects about 20% of the American population (Surgeon General, 1999) with similar rates worldwide (WHO, 2001). In its more severe forms, mental illness is "accompanied by significant functional impairment, disruption of normal life tasks, periods of hospitalization, and need for psychotropic medication" (American Psychiatric Association, 2004) and affects around 2.6% of the population (Surgeon General, 1999).

Mental illness, especially in its severe forms, has various high-impacting consequences on people that suffer from it, the main ones being low self-esteem and what has been defined as "existential loneliness" (Nystrom, Dahlberg, & Segesten, 2002). Low self-esteem can be due to past episode behaviours (Hayward, Wong, Bright, & Lam, 2002), labeling subsequent to diagnosis (Lai, Hong, Chee, 2001) and residual reduced functioning (Gunatilake, Ananth, Parameswaran, Brown, Silva, 2004). Existential loneliness stems from physical isolation due to acute symptoms, social isolation due to consequences of symptoms (such as addiction, incarceration, homelessness, low income status) and cultural isolation that produces stigma, which in turn affects self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), acceptance of the illness, treatment adherence and functioning (Dinos, Stevens, Serfaty, Weich, & King, 2004). Stigma can however milder or more severe, varying from a label to another (Angermeyer & Matschinger, 2003) and being strongly related to culture (Angermeyer, Buyantugs, Kenzine, & Matschinger, 2004). Different cultures stigmatize people with mental illness for different reasons (Ng, 1997; Papadopoulos, Leavey, & Vincent, 2002; Al-Adawi et al., 2002). When internalized, stigma correlates positively with depressive symptoms, and negatively with self-esteem, empowerment and recovery orientation (Ritsher, Otilingam, & Grajales, 2003). Perception of stigma also is important, in that persons perceiving to be stigmatized tend to have more severe symptoms

(Ertugrul & Ulug, 2004).

There are different kinds of severe mental illnesses, depending on degree of functional impairment and disruption of normal life, requirement of hospitalizations or need for medications (American Psychiatric Association, 2004). Though schizophrenia tends to have the worst outcome (Harrow, Sands, Silverstein, & Goldberg, 1997), all of these illnesses have a range of possible outcomes, which spans from psychiatric disability to residual symptoms (due to both illness and treatment) up to full recovery. In modern psychiatric rehabilitative tools, recovery is being targeted right from the start while in previous models the targeted outcome was maintenance. The reasons for this change are that recovery has been shown to happen much more often than previously believed (Harding, Brooks, Ashikaga, Strauss, Breier, 1987) and programs that are recovery-oriented right from the start improve the chance of recovery as desired outcome.

Volunteering has a positive effect on health in terms of increasing self-esteem and decreasing isolation (Graff, 1991) and according to Ellis (1994), it can be initiated to use skills previously acquired or as a wish fulfillment, both of them being very important psychiatric rehabilitative tools. In a study on volunteers with mental illness, Keys (1982) found out that they stayed in placement for an average of nine months and worked an average of 15 hours a week.

## Methods

We confronted findings in medical (MEDLINE) and psychological (psycINFO) literature to the ones on volunteering and structured those findings into two frameworks, one for volunteering and another for psychiatric rehabilitation. We then confronted these frameworks and discussed how volunteering can be used as a psychiatric rehabilitative tool and its possible limitations.

## Theoretical Framework

The target of any psychiatric rehabilitative intervention is recovery. There are many models (Jacobson, and indicators of this process (Harding, Brooks, Ashikaga, Strauss, Breier, 1987a; 1987b; DeSisto, Harding, McCormick, Ashikaga, Brooks, 1995a; 1995b). The model we find more suitable to the purpose of this paper sees the external conditions of recovery as composed of self-determination, empowering relationships, meaningful roles and elimination of stigma and discrimination (Burti & Guerriero, 2003). Indicators of recovery are being in a relationship, being part of the community and holding a job or volunteering (Stromwall & Hurdle, 2003). It is important to stress our how this set of indicators is less discriminating than those encompassing “being in a marriage”, thereby classifying all persons with non-mainstream orientations and values as “less in recovery” than others by default.

Psychiatry rehabilitation consists in teaching skills to people with severe mental illness so that they can counteract the low level of functioning the illness tends to stabilize them to. Traditional rehabilitation is associated with assertive community treatment and therapy maintenance (Philips et al, 2001), while newest forms are based on self-determination and empowerment (Anthony, 1993) or a mix of these two models (Kramer, Anthony, Rogers & Kennard, 2003). Problems to be solved by rehabilitative interventions are mainly about cognitive impairment and psychosocial functioning (MacDonald-Wilson, Rogers, Massaro, Lyass & Crean, 2002), thus the rehabilitative approach can be medical, psychological (Spivak, 1977; 1987), or psychosocial (Gasset et al., 2004). Limitations in the workplace are not specific but can be both emotional and cognitive, so situational assessments have to be performed (McDonald-Wilson et al, 2002). Work training is achieved by either vocational rehabilitation (Bond, 1992), rehabilitation rounds (Greig, Zito, & Bell, 2004) or supported employment (Moll, Huff, & Detwiler, 2003), the last one being the best evidence-based tool for this purpose (Mueser et al., 2004).

There isn't only one definition of psychiatric rehabilitation (Cnaan, Blankertz, Messinger, & Gardiner,

1990), but according to Barton (1999) its components are: skill training, peer-support, vocational (in term of individualized approach to training and support) and community resource development. Illness management is a skill that has to be included in the training (Mueser et al., 2004).

Volunteering is a process that encompasses motivation on the volunteers' side (Meneghetti, 1999) and professionalization on the managers' (Flynn & Feldheim, 2003). Even though there are six kinds of motivations (Clary, Snyder & Ridge, 1992; Clary, Snyder & Stukas, 1996), volunteers tend to be focused on two or three main reasons to serve, however they don't serve for only one reason (Van Til, 1988). Because of this, they have also been classified in four clusters, depending on where the focus of their motivations lays (Butler, Duffy, & Miller, 2002). The professionalization of volunteer managers pushed this field to adopt a minimum set of practices: screening, training, and ongoing management and support (Grossman & Furano, 1999). According to these practices, organizations select those volunteers who are most likely to be successful by providing individuals who already have the appropriate attitudes of the skills necessary to succeed. Through orientation and training these volunteers build the specific skills they need to be effective in that organization, meanwhile they get realistic expectations of what they can accomplish. Ongoing management and support of volunteers ensure that volunteer hours are not squandered, weak skills are strengthened, and volunteers are used most effectively. Brudney and Hager (2004), in a research for the Urban Institute, selected nine "best practices" for managing volunteers: screening, written policies and job descriptions, liability protection for volunteers, volunteer training, supervision and communication with volunteers, information on volunteer numbers and hours, recognition, measurement of volunteer impact, training for the staff working with volunteers. The Voluntary Sector National Training Organization [VSNTTO] (2003) identified a functional map of the management of volunteer process, which serves as a conceptual framework that hierarchically guides volunteer managers through implementing new programs. Among effective recruitment practices, McCurley (1995) distinguishes four types of approaches that can be

used: warm body, targeted, combining warm body and targeted, concentric circles. Volunteer management is also about assessing volunteers' work quality (through support, feedback and training), stimulating volunteers to start and accomplish their tasks as well as remember procedures, and having them interact with paid and unpaid staff, served people and supervisors.

On the other hand, volunteering is also about belonging to social networks and supervising is also about communication (National Crime Prevention Council's AmeriCorps Supervisory Training and Technical Assistance Project, 1996). Relationships and peers' role model (Frese & Davis, 1997; Mowbray & Moxley 1996) play a major role in any psychosocial rehabilitation model. Volunteers also benefit from helping people, according to the helper therapy theory (Riessman, 1965).

Managing volunteers could therefore be adapted to a rehabilitative framework and conceptualized as follows:

- illness management skill training: an educated supervisor helps volunteers gaining awareness and managing their illness;
- individualized approach to vocational support: the supervisor gives work training, in terms of both hard and soft skills, while supporting volunteers during the training itself;
- peer-support and social networks: other volunteers give support and social connections, supervised and proactively facilitated by the manager.

All of this highlights the importance of the supervisor/manager and of his/her managerial style. In fact, the trend toward volunteering as rehabilitation hasn't been received well in the past, and that happened mainly because of problems on the volunteer directors side (Weaver, 1993). This was presumably due to the lack of mental illness education as reflected from the absence of specific education in most volunteer management curricula.

## Conclusions

Volunteering and psychiatric rehabilitation frameworks actually overlap, proving how volunteering can be used as psychiatric rehabilitative tool. There are two main components in this process, motivation and management style.

Volunteer managers have to approach, discover and probe volunteers' self-motivation, using Deci's and Ryan's approach (1987), thereby paying attention to distinguish intrinsic from extrinsic motivation and committing to elicit and reward only (or at least mainly) the former. Intrinsic motivation was found to enhance self-determination and competence, two key characteristics of empowered persons.

Volunteer managers have to promote a management style that fosters autonomy and ability to choose, because they both enhance intrinsic motivation which leads to self-competence, which is a cross-generalizing property (Enzle, Wright, & Redondo, 1996). Also, task contingent rewards (Lepper, Greene and Nisbett, 1973) and controlling surveillance (Enzle and Anderson, 1993) have to be avoided because they are proven to diminish intrinsic motivation. Reconsidering actual recognition "best practices" is mandatory, because what is considered to be "best" for usual volunteers is not at all the best to this population. Since people more prone to attempt suicide are those more reward dependent (Engstrom, Brandstrom, Sigvardsson, Cloninger, & Nylander, 2004), volunteer managers recognition practices have to foster reward independence instead.

The second important point emerging from this paper is that volunteer managers should use Scheier's (1981) people approach, if they want to be effective at rehabilitating volunteers with mental illness. It consists in the belief that anybody has something to give and that volunteer managers are able to connect those "glad gives", in terms of desires and abilities, to community needs. In these settings, communication is important as well. Supervisor is a role that can be conceptualized as having two major components: problem analysis and decision making and communication (Brewer, 1995). The volunteer manager, as a supervisor, has a pivotal role in adopting an empowering approach as defined

by Jacobson (2000). This approach sometimes is not the most intuitive but is effective in empowering our volunteers with mental illness. For all these reasons, volunteer managers have to recognize and explore personal problems of volunteers with mental illness, resisting the temptation of hiding them in the attempt of “protecting” these volunteers. It is also better to help our volunteers to face and solve the problem(s) mentioned above. When required by the circumstances, change has to be encouraged and helped rather than not even asked and progresses have to be asked in small but constant steps. The latter is essential in generating self-efficacy (Bandura, 1994). Volunteer managers are called to face their own tendencies toward control and micromanaging, allowing volunteers to be in control of their own workload and workspace, as Scheier already suggested in his people approach (“give personal space to volunteers, allow them to define their work and how they deal with it”). Autonomy has to be encouraged and fostered in form of knowledge, self-confidence and availability of choice.

Responsibility has to be coached as well, in form of goal-setting, decision-making and self-care.

Volunteering also is about receiving training, either about work skills or soft skills or both, and many workplace accommodations can be borrowed and, when necessary, modified so to suite unpaid staff settings. Education about mental illness is particularly important for managers and supervisors, not just to understand accommodations, but also the rationale that lies behind it that enables them to think about possible new ones.

This approach requires a paradigm shift in our management practices that is just at its beginnings. It may take some time to find empirical validations on which ones among its possible implementations could be the more reliable and worthy advocating on larger scale.

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