STRENGTHENING THE VOLUNTEER VISITOR SUPPORT SYSTEMS IN EXTENDED HEALTH CARE SETTINGS: AN EDUCATIONAL INTERVENTION

BY

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MASTER OF SOCIAL WORK

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CHANGE, LOSS AND GRIEF

A Training Program for Volunteers Visiting Institutionalized Patients in Extended Health Care Settings

Designed and Compiled by:

Gen Henderson B.S.W.
June 1986

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I am especially grateful for having known and worked with the following volunteers: Alison, Brian, Elizabeth, Gerry, Germaine, Jake, Jeanette, Lee, Lorraine N., Lorraine S., Marion, Nelly and Wilma, without whom this project could not have been completed.

P R E F A C E

The following instructional package was designed for volunteer visitors working with the institutionalized patient in long-term facilities. The present and potential role volunteer visitors can play by virtue of their mandate is significant. The provision of social and emotional support through the informal helping system of volunteers indicates that this service is a largely untapped resource that awaits further development within the scope of health care delivery services.

The educational program for informal helpers has as its aim the goal of improving the quality of volunteer-patient relationships through knowledge/skills/attitude training. The sessions provide for greater self-awareness and thus pave the way for increased sensitivity and empathy for the patient. Communication/helping skills training further enhance the establishment of meaningful, supportive relationships.

As well-intentioned as an educational process is, the success of a training program is only as good as its participants. The volunteers who were involved in this pilot project taught me more than I could teach them. Their desire to learn more, to improve their own relationsips and their relationships with the patient, was exceeded only by their generosity, their willingness to risk and above all, their "from the heart" spirit. In this climate of learning, the teacher truly became the learner; the learners, teachers.

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Training Program Appendices

SESSION I

Aging

I Objectives

The participants will

- Gain an understanding of stereotypic attitudes to the elderly
- Increase awareness of the effects of social, psychological and behavioural changes in the aging process

II Agenda

- Welcome and REGISTRATION PACKAGE
- INTRODUCTION
- Get-Acquainted Exercise or ICEBREAKER
- VOLUNTEERISM: Community Building
- GROUND RULES for Workshop
- ATTITUDES TO THE ELDERLY - Brainstorming
- SOCIAL BREAKDOWN - Lecturette

  Coffee
- FILM - "Peege"
- Group Discussion
- Wrap-Up
- Evaluation

REGISTRATION PACKAGE

Purpose

To establish a positive learning climate

Registration Package or Kit for each participant, consisting of:

- A colourful folder with inside pockets
- Personalized name tags*
- Updated program outline
- Information sheet, map and brochures about the host institution
- Master list of participants with names, addresses, phone numbers
- Volunteer information: Manual, Volunteer Bureau** activities, pamphlets, tokens, pins and stickers
- Pen, pencil, writing pad
- Resource materials relevant to course content - for example

  Manitoba Senior Citizens' Handbook
  Age and Opportunity Service Pamphlets
  Council on Aging
- Handouts: relevant articles, newspaper articles, poems, etc. for self-learning
- Bibliography and suggested reading
- Any favourite items for a nice added touch to an attractive and desirable registration kit

* Personalized name tags can be incorporated in an "ice-breaker" activity. Participants can be asked to design their own name tags; then introduce themselves to each other and/or to the group. Creative name tags can provide a focal point for introduction.

** If the workshop is scheduled concurrently with Volunteer Week in Canada, pins, stickers, recognition tokens, activity bulletins, posters, etc. can be included in the registration kit.

INTRODUCTION

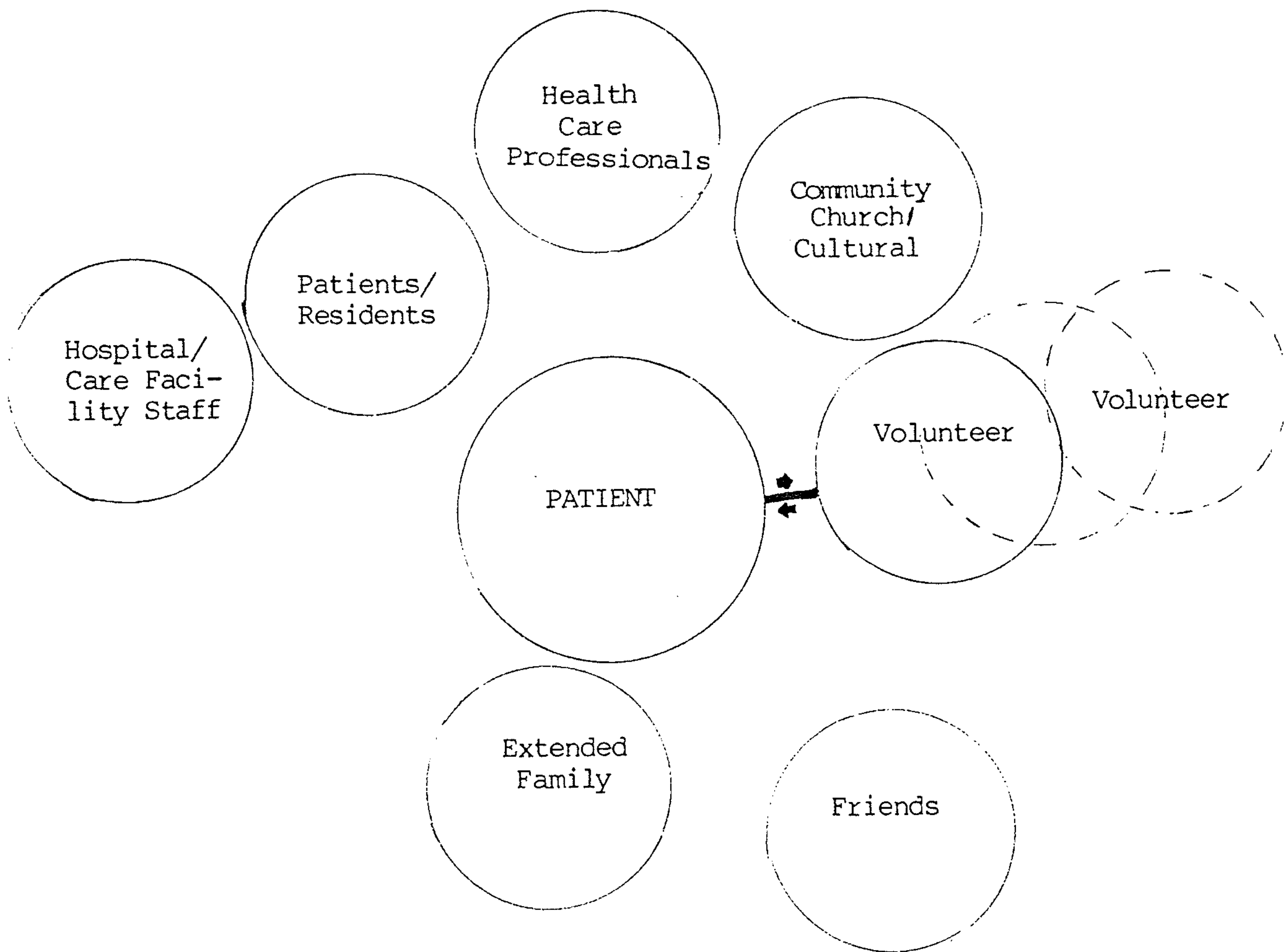
I Overall Goal of the Training Program

To improve the quality and effectiveness of the volunteer's supportive relationship with the institutionalized patient.

Process

- The facilitator depicts visually, through the use of a modified eco-map, the position the volunteer might occupy in the network system of the patient.
- Participants are involved in the process of speculating and identifying possible patient supports and their proximity to each other.
- The facilitator demonstrates the outcome of fulfilling the primary goal of the program, by diagramatically moving the volunteer system closer to and strengthening the reciprocal relationship of the volunteer to the patient.

PROJECTED OUTCOME



Eco-Map Directions*

- Indicate position and distance of support systems (significant people) in relation to the quality and quantity of support afforded the patient.

- Fill in the connections where they exist.

- Indicate nature of connections by drawing lines

  ———— for strong

  - - - - - for tenuous

  +++++++++ for stressful

- Draw arrows along connections to signify reciprocity and exchange (if existent) of support resources (physical, emotional and social). Flow may also be uni-directional.

* Modified and Adapted from Hartman, A. (1978). "Diagrammatic Assessment of Family Relationships". Social Casework, 59 (18), pp 456-476.

II Overview of Session I and Session II on Aging

The facilitator will identify the objectives of Session I and Session II

The facilitator will provide an overview of the sessions on aging, which will focus on the forces affecting aging.

- In Session I, the group will examine the societal and psychological impact on aging.
- In Session II, physiological changes, both age and illness-related, will be the focus.

The integration of all three forces - societal, psychological and physiological - are reflected in the individual's social and behavioural adaptation to aging and life in general.

ICEBREAKER A "Get Acquainted" Exercise

Purpose

- To set the climate for positive learning
- To facilitate the members of a newly formed group in becoming acquainted and to foster a collective identity
- To introduce the concept of attentive listening skills

Group Size

Ten to twelve participants

Time Required

Approximately five minutes interview time plus three minutes introduction per pair of participants

Physical Setting

Room enough for a large group

Process

1) Participants are asked to choose a partner in the group who is unfamiliar to her/him.

2) In paired interviews, the participants address (without the aid of note-taking) the following questions to each other:

   - Name
   - What area of the hospital/personal care home do you carry out volunteer visiting (i.e. Admissions, Extended Care, Palliative Care)?
   - State your reasons for volunteering
   - What do you hope to gain from this training program (your expectations)?

3) The participants, in turn, introduce their individual partners to the group.

Predicted Outcome

1) Reasons for Volunteering may be:

Altruistic

- Want to help people
- Serve others' needs
- Make others happy
- It is a human and personal way of giving

In One's Self-Interest

- Further my self-development
- To help me in a career
- I enjoy doing it
- I find it personally rewarding
- To satisfy my conscience
- Hope to be repaid in the same way when I'm older

2) Expectations of the Training Program cited may be:

- Improved interpersonal relationships with the elderly
- Knowledge about aging and dying to improve awareness of self and others
- Communication skills
- Helping skills
- Increased confidence in dealing with members of the health care team
- Getting together with other volunteers to discuss mutual concerns

COMMUNITY BUILDING

Volunteering: A Group Discussion

Purpose

- To establish trust and rapport
- To affirm the value and worth of volunteerism
- To identify the needs of the volunteer
- To identify the advantages of volunteering

Group Size

Ten to twelve participants

Time Required

Approximately fifteen minutes

Physical Setting

Room large enough to accommodate participants seated in a half circle

Materials Required

Chalkboard and chalk
Flip chart and felt marker

Process

1) As a starting point, the facilitator reflects on the reasons cited for volunteering by the participants in the previous exercises. These are written on chalkboard or flip chart.

2) The facilitator clarifies the motives behind volunteering, legitimizes the volunteer's altruistic need to serve others, but also the need to serve one's own self-interests. The latter is acknowledged as a factor in motivation and therefore valued.

GROUND RULES

Purpose

- To maintain a positive learning climate by clarifying expectations of the facilitator and the participants.

Time Required

Approximately five minutes

Materials

Overhead Projector

Process

An overhead transparency itemizes the ground rules outlined below. The facilitator provides a brief explanation of each point and invites questions for clarification. The participants can stipulate changes or additions as required.

GROUND RULES:

Adult Learning Model

This training program is based on the adult learning model which stresses:

1) The reciprocity between teaching and learning. The facilitator (teacher) is not an "expert", rather a resource provider and co-inquirer in the learning process (Knowles 1970).

2) As participants, you bring a valuable resource to the learning group - values, beliefs and life experiences unique to you as individuals.

Group Participation

Learning is a collaborative process. By sharing our thoughts, opinions and life experiences, we contribute to mutual group learning. To ensure that each person has an opportunity to contribute to group discussion, you will be asked from time to time to limit your input to one thought or point until your turn comes up again.

Options: Voluntary Participation

No one is required, nor is anyone to be pressured to make any comment that might expose one in a personally threatening way. Therefore, at all times, participation is voluntary.

Confidentiality

It is expected that confidentiality will be strictly observed. Discussion about patients, volunteer experiences and self-disclosure will be treated as private matters relevant to the group.

Interchange: Patient/Resident
Hospital/Nursing Home

Institutions refer to persons in care as patients or residents. Hospitals traditionally regard persons in care as "patients"; nursing homes are more inclined to address them as "residents". Therefore, the terms will be used interchangeably for purposes of this training program.

Agenda/Objectives

Each session will be preceded by a brief overview, a written agenda and the learning objectives.

Evaluation

An evaluation will be distributed at the end of each session. Your responses on the evaluation will provide me with valuable feedback to:

- Improve the quality of the process and content of the training session
- Determine the extent of your knowledge and skill development
- Improve training to meet your learning needs
- Assess my personal learning needs as a facilitator and student

Your co-operation in completing the evaluation would be most appreciated.

ATTITUDES TO THE ELDERLY – A BRAINSTORMING EXERCISE[1]

Purpose

- To assist the participants' recognition of their own images of aging
- To increase personal awareness of socially reinforced stereotypes of the elderly

Group Size

Unlimited

Time Required

Approximately ten minutes in duration

Educational Tool

Blackboard, chalk

Process

1) The facilitator generates from the participants a list of common terms and expressions applied to older people generally. These might come from television programs, written literature, adages and contemporary slang. These are listed on the board.

2) The participants are then asked to use terms that describe elderly people known to them, e.g. family members, friends and patients. The facilitator incorporates this list into the first list, but sets the latter apart somewhat.

3) The participants are asked to rate each term and expression with a + for "positive" connotation, - for "negative" value and 0 for a "neutral" designation.

Predicted Outcome

When asked to identify common expressions and labels applied to the elderly by "others", the participants are able to list without difficulty, numerous negative stereotypes*. The contrast between their personal attitudes (which are positive** overall) and societal attitudes, provides insight into the perpetuation of the stigmatization of aging, based more on generalization and less on individual merit.

* ** See following page for examples

1. Adapted from Astill-McNish, Susan (1984) "A Sensitization Program for Geriatric Nurses, Games That Make you Care". The Canadian Nurse.

* Examples of <u>Negative</u> Labels:

Rigid, meddlesome, sexless, unhealthy (sick), lonely, helpless, angry, bitter, confused, feeble, complaining

Examples of Caricatures:

Old geezer, senile old fool, old goat, old biddy, old maid, old hag, old cronie, dirty old man, absent-minded professor, wicked witch, busy-body

Examples of Expressions:

"Old people are sickly"
"They are crabby, narrow-minded, conservative"
"Most live in the past"
"Can't teach an old dog new tricks"
"All they seem to do is play bingo or cards"

** Examples of <u>Positive</u> Traits:

Active, productive, wise, influential, proud, loving and caring

LECTURETTE "Labels that Limit"

"Ageism" (Butler 1980), unfair stereotyping and discrimination against the elderly, is perpetuated by prejudicial attitudes and societal role expectations that undermine the personal dignity of the older individual. How we perceive the elderly and how they perceive themselves has implications for the quality of our intergenerational relationships.

I Definition of Stereotyping

Allport's (1958) definition of stereotypes is exaggerated, categorical beliefs about a specific group usually based on misconception, prejudgement or categorization. Stereotyped groups usually have some visible and conspicuous feature. Stereotypes can be favourable but as the previous exercise demonstrates, many terms used to describe the elderly are ambivalent or neutral and negative in nature.

II Societal Attitudes: The Influence of the Media

The media reinforces and perpetuates the negative values placed on the elderly by society. Stereotypical attitudes reflected in media messages include:

- Aging is to be feared and denied

  The commercialism and marketing of beauty products (creams, dyes, etc.) designed and packaged to exploit the fear, insecurity, tensions and guilt associated with physical changes in appearance (grey hair, wrinkles, age spots) is a billion dollar business. Its target is a youthful self-image, its victims are women.

- Aging is a proces of decline rather than of fulfillment

  In the communications industry, the good things in life are equated with culturally predominant and sanctioned values of youth and beauty. Being old is both physiologically and socially incongruent with this picture.

- Aging is not part of the normal and natural life cycle

  By either ignoring the presence of older peopele or by treating them as caricatures, the media reinforces the social isolation of the young from the old.* One might conclude that this is society's defence mechanism - a way of coping with the reminder that aging and death define the physical limits and the ultimate mortality of man.

* See following page for Adjunctive Educational Tool

2. Butler, Robert N. (1980). "Ageism: A Foreword". Journal of Social Issues, 36 (2), pp. 8-11.

* ADJUNCTIVE EDUCATIONAL TOOL:

i) Homework Assignment

The participants might be challenged to find photographs of older people in magazines and identify television advertisements depicting older people.

ii) Predicted Outcome

Pictures will be difficult to find. Advertisements portraying older people focus on laxatives and life insurance.

Alternatively, as the elderly (e.g. Grey Panther Movement) lobby for political change and social betterment through techniques such "media watch", content in printed and visual media is incrementally upgraded.

iii) Group Discussion

Group findings can provide a focal point for group discussion. Changes over time can be noted with emphasis on possible influencing factors (sociological, political and demographic shifts) in the aging population.

III Role Expectations - Impact of Sociological Changes

Two hundred years ago, history tells us that the elders in society commanded respect, privilege and power. Youth of the times tried to make themselves older by wearing white hair and wigs.

With the advent of the 20th century, several social and economic changes affected the status of the elderly:

- Industrialization
- Technological change
- Communication (dissemination of information)
- Higher education
- Increased mobility
- Retirement

These factors have had the adverse effect of decreased reliance on the elderly for knowledge; a phenomenon of role reversal where the young began to lead the old evolved. Today's society, which equates success with youth, which measures worth by one's ability to "earn and return", by "doing" rather than "being", has further crystallized diminished power, lowered expectations and social isolation of the aged.

IV Socio-Psychological and Behavioural Impact

Social labelling or stigmatization - both covert and overt, contradictory and blatant - of the older person creates a behavioural and attitudinal chain*, a vicious cycle of physical and socio-psychological breakdown (Kuypers and Bengsten 1973).

Through the loss of norms and reference groups, and with no bargaining power and fewer alternatives, the older person is susceptible to feedback from society to conform to roles. The induction into the role of incompetence and dependence, of "learned helplessness", is sustained by a climate of prejudice, followed by an atrophy of work and social skills and finally, self-labelling. The crystallization of psychiatric and pathological behaviour further stigmatizes the victim and perpetuates a self-fulfilled prophecy.

The resulting lowered self-esteem and diminished feelings of control are further exacerbated in the context of loss and change, which will be addressed in the next portion of this session.

* See Appendix A for a diagrammatical illustration of the concept of social breakdown syndrome theorized by Kuypers and Bengsten 1973.

V) Strategies for Changes

Prescription for change lies in a shift of societal values, a seemingly overwhelming task. Realistically, change at the system (institutional) and individual levels is considerably more feasible and well within the grasp of the volunteer.

VI) Promoting Changes

- KNOWLEDGE

Increasing our knowledge base of the aging process focused on facts as opposed to misconception, can promote understanding of this neglected and feared part of the life cycle (see self-learning exercise).

- ATTITUDES

In the institutional setting, the health care team of which the volunteer is a part, can begin by changing negative attitudes to the patient/resident. Individually, we can become aware of predominant societal values based on myths and understand how these beliefs can be unconsciously incorporated into our own perceptions of the elderly (thus the exercise on stereotyping).

- BEHAVIOUR

Increased knowledge in conjunction with positive attitudes can improve our interpersonal behaviour with the elderly.

Question: What are some ways of positively changing our behaviour toward the elderly?*

<u>Individual Changes</u>

1) Avoid patronizing statements that will erode the patient's self-worth.

2) Reinforce the resident's right to make choices to retain some sense of control and independence over her/his daily life, taking into consideration the restrictions of the institutional environment.

3) Acknowledge the individual differences - needs, preferences and abilities - of the patient/resident. Focus on the strengths versus limitations of the individual.

* Responses to this question can be elicited from the group.

4) Treat the patient/resident as you would want to be treated - with dignity and respect, through

- Non-judgemental acceptance
- Developing effective communication and helping skills to enhance personal interaction (Session III and IV)

Systemic Changes

1) Advocate for the patient where possible to effect outer changes in the environment and strengthen the resident's inner coping capabilities.

2) Act as a role model to other staff in your interactions with the elderly:

   - Express issue of concerns to medical staff so appropriate changes can be made to enhance physical, social, emotional and spiritual health care.

   - Make innovative environmental changes to increase options for the patient.

     a) re-arrangement of furniture, personal items (private space) for comfort and enjoyment

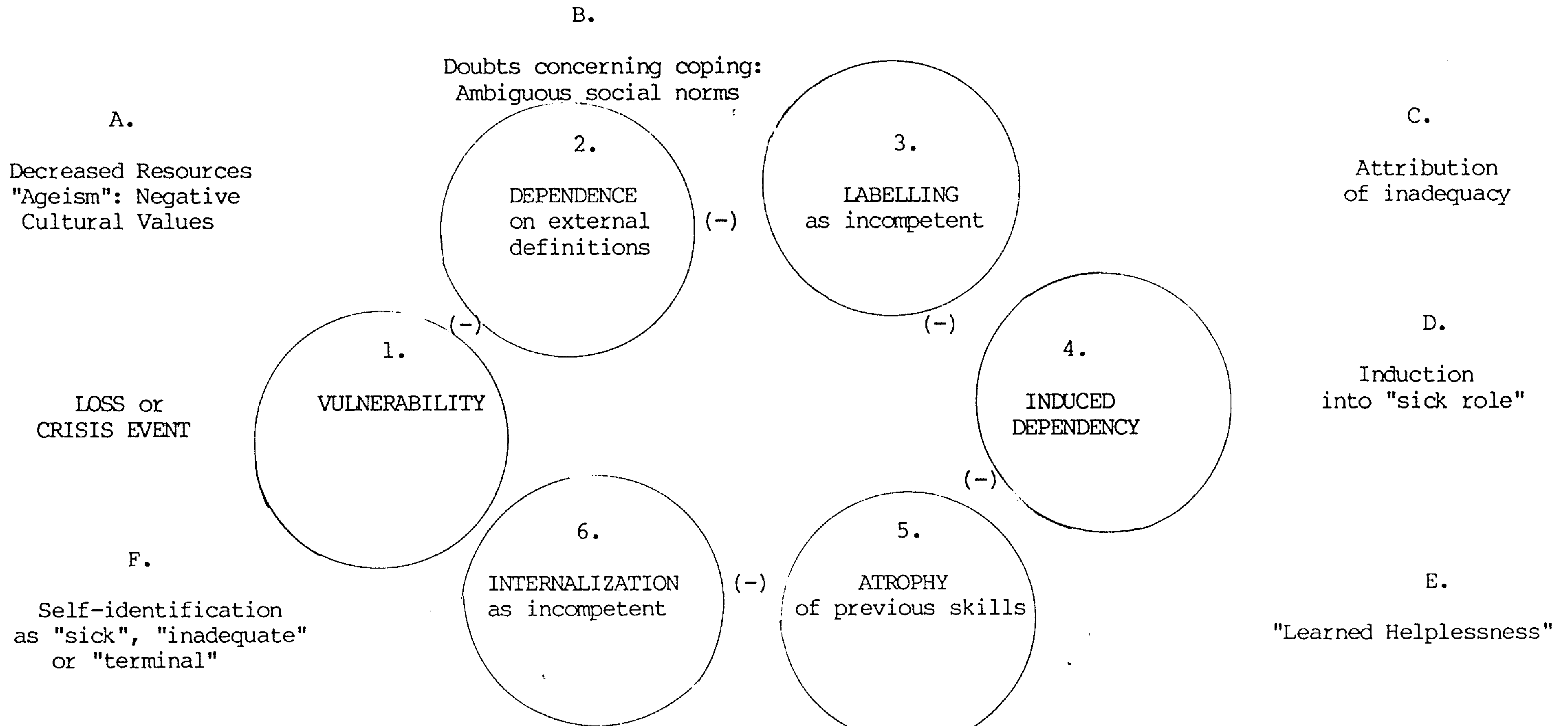
     b) use of recreational and educational tools (games, arts, pets, music, books, objects, etc.) to provide mental stimulation

     c) explore creative possibilities within the framework of institutional rules

3) Lobby the organizational, political and community levels to affect broader change to improve life for the aged.

APPENDIX A

SOCIAL BREAKDOWN IN OLD AGE: A VICIOUS SPIRAL OF INDUCED INCOMPETENCE
PSYCHOLOGICAL AND BEHAVIOURAL INFLUENCES



From: Zusman, J. (1966). "Some Explanations of the Changing Appearance of Psychotic Patiensts: Antecedents of the Social Breakdown Concept". Millbank Memorial Fund Quart., 64. In J.A. Kuypers; and V.L. Bengston (1973). "Social Breakdown and Competence: A Model of Normal Aging. Human Development, 16, pp. 181-201.

RECOMMENDED ALTERNATIVE* EXERCISE: "AGING FANTASY"
*(To Session I Stereotypes and "Peege")

Objectives

- Increase consciousness about attitudes to the elderly
- Clarify the participant's own expectations of the aging process

Group Size

Twelve to fifteen participants

Time Required

Two hours minimum - approximately
45 minutes for fantasy exercise
15 minutes for break
45-60 minutes for group discussion

Materials

For each participant

- a piece of paper with pre-prepared "Fantasy" headings
- pen or pencil

For the facilitator

- fantasy questionnaire [3]
- group leader's comments [4]

Physical Setting

Large quiet room that allows participants to be comfortable in preferred position (reclining on floor, sitting, etc.). Soft background music can be played as the questions are read.

3. From a Fantasy Questionnaire (Appendix B) in Green, Clarissa P. (1981). "Fostering Positive Attitudes Toward the Elderly: A Teacher's Strategy for Attitude Change". Journal of <u>Gerontological Nursing</u>, <u>7</u> (3) pp. 169-174.

4. For Group Leader's Comments, please see above: Green, Clarissa P.

Process

1) The facilitator gives a brief outline of the goals and structure of the exercise.

2) A paper, outlined with headings of the guided fantasy, is handed to each student.

3) In response to open-ended questions, participants are asked to jot down descriptive words, phrases and statements.

4) Participants are given the voluntary option of sharing those aspects of their fantasy in the group discussion to follow.

5) The discussion focuses on contributions from the participants' fantasies, factual information and current research about aging. The implications of negative or stereotypic attitudes toward the elderly are explored.

APPENDIX B
FANTASY QUESTIONNAIRE AND GROUP LEADER'S COMMENTS

Headings on Student Handouts	Questions and Comments Read by Group Leader
A. Age_____ Year_____	A. What age are you as an "old person"? What year is it when you are this age?
B. Significant	B. Who are the most important people in your life? Jot down if you are married, widowed, single, divorced, and for how long? Who are your three closest friends? Are your parents, children, grandchildren, sisters and brothers alive or dead? When did they die? How much satisfaction do you derive from your current relationships? How often do you see your significant others? Do you live with any of them?
C. Health Status and Health Behaviours	C. Describe your current health status. Consider: your five senses, joints and muscles, lungs, cardiovascular system, GI tract, reproductive tract, mental status. What are your current disabilities? What acute or chronic diseases do you have? What medications are you taking? What is your nutritional status? Weight? How much tobacco or alcohol do you use each day? How often do you exercise? How do you deal with stress?
D. Financial Situation	D. What are your sources of income and how much money is available each month? What are your priorities for spending? Describe your level of satisfaction with your current financial status.
E. Living Situation	E. Where do you live? Briefly describe the building, the environs. Who is there with you? How long have you been there?
F. Daily Activities	F. Where do you spend your days, weeks and week-ends? Do you work? if so, doing what? With which activities do you need help? How many falls or other accidents have you had in the last week? Do you drive? How is your reaction time?
G. Sexuality	G. What is your interest in sex? Your capacity? What partners are available? When was your last sexual contact? How much cuddling or caressing do you receive or offer? What are your feelings about yourself as a sexual being?
H. Feelings About Self and Life	H. Describe how you feel about who you are and how you've spent your life. What is your predominant mood state? How lonely are you?
I. Age and Cause of Death	I. Write down how old you will be when you die and how it will happen.
J. Picture	J. Turn your paper over and draw a picture of yourself as an old person, including any aids and devices you need in your daily activities.

VARIATION: Aging....? Moi?[5]

Objectives

- Increase self-awareness about attitudes to the elderly
- Clarify the participant's own expectation of the aging process

Group Size

Twelve to fifteen participants

Time Required

Approximately one and a half hours

Materials

For each participant

- piece of paper or notebook
- paper and pencil

For the facilitator

- attached questionnaire
- Group Leader's Comments (from Green's Aging Fantasy)

Physical Setting

A large quiet room free from noise and interruption. A peaceful environment can be enhanced by softened lights and soothing background music. The members of the group are asked to find their own space, both physically and mentally.

Expectations of the Group

Participants will be asked to voluntarily share their thoughts and perceptions in group discussions.

5. Adapted from Astill-McNish, Susan (1984). "A Sensitization Program for Geriatric Nurses: Games That Make You Care." The Canadian Nurse.

Process

1) The facilitator will follow the questionnaire format attached.

2) Adequate time for discussion will be allotted to allow for participants' views, accurate facts and solutions to problems.

3) The Group Leader's Comments will be utilized to correct misconceptions and identify factual information.

4) The sociological realities of institutionalization will be addressed, drawing on the experiences of volunteers with the elderly in the hospital/nursing home setting.

5) Question #6 could be structured as a brainstorming session to enable problem-solving and explore alternatives.

Predicted Outcome

The nature of the exercise lends itself to humour and so people may not take it seriously at first. It must be stressed at the beginning of the exercise that the process is only as effective as the members of the group make it.

QUESTIONNAIRE AGING....? MOI?

1. Think about the future, about growing old. Try to picture yourself at 72 years of age.

2. On a piece of paper, draw a picture of yourself at 72. Include any mechanical aids you might need at that age (glasses, canes, walker, etc.). Allow approximately three to five minutes.

3. Keep this picture of yourself in mind and respond to the following questions:

   - Who do you live with?
   - Where do you live?
   - Do you have any other significant family members?
   - Where do those family members live?
   - What is your income?
   - How do you spend your time?
   - Are you healthy?
   - Do you have any pets?

4. If you become disabled and you are admitted to an institution, describe what you would like the environment to be like. Consider your living space, list the things you would like to be responsible for and the control you would like to have over that space. Response time approximately 5 minutes.

5. Consider the staff of that institution. What would you like them to be like? Response time appproximately 3 minutes.

6. The group should then make a list of environmental and attitudinal changes that staff in an institution could make without significantly changing ward routines or the physical layout of the building.

FILM "Peege"[6]

Purpose

- To reinforce the participants' awareness of adverse effects of stereotypic attitudes on relationships
- To promote a beginning awareness of family dynamics
- To identify the concept of concomitant loss and its impact on the institutionalized elderly
- To develop an understanding of effective non-verbal communication
- To recognize the role of reminiscence in validating relationships and affirming the worth and value of the individual

Time Required

Approximately 20 minutes viewing time plus one hour discussion

Materials

Film - "Peege"
Projector and screen
3 x 5 cards
Pencils
Blackboard and chalk

Physical Setting

Room large enough for film viewing

Process

- Prior to the film showing, the facilitator will introduce the film carefully and without prejudice. The participants can be asked if the film has ever been viewed before, however, the quality of this film is conducive to repeated viewings.
- Each participant is given a 3 x 5 card and is asked to:

  a) print one overwhelming basic "gut" feeling on one side
  b) write "One thing I learned..." on the other side

- The cards are collected at the end of the film.

6. "Peege" - Produced by David Knapp, Bedford Films, and distributed by Phoenix Films

Discussion

- The facilitator will write the "feelings" identified on the blackboard and comment on the spectrum of feelings.
- The facilitator provides feedback on the results of "What I learned..." through reinforcement and reflective discussion.[7]

Group Discussion

- At the participants' discretion, the group can either remain together or be divided into triads for discussion.
- A series of questions written on the blackboard can provide the framework of discussion. Responses can be noted under pre-headings outlined on notepaper.

Questions

Feelings	. Impact on Family 1) Describe some of the feelings the family were experiencing. List these.
	. Implications for Meaningful Interaction 2) How do these feelings impose restrictions on the potential for meaningful interaction?
Stereotypic Attitudes	3) Identify any stereotypic attitudes portrayed in the film.
Losses	4) Itemize the losses encountered by Peege.
Communication	5) How does the grandson attempt to communicate with Peege? What effect does this have on their relationship? on Peege's self-concept? on the grandson's self-concept?

Predicted Outcome

The emotional impact of this film is overpowering. Participants openly express a pressing need to discuss the implications in detail. This presents an excellent oppportunity for group exploration of personal affective meaning and self-reflection. Content and process issues in the program can also be addressed in the context of the film.

7. Adapted from Johnston, Richard (1979). "Marriage Enrichment: A Developmental Preventive Approach to Social Work in the Military Community. Unpublished Practicum Report, School of Social Work, University of Manitoba.

FACILITATOR'S GUIDE

Feelings:

There is a tendency for the participants to personally over-identify with Peege's plight and project blame onto the family. It is helpful to objectively identify the feelings experienced by family members, especially the middle-aged children or "sandwich" generation - uncertainty, relief (at not having to assume full responsibility for care), feelings of sadness, anxiety, anger, hopelessness, denial, helplessness, fear (of illness, aging and dying) and guilt, to name a few, to allow an empathetic understanding of family dynamics.

The facilitator can point out the role of defense mechanisms in coping with anxiety and fear of aging and death.

Stereotypic Attitudes:

- Aging is equated with decline, e.g. daughter-in-law expresses wish for an overdose of sleeping pills if subjected to chronic illness in aging process.
- Repulsion of institutional setting
- Patronizing statements, e.g. "Is he your boyfriend?"
- Treatment of elderly as children

Losses:

For Peege: Loss of privacy, control, independence, home, cottage, car, pet, family, laughter and happy times, relationships, health but not memories.

Communication:

Several attempts are made to communicate with Peege through tactile stimulation. The grandson uses endearing hugs to communicate to his grandmother his love and concern.

Through reminiscence, he attempts to relive the positive contributions of a lifetime, affirming the value of family relationships and reinforcing the worth of Peege as a unique individual. In reviewing past experiences together, the grandson is able to restore a positive and reassuring perspective to a life distorted by excess preoccupation with illness and death.

The reciprocity of the life review process therapeutically facilitates adjustments to multiple changes - changes that threaten self-esteem in the patient and family members.

SESSION I

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S E S S I O N II

Physiological Changes in the Elderly

Objectives

The participants will:

- Gain awareness of age-related physiological changes in sensory functions in the elderly
- Increase their knowledge base of common chronic illness conditions found in the institutionalized elderly
- Acquire beginning skills in interacting with the unwell elderly

Agenda

- Introduction
  - Brief overview of Session I
  - Review of homework assignments (as indicated) and/or assigned readings
  - Discussion of objectives of Session II
- EXERCISES in Physiological Changes (Age-Related)
  - A timed exercise
  - Unfair hearing test
  - Visual impairment
  - Tactile senses simulation
- Lecturette "PHYSIOLOGICAL LOSSES IN THE ELDERLY"

  Coffee Break
- Overhead Presentation: Chronic Illness and Disability
- ILLNESS AND DISABILITY SIMULATION
- Wrap Up/Evaluation
  - Summarize Session II and its relationship in the context of the training program
  - Assign readings
  - Feedback

A TIMED EXERCISE[1]

Purpose

- To simulate age-related decline in physical response rate
- To increase awareness of how diminished physical response might affect behaviour and interpersonal relationships

Time Required

Approximately fifteen minutes to include brief discussion and feedback

Materials

Pens or pencils
3 x 5 cards

Physical Setting

Room large enough to accommodate participants seated at tables in a U-shape

Process

- The facilitator carefully avoids introducing the intent of this exercise and matter-of-factly requests the participants to take the pencil/pen in the hand unaccustomed to writing (i.e. in most cases, the left hand).
- In a voice that is deliberately authoritarian, the facilitator instructs the group members to print on their cards: their full name, address, postal code, occupation and date and year of birth.
- The instructions are excessively and continuously repeated for a time period not exceeding 30 seconds. At the end of that time, the participants are directed to stop printing.

1. Adapted in part from Fales, Ann W.; MacKeracher, Dorothy; and Vigoda, Deborah (1981). The Isis Kit. The Ontario Institute for Studies in Education: Oise Press.

Predicted Outcome

This exercise creates anxiety, sometimes in the form of nervous laughter in the participants. The facilitator's stance as an authority figure can produce surprise and confusion.

To diffuse some of the emotional and distress responses of the group members, the facilitator explains the intent of the exercise, then solicits feedback on the emotions that surfaced. Common emotions expressed: angry, frustrated, out of control, nervous, annoyed.

This simulation aptly reflects the reactions of older people, slowed by diminished physical response, being hurried by impatient people and being treated as if they were mentally-senile as well as physically slow.

Group Discussion

- Cite examples of situations where you might have seen similar unrealistic demands placed on the elderly, i.e. being hurried and talked at constantly.
- Based on our experience, how might we change our behaviour and attitudes to older persons whose physical responses have slowed?

Recommended Reading: Mary W. Judd, A Sense of Touch, Municipal Hospital 1983.

Facilitator's Comments

Age-related physical responses in the elderly are evident in:

- increasing stiffness in joints
- decreasing elasticity in muscles
- reduced vital capacity
- diminishing energy levels
- erratic control of body temperature
- slowed speed in response to emergency or stressful situations

Slowed physical responses are not in themselves problems; rather how others <u>perceive</u> and <u>react</u> to the elderly is the problem.

Sensory deprivation, a condition where the amount and accuracy processed in the sensory system and brain is reduced can be greatly exacerbated in an environment of isolation/institutionalization. Limited access to amount and variety of information and stimulation reinforces behaviours of confusion, disorientation, hallucinations, rigidity, disorganization, dizziness, lethargy and memory lapses - commonly labelled as "craziness" or "senility".

AN UNFAIR HEARING TEST

Purpose

- To increase, through simulation, the participants' personal experience with age-related hearing losses
- To explore the various stress responses related to hearing changes
- To focus on alternative strategies in assisting the older person with hearing loss to cope

Time Required

Approximately fifteen minutes, including group feedback, discussion and facilitator's comments

Materials

Isis Kit, sound controlled tape[2] (an unfair hearing test)
Tape recorder
Pre-prepared test sheet (Appendix D, Exercise 1)
Pen or pencil
Flipchart
Marker

Physical Setting

Room large enough to accommodate up to fifteen participants seated at a U-shaped table arrangement

Process

- The facilitator pre-tests the tape sound prior to the session; then ensures in a preliminary test-run that all participants can hear properly and comfortably.
- Once the correct sound level is established, no further volume adjustments are made (a drop in sound on the tape is part of the simulation).
- The facilitator instructs the participants to write on paper the sentences verbalized on the tape.
  (Correct sentences given in Appendix C, Exercise 1)

2. From Isis Kit, taken from "Getting Through" produced by Zenith Radio Corporation (HA 60, 1971)

- For Exercise 2, the participants are directed to fill in columns A, B and C respectively after each of the three readings on the tape (Appendix D, Exercise 1).

- After the exercise is completed, the facilitator turns the tape off, writes the correct words on the flipchart (Appendix D, Exercise 1).

Group Discussion

- Hearing difficulties incurred in the unfair hearing test.
- Emotional impact of hearing changes and loss.
- Effect on personal relationships, day-to-day functioning, enjoyment of life.
- Utilization of coping mechanisms to compensate for hearing deficiency.
- Effective ways of working with older persons with hearing impediments.

Reading Assignment: "A Sense of Touch" by Mary W. Judd (1983), Winnipeg Municipal Hospital, especially the sections on auditory and vision senses.

Facilitator's Comments

- The drop in sound level on the tape is caused by loss of high frequency sounds.
- Most age-related hearing loss is characterized by a loss of high frequency sounds accompanied by a drop in sound level.

Q . How might we correct our verbal interaction to compensate for auditory losses?

A . Speak clearly; reduce high, squeaky voice sounds to low bass sound levels.
Speaking loudly is counterproductive and aggravates the situation.

Predicted Outcome

This exercise tends to be highly rated for its experiential component, however, can be threatening to those older volunteers already experiencing age-related hearing changes (especially if they are unaware of the subtle decline). It is recommended that the facilitator approach this exercise with tact and discretion, offer anticipatory guidance and support by emphasizing that difficulty will vary with the individual. Older volunteers might be encouraged to move closer to the tape. After the exercise, the facilitator must be prepared to normalize emotions generated as a result of personal revelation and strive to place this within the context of learning.

A P P E N D I X   C

EXERCISE 1

Sentences:

1. I don't want to go to the movies tonight.

2. Put that cookie back in the box!

3. How do you spell your name?

4. This suit needs to go to the cleaners.

5. Where have you been all this time?

APPENDIX D

EXERCISE 1

	Column A	Column B	Column C
1.	______	______	______
2.	______	______	______
3.	______	______	______
4.	______	______	______
5.	______	______	______
6.	______	______	______
7.	______	______	______
8.	______	______	______
9.	______	______	______
10.	______	______	______

CORRECT WORDS:

1. Fill
2. Catch
3. Thumb
4. Heap
5. Wise
6. Wedge
7. Fish
8. Shows
9. Bed
10. Juice

VISUAL IMPAIRMENT

Purpose

- To increase, through simulation, the participants' personal experience with age-related vision changes
- To identify various response stresses related to vision losses
- To identify, through discussion, helpful strategies in relating to older persons with visual limitations

Time Required

Total of thirty minutes for activities and group discussion

Materials

Eight sets of goggles obtained from the Isis Kit
(Diagrammatical description provided in Appendix E)
Newspapers
Book with small print
Empty food packages and soup cans, etc.
Coloured buttons and pills in paper cups
Pencil or pen
3 x 5 card

Physical Setting

A building setting that provides darkened hallways and rooms, stairways off the classroom. A long table to accommodate at least four sets of the above materials (with the exception of the goggles).

Process

a) Preliminary

- The facilitator pre-tests the exercise with each set of goggles prior to the actual session and identifies potentially dangerous activities.
- Safety precautions are ensured - clutter cleared away, chairs and unnecessary tables removed, electrical wires taped to the floor.
- The facilitator assures the participants that the goggles will simulate basic distortions in vision. Although some dizziness, eye strain or mild headache may occur while wearing the goggles, no vision damage will result.

- Participants who wear glasses will have to remove them prior to wearing the goggles. If eyesight is very poor, they can at least do the colour-discriminating tasks.

- Participants work in pairs, taking turns with one observing partner monitoring and providing close assistance in the exercise tasks.

b) Exercise

- Participants wearing goggles will, with guidance from their observing partners -

  1) Climb up and down stairs
  2) Walk in dimly lit hallways, around corners and into rooms
  3) Read a newspaper or book with small print
  4) Find and read instructions on a variety of food packages and cans (the smaller the print, the better)
  5) Pick up coloured buttons and pills (particularly yellow, blue and purple) and identify their colours
  6) Write name and address on a 3 x 5 card

- After ten minutes, the participants switch roles with their partners. Goggles remain the same. The second goggle-wearer carries out the tasks in the designated ten-minute period.

- Two pairs of participants will join together in a group of four for discussion.

Group Discussion

- Discuss changes in one's physical abilities in coping with visual deficiencies.

- Describe the task that presented the most difficulty.

- Identify briefly some feelings you had while performing the tasks.

- Suggest how your partner might have been more helpful to you. Did you trust your partner?

- Suggest how the physical environment could be modified to meet the needs of the visually impaired.

Facilitator's Comments

The importance of trust in interpersonal helping skills is briefly introduced. This subject will be explored from an in-depth perspective in Session IV "Helping Skills".

Adjunctive Tool:

- The facilitator briefly introduces the "Social Readjustment Rating Scale" (see handouts), pointing out the stress values of failing eyesight (ranked 10th with stress value of 51) and failing hearing (ranked 15th with stress value of 46).
- Additionally, the facilitator focuses on the multiple stressors incurred for the unwell elderly who have undergone major life changes as a result of institutionalization. Using case histories, the group can tabulate stress values incurred for individuals in institutions.*

HANDOUT: Social Readjustment Rating Scale **

Predicted Outcome

- Some participants experience lack of challenge in the milder visual impairment simulation. Allowing extra time for exchange of goggles to provide for equal opportunities would enrich the learning experience.
- The Social Readjustment Rating Scale was well received as a teaching tool, promoting awareness of others and self. Participants expressed an interest in measuring stress values for themselves and others (patients, friends, family) known to them.*

* Recommendation: Alternatively, the facilitator can direct the participants' interest in the Scale, into homework assignments designed to increase self-learning and reflection. Group discussion can focus on stress value measurement in the following session if desired.

** Holmes, T.H. & Rahe, R.H. (1967). "The Social Readjustment Rating Scale." Journal of Psychosomatic Research, 11, 213.

Amster, L.E. & Krauss, H.H. (1974). "The Relationship between Life Crises and Mental Deterioration in Old Age." International Journal of Aging and Human Development, 5, no. 1.

APPENDIX E

Visual Impairment Description

Simulates cataracts
Both lenses fogged

Simulates cataract in one lens; night blindness in other lens (blackened on outside edges)

Simulates blind spots caused by local bleeding of retina

Simulates night blindness and partial tunnel vision

Simulates night blindness and increased tunnel vision

Simulates night blindness and extensive tunnel vision
Caution: Dizziness, vision distortion and reading difficulty

Simulates night blindness, extensive tunnel vision, loss of centre field of vision
Caution: Dizziness, vision distortion, reading difficulty, confusion in conversation
Precaution: Close assistance and supervision by observer partner

Simulates total blindness
Caution: Emotional distress symptoms of frustration, anger, confusion
Precaution: Full assistance in all activites

CHANGES IN TACTILE SENSES

Purpose

- To increase, through simulation, the participants' personal experience with age-related tactile losses
- To identify the various stress responses associated with sensory limitations
- To consider ways of increasing coping strategies for the elderly with sensory loss

Group Size

Twelve to fifteen participants

Time Required

Approximately fifteen to twenty minutes

Materials

See Appendix F

Physical Setting

A room large enough to comfortably accommodate movement of participants around a U-shaped table arrangement.

Process

- The facilitator distributes the gloves/mitts to the participants
- Participants are given equal opportunity to:

a) Turn pages of the newspaper/books
b) Button up at least five buttons
c) Zip and unzip a zipper
d) Undo bottle caps
e) Open a can with a can opener (hand-held)
f) Thread a needle
g) Pick up small objects - pencils, paper clips, pins and nails
h) Write name and address on a 3 x 5 card
i) Hold someone's hand
j) Open a door
k) Use a teacup
l) Any other activities initiated/suggested by the participants

- Half-way through the exercise, the participants can complicate the exercise by wearing the goggles designated for Exercise 3 (Vision Impairment).

- Work at the activities for approximately ten minutes.

Group Discussion (Triads)

- The participants will then break into triads to discuss the following:

Q. a) What difficulties were encountered in this exercise?
   b) What were your "feeling" responses to having tactile limitations? (tendency to give up, etc.)
   c) How might the behaviours of helpers be changed to help older persons adapt/cope with sensory limitations in touch?
   d) How could the environment (and the household and hospital equipment in it) be modified to suit the needs of the institutionalized elderly?

Predicted Outcome

The facilitator must attempt to make this exercise as challenging as possible. Some participants find the exercise too "easy". The inclusion of the goggles is helpful. Addition of another sensory loss is effective in demonstrating the effect of multiple loss.

APPENDIX F

Materials Required

Three to four pairs oven mitts) modified as per
Three to four pairs gloves) instructions below
Three to four pairs heavy winter mitts)
Newspapers
Garments with zippers, small buttons
Books with small print
Bottles with child-proof caps
Food packages, empty cans with bottoms intact
Small buttons of various colours
Coloured pills in little cups
Needle and thread
Small objects to be handled: toothbrushes, combs, pencils, paper clips, nails, pins
Tea cups (with fancy handles)
Pen/pencil
3 x 5 card

Preparation

- To simulate extensive grasping and holding disability, the thumb and adjacent fingers in the gloves can be taped or securely sewn together. Likewise, the thumb in the mitts can be sewn to the palm.

- The facilitator will conduct a preliminary pre-test of the sensory activity.

- Objects can be distributed on the table surface to allow equal opportunity for each participant to experience their use.

- If gloves are limited, the participants can be instructed to use one glove on their dominant (writing) hand.

PART II

Physiological Losses in the Elderly

Purpose

- To increase the participants' knowledge base in physiological symptomology in the institutionalized elderly
- To outline specific guidelines for visiting the unwell elderly

Group Size

Twelve to fifteen participants

Time Required

From thirty minutes to one hour, depending on whether case examples and group discussion are encouraged

Materials

Overhead transparencies (Appendix G designed* for this instructional unit)

Overhead projector
Screen

Physical Setting

Room large enough to comfortably accommodate the participants and to permit the use of an overhead projection

Recommended Resource Person

Experienced volunteer with nursing or medical background

Process

- The facilitator and/or resource person presents, through visual aids/overhead transparencies, an overview of symptoms typical of common, chronic diseases/illnesses.

* Acknowledgement of thanks to Nancy Tidmarsh, R.N./Volunteer Visitor for the basic framework of this presentation.

- "Hints to Volunteers" will address interpersonal visiting skills appropriate to working with the unwell elderly.
- The participants are encouraged to use illustrations of situations in their volunteering experience.
- Additionally, questions and large group discussion can be promoted.

Predicted Outcome

This portion of the session appears to be well received, especially when led by an experienced peer with medical/nursing background. Chronic illness must be broached sensitively and matter-of-factly. The limitations of the helper under the circumstances can be addressed to reduce unrealistic expectations. Overall, it is important to interject anecdotal references to give personal meaning to this unit.

There appears as well to be a high level of interest in the subject of illness, perhaps because lack of awareness and understanding leads to unrealistic expectations, avoidance, and fear. These negative attitudes can act as barriers to the formation of meaningful relationships with geriatric patients/residents.

Illness and Disability Simulation: Adjunctive Exercise

- If time permits, the facilitator may incorporate role-playing into the learning experience. Acting as a role model, the facilitator may demonstrate an initial role-play with a volunteer participant, using illness symptoms to characterize the patient/resident. A combination of various symptoms of multiple concomitant illnesses can be depicted in the improvisations.
- The group is then divided into pairs.
- Each participant is given a card outlining in detail, symptoms of specific illnesses. Necessary equipment (wheelchair, canes, ear plugs, blindfolds, etc.) can be provided to add realism to the role-play.
- One partner role-plays a patient/resident with illness symptoms, while the other role-plays a volunteer coming to visit.
- After ten minutes, the participants will reverse roles.
- The participants will discuss physical and emotional reactions and suggest ways of improving skills in working with the unwell elderly.

Note to Facilitator: The brilliant colour backgrounds and typeset on the transparencies present difficulties in clarity. Participants can be seated in close proximity to the screen to alleviate this problem.

APPENDIX G

a) Specific illness and relevant characteristics/symptoms are itemized under the following headings:

1) Alzheimer's Disease
2) Amputation (Cross Ref: Diabetes)
3) Angina
4) Aphasia (Cross Ref: Hemiplegia)
5) Cataracts
6) Confusion-Disorientation
7) Congestive Heart Failure
8) Depression
9) Diabetes Mellitus
10) Fracture (Fractured Hip)
11) Hemiplegia
12) Hiatus Hernia
13) Multiple Sclerosis (MS)
14) Osteoarthritis
15) Quadraplegia (Post-Polio Paralysis)
16) Rheumatoid Arthritis

b) "Hints to Volunteers"; guidelines for effective personal interaction accompany each illness profile.

SESSION II

BIBLIOGRAPHY

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Judd, Mary W. (1983). A Sense of Touch. Winnipeg Municipal Hospital, Winnipeg, Manitoba.

SESSION III

Communication Skills

I Objectives

The participants will:

- Conceptualize the communication cycle and understand the reciprocal process of two-way communication
- Develop a beginning level in communication-listening skills
- Acquire introductory knowledge about the helping relationship
- Become aware of the role of reminiscence and life-review in interpersonal communication

II Agenda

- Introduction
  - brief overview of last session
  - discussion of feedback and homework tasks (as required)
  - statement of objectives for Session III
- LECTURETTE
  1) Communication Cycle
  2) Conditions for Open Communication
  3) Barriers to Communication
- Active Listening Skills
  1) ATTENDING: Group observation of attending and non-verbal communication
  2) CHARADES: Small group exercise in behaviour description and perception checking
  3) REMINISCENCE: Encouraging/Empathetic Leading
  4) RESTATING or Paraphrasing
- LECTURETTE: "REMINISCENCE IN INTERPERSONAL COMMUNICATION"
- Wrap-Up
  - summary of Session III and objectives
  - formative feedback
  - handouts and homework tasks
  - overview of coming session
- Evaluation

THE COMMUNICATION CYCLE

Purpose

- To conceptualize the two-way communication cycle through diagrammatical representation
- To increase understanding of the complex components of communication
- To identify barriers to effective communication
- To examine conditions for open communication

Group Size

Ideal size twelve to fifteen participants

Time Required

Twenty to thirty minutes

Materials

Overhead projector
Overhead transparency - depicting communications cycle (Educative Tools)
Diagrammatical representation of communications cycle (Appendix H)

Physical Setting

Room large enough to allow viewing of overhead projection

Process

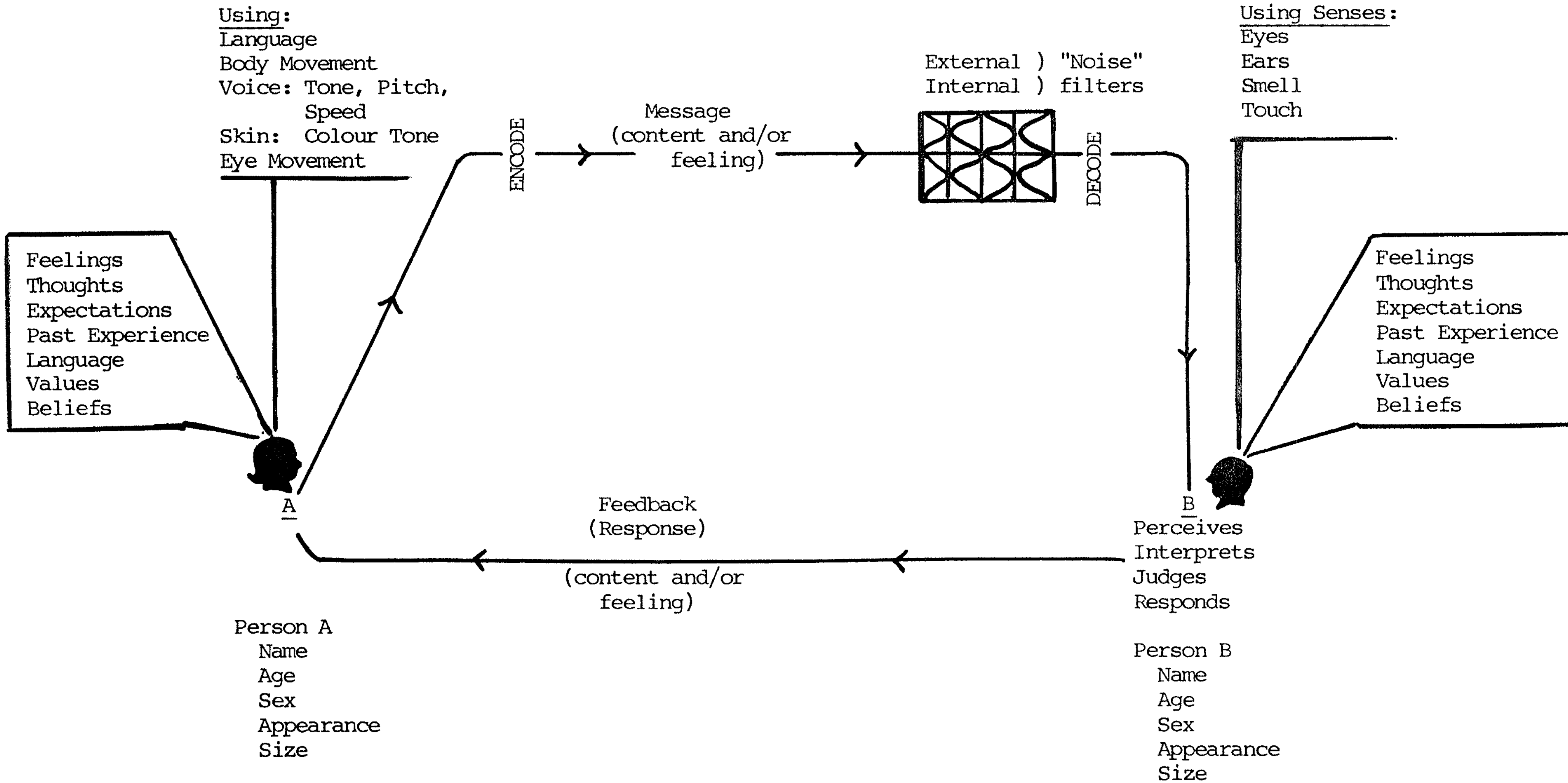
- The facilitator demonstrates the concept of the communication cycle through visual depiction -

  a) on an overhead transparency
  and/or b) by posting a diagrammatical representation on a blackboard or flipchart for continued reference throughout the session

- The following lecturette is given.
- The facilitator introduces barriers to effective communication. The participants are invited to identify from their personal experiences, barriers to communication.

APPENDIX H

PLACE . SITUATION . PURPOSE . SPACE . TIME . FOCUS



Acknowledgement of thanks to Maureen MacKintosh for her contributions to this diagrammatical representation of the communication cycle.

LECTURETTE "THE COMMUNICATIONS CYCLE"

I Principles of Communication

Communication is a process both verbal and non-verbal, involving at least two individuals -

A) the communicator or sender and
B) the receiver

The process of communication is reciprocal and complementary when the individuals involved feel that the meaning of the message between them has been clearly transmitted and understood.

Process

- The sender (A) encodes and transmits a clear message of thought and/or emotion to the receiver (using "I" messages).
- The sender (A) ensures that verbal and non-verbal communication are congruent to reduce confusion in message transmission.
- The receiver (B) decodes the meaning of the message through active listening.
- The receiver (B) checks out what he/she has heard is in fact the message sent; through response or feedback

  e.g. As I understand it, your idea is...
  I hear what you're saying...
  What I think you mean is...

- The sender (A) confirms message received is message sent. If not, a restatement is made and the process repeated.

II Communication Involves Three Processes

a) Sharing - sending and receiving messages
b) Understanding - what is said = what is heard
c) Clarifying - understanding what has been said through response and feedback. Additional information may be obtained through questions: who, what, where and how (never why, which implies justification or instills guilt).

III Conditions for Open Communication

1) Non-judgemental attitude

2) Acceptance of and respect for the individual

3) Mutual trust and risk-taking

4) Empathetic understanding

5) Active listening skills

The conditions for open communication have significance for the helping process and will be addressed in greater detail in Session IV.

Active listening skills, i.e. receiving the meaning behind the message plus responding through feedback, involves skills in:

1) Attending
2) Behaviour Description
3) Perception Checking
4) Encouraging or Leading
5) Paraphrasing
6) Summarizing

For purposes of this session, the first five skills will be practised through simulations/experiential exercises.

COMMON MISTAKES IN ACTIVE LISTENING:

1) Assumption of meaning, second guessing
2) Misinterpretation/exploration
3) Advice/persuasion
4) Analyzing
5) Demanding
6) Personal disapproval
7) Parroting
8) Anticipation of what's coming
9) Personal agenda
10) Obligation - asking why questions

BARRIERS TO COMMUNICATION

Process

A The facilitator provides introductory comments on the barriers to effective communication

B The participants are encouraged to identify barriers to communication encountered in an institutionalized setting in their visiting experiences

A. Facilitator's Comments

Barriers to communication, sometimes called "noise", interfere with understanding the meaning of the message.

B. Group Discussion

Examples of barriers or obstacles to communication identified:

i) Environmental - In institutions/hospitals: lack of space, privacy and confidentiality; close quarters, number of people; noise levels, lack of comfortable seating; interference of institutional rules, routines, regimes.

ii) Illness - Fatigue, energy level, pain, restricted mobility, visible illness symptoms of discomfort, odours, sounds, necessity of medical/technical equipment.

iii) Status - Real and perceived power/economic status differences.

iv) Personal - One's own attitudes, beliefs, values, past experiences (history), current needs and goals, defense mechanisms, self-concept, self-esteem, personality, age, sex, unwell appearance (facial, gestures).

v) Cultural - Values, beliefs, customs, tradition, expectations.

vi) Language - Accent, comprehension, expression.

vii) Cognitive Ability - Intelligence levels.

Note to Facilitator: Obstacles to communication are not readily apparent. Categories as above may be identified by the facilitator. Specifications may be elaborated upon by the participants.

ACTIVE LISTENING SKILLS - EXERCISE 1
Attending Skills

Purpose

- To promote understanding of attending behaviour
- To demonstrate, through modelling, skills of attending
- To identify, through group observation, attending behaviour and non-verbal communication

Group Size

Twelve to fifteen participants

Time Required

Approximately ten minutes

Materials

Flipchart

Physical Setting

Room large enough to accommodate participants seated in a half-circle

Process

- The facilitator introduces the concept of attending behaviour: Attending behaviour is the physical act by which the helper in some way communicates to the other an interest in her/him as a person. Attending involves non-verbal cues of communication.
- The facilitator assumes the role of helper/volunteer visitor and solicits a volunteer to role-play a helpee/patient (known to the volunteer through personal experience).
- The facilitator models skills in attending.

  Demonstrated attending skills will include tuning in (clearing away one's personal agenda); warm sincere greeting; appropriate spatial distance; compatible eye level; positive eye contact; natural relaxed open posture (arms and legs not crossed) leaning slightly forward; pleasant, even voice tone; use of silence and touch as indicated.

- The participants are asked to identify non-verbal communication observed in the attending behaviour demonstration.

  Non-verbal cues can be itemized on a flipchart.

- The facilitator may take this opportunity to elaborate on the appropriateness and acceptability of touch and the use of silence when communicating with the institutionalized elderly.

- The facilitator closes the exercise by reinforcing the principles of attending skills.

ACTIVE LISTENING SKILLS - EXERCISE 2
Behaviour Description
Perception Checking

Purpose

- To promote an understanding of behaviour description and perception checking skills in communication
- To practise skills in a) reflecting expressed behaviour through behaviour description
  b) clarifying manifest or expressed feelings through perception checking
- To stress the importance of "I" messages

Group Size

Twelve to fifteen participants

Time Required

Approximately twenty to thirty minutes

Materials

"Feeling" cards (Appendix I(1))
Handouts with guidelines for behaviour description and perception checking (Appendix I(2))

Physical Setting

Room large enough to accommodate small group arrangements

I Process: Behaviour Description

- The facilitator comments on <u>behaviour description</u> and "I" messages (see facilitator's comments).
- The facilitator introduces CHARADES as an exercise in behaviour description. The participants break into groups of four.
- Each member is given a "feelings" card.

- Instructions for Charades:

  a) Do not show your card to anyone.
  b) At your turn, recall a situation in which you felt this way. Breathe deeply and tune in. Act out the feeling without speaking.

- The other participants have two rotational turns each to describe the behaviour (facial expression, body posture, gestures, skin colour) using the guidelines stated on the handout (I notice that...).

- Where necessary, the facilitator may model the behaviour description technique.

Facilitator's Comments

- Behaviour description is used to factually describe or report to the other person her/his specific observable actions or behaviour without placing value or judgement on them, and without making accusations or generalizations about motives, attitudes or personality traits. This skill is used to help the other person become aware of her/his behaviour and may promote understanding of her/his personal self.[2]

- "I" messages denote the sender's ownership of attitudes, opinions and feelings. In the communication process, the sender takes responsibility for ownership of meaning of the message. Therefore, "I" messages become a statement of fact rather than an evaluation. "I" statements are less threatening to the receiver's self-esteem; less likely to provoke anger, resentment or hurt emotions.

  At the same time, "I" messages involve risk, vulnerability, honesty and openness - elements of the helping relationship.

II Process: Perception Checking

- The facilitator briefly comments on perception checking and reinforces "I" messages (facilitator's comments).

- The small groups of four pair off in partners.

- Partner A, the speaker, describes her/his feelings in the imagined situation <u>or</u> her/his feelings about doing the charades.

- Partner B, the listener, uses guidelines for perception checking (I get the impression that you are feeling..., I sense that you feel...) to respond to A's message.

2. From: Interpersonal Communication Skills Course Outline 47:208, School of Social Work, University of Manitoba, page 12.

- After five minutes, the partners switch roles - B becomes the speaker; A the listener and the process is repeated.

- When necessary (where difficulties arise), the facilitator may model the perception checking technique.

Facilitator's Comments

- Perception checking is the listening-responding skill of describing what you perceive to be the other's inner state, i.e. feelings in order to check whether you understand what she/he feels. Perception checking, a way of reflecting, helps the person clarify and accept her/his feelings.[3]

- Perception checking is one way of listening with understanding or empathy. Listening with understanding -

  > "means to see the expressed idea and attitude from the other person's point of view, to see how it feels to him/her, to achieve his/her frame of reference concerning his/her subject"[4]

Predicted Outcome

Process I - "Behaviour Description" utilizes a game as a teaching/learning tool. This exercise is well received but pre-exercise instructions must be clear. The facilitator should be prepared to model communication techniques as required.

Of the range of emotions depicted from the "feelings" cards, frustration, elation and embarrassment prove to be the most challenging and most prone to misinterpretation. The facilitator can capitalize upon this "teachable moment" in the exercise to point out the risk of misinterpretation, thus the importance of perception checking.

3. Interpersonal Communication Skills.
4. Burke, W. Werner, Interpersonal Communication, National Institute for Applied Behavioural Science, in Interpersonal Communication Skills, page 33.

A P P E N D I X I (1)

"FEELINGS" CARDS:

Sad	Relieved
Playful	Bored
Determined	Lonely
Excited	Angry
Suspicious	Elated
Afraid	Embarrassed
Confused	Frustrated

A P P E N D I X I (2)

GUIDELINES:

BEHAVIOUR DESCRIPTION:

"I Notice That...."

PERCEPTION CHECKING:

"I Sense That You Feel...."

"I Get the Impression You are Feeling...."

"REMINISCENCE" An Exercise in Encouraging and Empathetic Leading - EXERCISE 3

Purpose

- To gain an understanding of leading as part of clarifying and exploring skills in communication
- To practise and develop through simulation, beginning communicating skills in encouraging and empathetic leading
- To promote an awareness of the place and value of reminiscence or life-review in our interpersonal relationships with the elderly and with each other

Group Size

Twelve to fifteen participants

Materials

Role-play descriptions of 1) story-teller (Appendix J)
2) listener

Time Required

Approximately thirty minutes

Physical Setting

Room large enough to allow for comfortable seating and spacing of six to eight pairs

Process

- The facilitator briefly introduces the concept of encouraging and empathetic leading (see facilitator's comments).
- The participants are given five minutes to think of a story from their own lives which best reflects some aspect of who they are (preferably an aspect unknown to other group members and unrelated to their role as volunteer).
- The participants are asked to pair off with someone they do not know well in the group (i.e. with someone they are acquainted but not familiar).

APPENDIX J

AS THE STORY-TELLER:

As you reminisce, do not "give the whole story", rather wait for your partner to encourage or "lead" you. Watch for natural, positive gestures such as eye contact, forward leaning, head nods and smiling.

AS THE LISTENER:

Practice encouraging or "leading" using positive non-verbal communication and attending behaviour such as leaning forward, eye contact, head nods and smiling.

Use such encouraging comments as:

"Go on."
"I see."
"Uh-huh."
"H-m-m-m."
"I understand."
"Tell me more."

- Partner A receives written instructions to role-play the story-teller.

- Partner B, the listener, receives guidelines for encouraging and empathetic leading (Go on.., I see.., Uh-huh.., Hmmm.., I understand.., and.., tell me more.., go on.., tell me more about.., etc.).

- After five minutes, the partners switch roles - B becomes the speaker; A the listener and the process is repeated.

- After the exercise, the participants are asked to assemble into groups of four for small group discussion (or if preferred, collectively as an entire group).

Small Group Discussion

Q . Did you feel your partner used listening-attending skills?
- What non-verbal communication (cues) were congruent with listening-attending?
- As the story-teller, were you permitted to explore in the direction of your choice? in your own way?
- How did you feel as the listener? as the story-teller?
- What did you learn about the value of reminiscence or life-review?
- What are your feelings and reactions to this experience?

Facilitator's Comments[5]

- Encouraging or empathetic leading is a communication-listening skill that permits the speaker/helpee to explore, clarify and elaborate on content/feelings in communication with the non-verbal and verbal encouragement of the listener/helper. This technique allows the helpee to explore in the direction she/he chooses.

- Leads can take the form of silence, word repetition, comments and open ended questions (starting with "what", "when" or "how", as opposed to "are", "is", "do" which invite a yes or no answer).

- For a more focused approach to encouraging and empathetic leads, the facilitator recommends a study of the handout "Empathetic Leads and Encourages in the Helping Interview", especially the sections on leading comments and questions, self-evaluation and reaching for feelings.

Lecturette:

The lecturette "Reminiscence" may be given following small group discussion or at the end of Session III to allow continuity of the experiential exercises in communciation.

5. Adapted from Interpersonal Communication Skills Course 47:208 Outline, School of Social Work, University of Manitoba.

Predicted Outcome

This exercise is exceptionally well received by group members and formative feedback indicates positive and enthusiastic response.

The benefits for teaching/learning include:

1) Integration of theories of communication-listening and reminiscence into skill practice

2) Promotion of individual and group development

RESTATING (OR PARAPHRASING)[7] - EXERCISE 4

Purpose

- To promote an understanding of restating or paraphrasing as a skill of responsive listening and feedback in the communication process
- To practice and develop skills in restating/paraphrasing

Group Size

Twelve to fifteen participants

Time Required

Approximately fifteen to twenty minutes

Physical Setting

Room large enough to accommodate six to eight pairs

Materials

Blackboard
Chalk

Process

- The facilitator briefly introduces the concept of restating or paraphrasing; guidelines for paraphrasing are written on the blackboard (see facilitator's comments).
- The facilitator, as responsive listener/helper, models restating or paraphrasing skills in a communication interaction with a volunteer as speaker/helpee.
- Suggested topics for the paraphrasing activity are introduced:

  1) Your ideas and feelings about institutionalization and possible proposals for change.

  2) Your reactions/thoughts/feelings about this training program.
- The group is asked to break into pairs.
- Partner A, the speaker, discusses her/his ideas and feelings in two to three statements on her/his topic of choice.

7. Adapted in part from Fales, Ann W.; Mackeracher, Dorothy; and Vigoda, Deborah (1981). "The Isis Kit" The Ontario Institute for Studies in Education: Oise Press.

- Partner B listens attentively and responds to A's statements by restating or paraphrasing content/feelings as per the written guidelines.

- Partner A can reply "yes", "no" or "partly" to B's responsive statement but does not elaborate on her/his original statement.

- Within an allotted time period of five minutes, B attempts to receive at least three "yes" replies to her/his paraphrasing statement.

- Then A and B switch roles and repeat the process.

- During the exercise, the facilitator monitors the paraphrasing process, provides guidance and models when required to facilitate learning.

Facilitator's Comments

- PARAPHRASING or RESTATING is a communication skill that is a means of feeding back to the other person the meaning of her/his message, i.e. both content and feeling. This is done by checking that you correctly heard and understood what was intended in the message.

- Restating involves restating all or part of the content and verbal part of the speaker's original statement in your own words, without adding any extra ideas of your own.

- Response Guidelines for paraphrasing might be worded:

  "I hear you saying that.. and that makes you feel..."
  "What I think you mean is..."
  "I sense that you feel...because.."

LECTURETTE: Reminiscence in Interpersonal Communication

- Where once reminiscence or life-review served an educative purpose, today this process of delving into one's personal past (both positive and negative aspects through verbal recollection) is becoming a lost art. Frequently, reminiscence has been associated with "senility" in the elderly.

- Benefits accrued to reminiscence include:

  a) Emotional - enhanced self-esteem and personal worth, ego integrity, personal satisfaction (stability of self-concept).

  b) Social - pleasurable and intimate sharing activity, tribute to longevity and validation of mental soundness.

  c) Therapeutic - enhanced interpersonal relationships, provides richness of insight into life's contributions, promotes an established sense of self and place (culture), gives meaning and purpose to life.

  d) Education - transmission of history and past.

  e) Recreational - can be used in the group context with a focus on memorabilia, story-telling, creative writing, archival and historical recording, autobiographies and genealogy.

- Reminiscence is a healing process; a way of resolving, reorganizing and reintegrating stress and loss.

  Note: Prolonged obsessive reminiscence can be maladaptive, and dysfunctional; it is precipitated by severe stress and lack of resolution of crisis. With these individuals, volunteers should make appropriate referral to a professional counsellor/ therapist.

Tools or Techniques in Reminiscence

- Written or taped autobiography
- Genealogy (family tree)
- Scrapbooks, photo albums, old letters, memorabilia
- Time era novels, books, records (songs, music)

Group Discussion

Q
- How can reminiscence change our perception of the patient in her/his sick role?
- The tools for reminiscence present opportunities for non-verbal and expressive communication. Can you think of other creative aids or tools that might promote and enhance interpersonal communication in an institutional setting?*

* An excellent reference source: Judd, Mary W. (1983). A Sense of Touch. Winnipeg Municipal Hospital.

SESSION III

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SESSION IV

The Helping Relationship *

Objectives

The participants will:

- Gain increased knowledge about basic concepts of the helping relationship
- Practice beginning skills in helping
- Develop understanding of self and others in relation to helping skills

Agenda

- Introduction
  - brief overview of Session III
  - feedback and homework tasks (as required)
  - statement of objectives for Session IV
- LECTURE: WHAT IS A HELPING RELATIONSHIP?
- HELPING CONCEPTS - a series of five simulation exercises
- "I DIDN'T KNOW THAT!" - an exercise in behaviour description and feedback
- JOHARI WINDOW - lecturette
- BLIND WALK
- BROKEN SQUARES
- Wrap Up
  - summary of Session IV and objectives
  - formative feedback
  - handouts and homework tasks (as indicated)
  - overview of coming session
- Evaluation

* Acknowledgement of thanks to Gordon Hancock, Chairman of Continuing Education in Gerontology, University of Manitoba, for the format and facilitation of this session.

LECTURE: WHAT IS THE HELPING RELATIONSHIP?

Purpose

- To define helping
- To identify key concepts/elements in the helping relationship
- To specify goals in helping
- To elaborate on the skills of helping

Group Size

Twelve to fifteen participants

Time Required

Approximately fifteen minutes

Materials

Blackboard
Chalk

Physical Setting

Room large enough to accommodate the participants in a didactic learning/teaching experience

Process

- The facilitator presents the attached lecture.

LECTURE: WHAT IS THE HELPING RELATIONSHIP?

Introduction

Potentially all relationships are helping relationships. It is important to keep in mind the fine line between professional helping and formal helping. As volunteer visitors, you are not professionals, but you are helpers nonetheless.

Therefore, improving the quality of our relationships with the institutionalized patient demands interpersonal skill development in communicating and helping. The following lecture will focus on fundamental concepts and skills in helping.

Definition of Helping

Helping is a process leading to new behaviour for the person being helped (Carkhuff 1980). The intent of helping is to promote development, maturity and improved coping with life of the helpee (Rogers 1961).

Elements in Helping

- It is a mutual growth experience; it is a reciprocal process of joint exploration, problem-solving, learning and responsibility; both helper and helpee may develop their latent inner resources as individuals in a good helping relationship (Rogers 1961).
- Shared trust and willingness to risk (therefore mutual gain).
- Climate of non-judgemental acceptance, genuine respect and caring, listening with understanding.
- Interdependence with autonomy.
- Power and control belongs to the helpee: she/he determines the outcome of the relationship, that is, the change in behaviour.
- Active listening/communication skills.

Goals in Helping

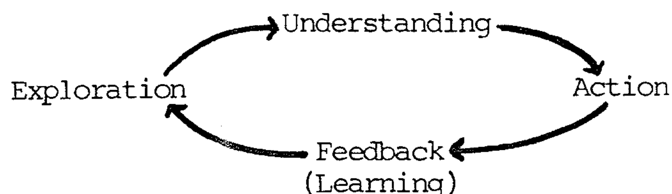
In order to learn new behaviour, the individual must be able to complete the following:

- EXPLORATION in relation to self and the world; must know the problems before behaviour can be changed.

- UNDERSTANDING through self-exploration and clarification of where person is in relation to where s/he wants to be.

- ACTION or the point at which self-understanding becomes real and the individual acts upon how to get from where s/he is to where s/he wants to be in a constructive way.

The process is cyclic when the helpee gets feedback from action, learns from it, and is provided the stimulus to further explore, understand and act. The cycle can be illustrated (on blackboard) diagrammatically as follows:



Helper's Skills

Robert R. Carkhuff (1980) identifies the helper's job as providing assistance to the helpee in exploring, understanding and acting.

The helper's skills needed for helping are:

A. RESPONDING SKILLS

- Attending (physically, contextually, personally)
  Tuning in, establishing a climate of trust and acceptance, giving the helpee a sense of security
  facilitates ---> INVOLVING the helpee in the helping process

- Responding (to feeling and content)
  Communicating empathy, understanding; a message of "I am with you" permitting freedom and encouragement
  facilitates ---> EXPLORATION of helpee's experience

- Personalizing
  Helping the helpee understand where s/he is in relation to where s/he wants to be. The helper clarifies and personalizes the problem, feelings and goals of the helpee through feedback and self-disclosure
  facilitates ---> UNDERSTANDING so the helpee can identify important goals

B. INITIATING SKILLS

Initiating involves a specific plan to reach the goal. By communicating fully, the helpee and helper together develop steps to
facilitate ---> ACTION

Conclusion

From our previous exercises in communication, you will note that the skills acquired in attending, behaviour-description, perception checking and paraphrasing, allow us to pay attention and understand what the other person is telling us about her/his feelings and thoughts, her/his values and expectations and her/his experiences and concerns. Additional responding skills of self-disclosure and feedback (to be studied later in this session) enhance and facilitate deciding (acting) steps of helping.

Facilitator's Guide

For a more detailed description of helper's skills, the facilitator recommends reference to:

1. Carkhuff, Robert R. (1980) The Art of Helping IV. Human Resources Development Press Inc.

2. Rogers, Carl R (1961). On Becoming a Person. Boston: Houghton Mifflin.

HELPING CONCEPTS: A SERIES OF FIVE SIMULATION EXERCISES

Purpose

- To operationalize some key concepts in the helping relationship, namely:
    - Initiation of help
    - Establishment of climate
    - Trust, risk
    - Self-Disclosure
    - Values Clarification

Group Size

Twelve to fifteen participants

Time Required

Approximately fifty to sixty minutes

Physical Setting

Room large enough to allow full movement and accommodation of members in small groups; in standing positions (no chairs)

Process

- The facilitator briefly introduces a series of five exercises that will enable the participants' exploration of helping concepts.
- The participants are instructed to keep in mind the question

  "What is establishing a helping relationship all about?"

Exercise A "What Do I Like About Being a Helper?"

- The facilitator instructs the group to find and pair off with someone in the group with whom they are least familiar.
- Partner A speaks for 2 - 2 1/2 minutes about the question. Partner B will listen with attending and encouraging leads.
- After 2 1/2 minutes, B becomes the speaker; A becomes the listener.
- Q - How do you feel doing this exercise here and now?

Predicted Outcome

The participants have a tendency to seek out the person closest to them. They express reluctance in making an initial move.

Facilitator's Comments

- Helping involves establishing a climate conducive to helping.
- Initiating the first move in a helping relationship involves risk, trust.
- The helper initiates a helping relationship.

Exercise B "Who Am I?"

- The participants find another partner.
- Partner A speaks for five minutes, describing her/himself, values, beliefs and things in life that are important to her/him.

  Partner B will utilize appropriate responding communication skills in attending, encouraging, behaviour-description, perception checking and paraphrasing.
- After five minutes, B becomes the speaker; A the active listener.

Exercise C "What are the things I do well (my strengths)?"

- The participants find another partner.
- The same procedure as per Exercise B is followed.

Exercise D "What are the things I don't do well (my weaknesses)?"

- The participants find another partner.
- The same procedure as per Exercise B is followed.

Group Discussion

Q . What kinds of feelings did you have in relating to one another?

- Were there differences in the encounters? Was one easier than another? more meaningful?
- Initially some reluctance in seeking out a relationship was expressed. Reflect for a moment on the feelings of a person who needs help. Would her/his feelings be similar to the ones you have just experienced?

Facilitator's Comments

SELF-DISCLOSURE

- Through mutual sharing and revealing of self, feelings and reactions in the preceding exercises, another fundamental and beginning dimension of helping - self-disclosure - has evolved.

- True self-disclosure is more than a revealing of highly personal and intimate details of your life. It is instead a sharing response of feelings and reactions about self, about others (whether helpee/helper) and about relationships between us (as they occur "in the moment"); it is a feedback technique.

- Examples of self-disclosure/feedback statements (note ownership and description of feelings)

About Self: At times I'm reluctant to ...
About Other: I am feeling concerned about you now ...
About Relationship: I'm feeling uncomfortable about...; I'm aware of ...

- Self-disclosure is appropriate:

  - if it is honest, genuine, authentic
  - if it is part of an ongoing relationship
  - if it is reciprocated
  - in stressful, crisis situations
  - if used to build an intimate, deeper relationship

VALUES CLARIFICATION

- In helping relationships we respond to another's self-disclosure through support and acceptance, in order to foster and facilitate openness and trust.

- In your visiting, you may find youself offended by a visitee's verbal abuse/behaviour to you. It is possible for you to express displeasure, dissatisfaction of the behaviour (I don't like it when you ...) without rejecting the person.

  In these instances,

- Avoid a judgemental statement, name-calling, labelling, accusations, orders, sarcasm.

BLIND WALK

Purpose

- To emphasize the importance of trust in interpersonal helping relationships
- To demonstrate the effect of feedback in interpersonal helping relationships

Group Size

Twelve to fifteen participants

Time Required

Ten to fifteen minutes approximately

Materials

Six to eight blindfolds (scarfs)

Physical Setting

A building setting that provides hallways, rooms and stairways off the classroom

Process

- Preliminary procedures are followed as per Visual Impairment Exercise, Session II.
- The participants choose a partner (not previously worked with in Session IV).
- Partner A is blindfolded. Partner B provides no feedback to A for the first 2 1/2 minutes of the exercise. After 2 1/2 minutes the facilitator informs the participants of time up, then instructs B partners to provide feedback to A partners.
- The partners switch roles and the exercise is repeated.

Discussion (Brief)

Q
- What were the differences between the two exercises?
- What key elements are necessary for effective helping?

Facilitator's Comments

The facilitator may comment on the vulnerability of the helpee and the need for growth/movement in the relationship through feedback.

"I DIDN'T KNOW THAT!"

Purpose

- To develop helping skills in feedback

Group Size

Twelve to fifteen participants

Time Required

Twenty minutes approximately

Materials

Paper
Pen/pencil

Physical Setting

Room large enough to accommodate six to eight pairs of participants

Process

Exercise A

- The group is instructed to break into pairs.
- On a piece of paper, each partner writes down:

  a) Five adjectives to describe her/himself.
  b) Five adjectives to describe her/his partner.

- Taking turns, the partners share, through feedback, descriptions/ perceptions about their behaviour.
- Before beginning, the facilitator reminds the group of:

  - "I" messages
  - Specific behaviour description/observation

Group Discussion

Q . Were the perceptions of your partner congruent with your own perceptions of self?

- Did the exercise increase your self-awareness, self-understanding and a desire to self-explore?

Predicted Outcome

This exercise presents an opportunity for surprises! Exchanges are lively, fun and pleasant.

Facilitator's Comments

In beginning helping relationships, feedback is generally positive. As mutual trust and openness develop, constructive negative feedback can be risked to promote growth and change.

Exercise B

- The group assembles into groups of four (two pairs from Exercise A).

- The facilitator instructs the participants to

  - Mentally choose a member of the group and observe them in a non-obvious way.
  - Introduce yourself as ... (one person in the group).
  - Act out this person utilizing non-verbal cues of posture, gestures and expressions. No verbal communication is permitted in the play-acting.

Group Discussion

Q . Did you learn something new? something you were unaware of?

. What does it feel like to receive this feedback here and now?

Predicted Outcome

More surprises! This exercise produces some smiles, laughter and a great deal of self-reflection.

Facilitator's Comments

Like a video playback, feedback of this type is close to ultimate mirroring - immediate and extremely effective.

LECTURETTE: THE JOHARI WINDOW

Purpose

- To conceptualize the component of openness in a helping relationship
- To identify, from a theoretical perspective, interpersonal communication/helping skills that facilitate openness in a helping relationship

Group Size

Twelve to fifteen participants

Time Required

Approximately fifteen minutes

Materials

Blackboard or flipchart
Teaching tool: Johari Window (Appendix K)

Physical Setting

Room large enough to accommodate group members in didactic learning/teaching

Process

- The facilitator gives the attached lecturette.
- The Johari Window (Appendices K, L) can be diagrammatically illustrated on blackboard or flipchart.

LECTURETTE:[1] JOHARI WINDOW

Introduction

In the preceding exercises, we have noted the helping relationship is one that evolves through a process of mutual growth. Healthy relationships are developmental and incremental in nature, building on the concept of openness.

Johari Window: A Model for Soliciting and Giving Feedback

- It is a tool which can be used to conceptually measure the degree of openness existing in a given relationship.

DIAGRAM I

- Section #1 My Public Self (open) is behaviour and motivation, known to self and others. It is the area of the self-system (needs, abilities) that can be freely and openly shared. The larger the area, the greater is the person's contact with reality.

- Section #2 My Unaware Self (blind spots) represents behaviour and motivation which is unknown to self, but which is readily apparent to others.

  Simplest example: mannerism of speech, gestures unknown to the person her/himself (refer to "I didn't know that!" exercise).

  Information from this window can be moved to window #1 through feedback.

- Section #3 Private Self (secrets) is behaviour and motivation open to self but unknown to others.

  Information from window #3 can be moved to open window #1 through self-disclosure.

- Section #4 Potential Self (unconscious) is behaviour and motivation unknown to self and others.

  Releasing the potential for new behaviour and motivation is facilitated through insight and reflective learning (refer to goals of helping: understanding, exploring, acting).

1. Adapted in part from Communication Skills Workshop by Gerry Kaplan in Itzlow, Martin (1980). Training the Volunteer Visitor: A Manual of Techniques and Experiences in Training Volunteers Visiting Isolated Retired Persons. Volunteer Centre of Winnipeg.

Growth in the relationship can be graphically represented by the contraction or expansion of the respective sections.

A newly formed relationship would resemble Diagram II, where private self would predominate. As the relationship evolves and grows, public self - the self that is open - grows proportionately (Diagram III).

APPENDIX K[2]

DIAGRAM I
JOHARI WINDOW *

DISCLOSURE

TRUST	KNOWN TO SELF	UNKNOWN TO SELF
known to others	PUBLIC SELF Open Window #1	MY UNAWARE SELF Bad-Breath Window #2 (blind spots) Information from this window can be moved to the Open Window through feedback
known to self	PRIVATE SELF Skeleton-in-the-Closet Window #3 (hidden areas, secrets) Information from this window can be moved to the Open Window through self-dislosure	POTENTIAL SELF Unknown Window #4 (unconscious) Information from this window can be moved to the Open Window through insight and reflective learning

* Named after the two psychologists who first used it, Joseph Lufts and Harry Ingham.

2. Adapted from P.C. Hanson (1973). "The Johari Window: A Model for Soliciting and Giving Feedback". In J.W. Pfeiffer and J.E. Jones (Eds.), The 1973 Handbook for Group Facilitators (1973, pp 114-119). La Jolla, California: University Associates.

APPENDIX L

DIAGRAM II

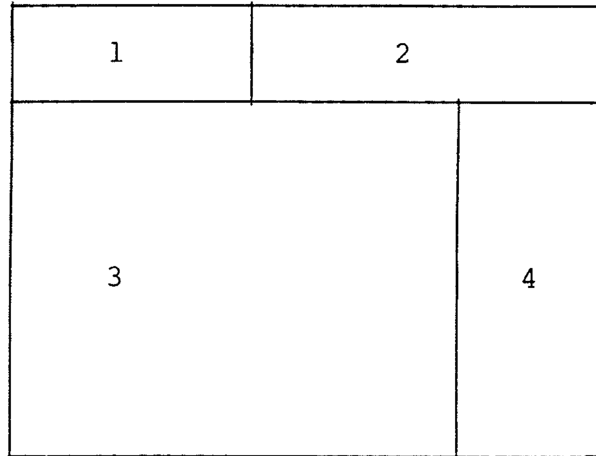
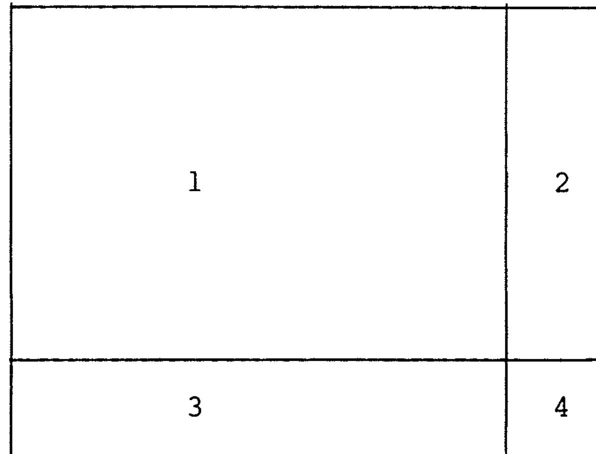


DIAGRAM III



BROKEN SQUARES

Purpose

- To operationalize, through a simulation game, key concepts in the helping relationship:
  - Joint exploration
  - Mutual problem-solving, learning and responsibility
  - Reciprocity: shared trust and wish for mutual gain
  - Interdependence with autonomy
- To introduce beginning skills in initiating

Group Size

Twelve to fifteen participants

Time Required

Approximately fifteen minutes for simulation plus fifteen minutes for discussion

Materials

Broken squares (Appendix M)
Chairs
Tables to seat five participants

Physical Setting

Room large enough to separate the groups

Process

- Group of six participants are assigned to a table.
- The facilitator chooses one group member as an observer/judge.
- The observers are given a copy of instructions (Appendix O).
- The facilitator distributes a pre-prepared packet of five envelopes to each table. The envelopes remain unopened until the signal to work is given.
- Instructions for the task (Appendix N) will be read to the groups by the facilitator.
- Groups are allowed fifteen minutes to complete the task.

Group Discussion

Q . What were some of the feelings/reactions you experienced in this exercise?

. What does the exercise tell you about issues of control and power? about the need for co-operation and teamwork?

. Based on the learning experience, identify elements necessary for effective helping.

Observer's Comments

The judges will supplement the group discussion by offering constructive feedback on their observations of non-verbal communication, relationship issues, etc.

Facilitator's Comments

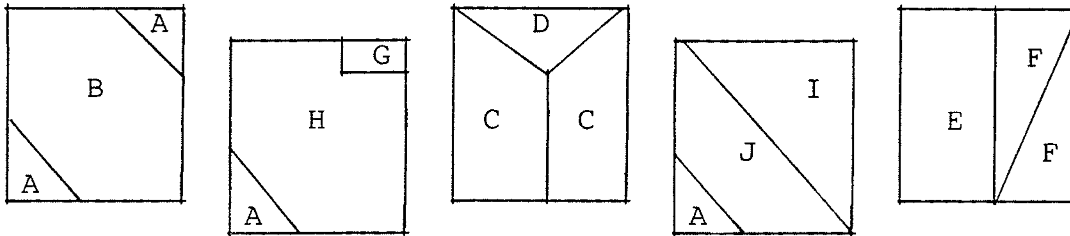
The facilitator will elaborate on concepts/principles of the helping relationship and reinforce the skill of initiating (joint planning and goal setting) necessary to bring about action and change.

APPENDIX M

BROKEN SQUARES *

Directions for Squares Construction:

- Prepare a set of squares, cut equal size 6 x 6 cardboard squares.
- Lightly pencil each square as per the illustration below and draw each puzzle piece so that lettered pieces are of equal size.



- Cut the 6 x 6 squares into puzzle pieces.
- Mark the five envelopes with A, B, C, D and E respectively.
- Distribute the puzzle pieces in the following manner:

Envelope		has pieces
Envelope	A	I, H, E
	B	A, A, A
	C	A, J
	D	D, F
	E	G, B, F, C

- Erase the pencilled letter and mark instead the envelope letter on each piece for identification.
- Assemble the five envelopes in a set or packet.
- Although multiples of three can be utilized to form one or two squares, the <u>goal</u> of the squares exercise is to form five squares 6 x 6.

* Adapted from Bavelas, Alex, "Communication Patterns in Task Oriented Groups"

APPENDIX N

BROKEN SQUARES

Instructions to the Group:

Task Rules

- Each envelope contains puzzle pieces designed to form squares.
- At the facilitator's signal, you may begin to work.
- Your group's task: Form five squares of equal size.
- Goal: Each group member must have, at the end of the task, a perfect square of the same size.

Specific Limitations

- No member may speak.
- No member may ask or in any way, signal another person to give a card.
- Members may give a card directly to another member, but no taking is permitted.

APPENDIX O

BROKEN SQUARES

Instructions to the Observer/Judge (to be seen only by these individuals)

<u>Enforcing Rules</u>

- No talking or pointing among group members.
- Participants may give pieces directly to another individual; taking is not permitted.
- Participants are not allowed to throw pieces in a common "pot" free for the taking.
- One square per participant.

<u>Observing</u>

- How many people are actively engaged in putting the pieces together?
- Periodically check out level of frustration among the participants.
- Observe and record as many different gestures of non-verbal communication as you can.

SESSION IV

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SESSION V

Your Grief and Mine: A Look at Loss, Dying and Death

Objectives

The participants will:

- Gain an awareness of the implication of loss and dying and be able to identify accompanying feelings
- Know the states of adjustment in coping with grief
- Gain insight into grief and dying from one person's perspective

Agenda

- Introduction
    - brief overview of Session IV
    - feedback and homework tasks (as required)
    - statement of objectives for Session V
- A JOURNEY THROUGH LOSS
- LOSSES
- STAGES OF GRIEF
- FILM "REFLECTIONS ON SUFFERING"
    - group discussion
- Wrap-Up
    - summary of Session V and objectives
    - formative feedback
    - handouts and homework tasks (as indicated)
    - overview of coming session
- Evaluation

"A JOURNEY THROUGH LOSS" *

Purpose

- To provide through a fantasy exercise, an insight into dying and feelings associated with impending death
- To identify feelings associated with loss

Group Size

Twelve to fifteen participants

Time Required

Fifteen minutes

Materials

Flipchart
Marker

Physical Setting

Room large enough to accommodate each participant comfortably in an individual private space. The environment should be free from noise and interruption.

Process

- The participants are asked to find their own space physically and mentally. No sharing of information verbally and/or non-verbally is permitted.
- The facilitator introduces the fantasy through a preparatory "tuning-in" process of physical and mental relaxation (mind cleared of thoughts, concentration, relaxed body, closed eyes).
- With paced deliberation, the facilitator takes the participants on an imaginary journey:

  Each participant is to imagine that she or he is leaving her/his home for the last time. The participant pauses at each room, remembers some significant event that has taken place there in the past. This could involve family members, friends, neighbours, pets, possessions, etc. The event might have been a celebration or gathering, hearing of special news,

* Acknowledgement of thanks to Chaplain John Dyck for suggested use and facilitation of this exercise.

or a private time. The participant reflects on her/his role in association with the room and the event (e.g. of roles: parent, spouse, home-owner, neighbour, friend, gardener, hobbyist, host/hostess, etc.).

As the participant moves through the home she/he will say goodbye to each room setting until the journey is completed, with a final goodbye as he/she is called to leave permanently.

Note: This exercise has the potential for evoking powerful emotions as the sense of loss becomes overwhelming. The group should be warned of the possibility of depressive thoughts and crying. Accepting these displays of emotions becomes part of the process.

Group Discussion

- Following the fantasy, the participants are asked to identify feelings associated with saying goodbye for the last time.
- The feelings are listed on the flipchart. Possible feelings are fear, despair, hopelessness, sadness, futility at loss of control, depression, denial, anger, resentment, bargaining, shock, disbelief, relief, feelings of unfinished business, etc.

Predicted Outcome

Reaction to this exercise is varied. Some participants report skepticism while others find it meaningful and realistic.

The facilitator can acknowledge the fact that dying/death presents us with no previous experience with which to relate. Therefore, the conceptualization of death cannot be operationalized in ways that are personally meaningful to us.

LOSSES (Adjunctive Exercise to Fantasy: A Journey Through Loss)

Purpose

- To identify losses that surfaced as a result of the fantasy experienced previously
- To apply the concept of loss to life experiences and situations other than dying/death

Time Required

Approximately twenty minutes

Materials

Flipchart
Markers
Pen/pencil
Paper

Physical Setting

Participants are seated in a group arrangement

Process

- After the fantasy exercise, the participants are asked to physically or mentally record the multiple losses that might be incurred as a result of "leaving home" for the last time.
- The facilitator lists the losses associated with dying on the flipchart (Appendix P).
- The facilitator will introduce a hypothetical situation of entering an institution or nursing home (refer to Peege) and present a comparison of losses cited.
- Other ways one might come to experience loss are explored: divorce; separation; illness; moving, displacement or migration; institutionalization (incarceration, hospitalization, foster home); unemployment; retirement; lost friendship, family, home, loss of family pets, possessions, etc.

Group Discussion

Q
- Need loss and strong feelings result from death alone? Does this surprise you?
- Identify losses you have personally experienced. Rank your losses in terms of having had difficulty in accepting.
- What does this tell you about each individual's unique perception and meaning of loss? the importance of a non-judgemental attitude to the losses of others?

Facilitator's Comments

The loss of cherished possessions is worth mentioning. Although this loss would appear seemingly insignificant (based on the premise that material things are not important in the larger context of loss), it presents an opportunity to point out the meaning of the object, that is, what it stands for (one's past identity, roles and memories).

In nursing homes/institutions it is not uncommon for the elderly to be attached to their possessions.

Predicted Outcome

This exercise is well received, especially if losses were not fully explored in the group discussion following "Peege" (Session I).

APPENDIX P

EXAMPLES OF LOSSES

Material:	furniture, possessions, garden, house (e.g. of "private space")
Status:	prestige, security
Roles:	spouse, parent, child, neighbour, friend, bread-winner, homemaker, employer-employee, hobbyist, community volunteer, etc.
People:	family, friends, acquaintances, fellow employees, etc.
Pets/Plants	
Places:	home, work, associations, community, school
Health or Physiological Loss:	body image, freedom from pain, disability illness
Social and Psychological Losses:	security, friendship, privacy, identity, control, dignity, self-esteem, independence, lost goals or ideals
Future Loss:	or loss of what might have been, i.e. loss of hopes, dreams and aspirations

LOSSES AND WHAT THEY DO[1]
(An Alternative Exercise to Fantasy/Losses)

Purpose

- To identify losses experienced by self and others
- To specify the range of feelings associated with loss

Time Required

Approximately forty-five to sixty minutes

Group Size

Twelve to fifteen participants

Materials

Pen/pencil
Paper for each participant
Flipchart/blackboard

Physical Setting

Room large enough to accommodate three to four groups of four people

Process

- The facilitator briefly introduces the activity, divides the class into small groups of four, and reads the following step-by-step instructions:

    1. Make a list of the five things which you associate most closely with yourself as a person. These may include people, places, possessions, roles, etc.

       Allow five minutes response time, or until everyone appears to have finished.

    2. Choose one item from your list and cross it off. Discuss - discussion should revolve around how this loss affects each person (i.e. individuality, sense of self-esteem).

1. Adapted in part from: Astill-McNish, Susan (1984). "A Sensitization Program for Geriatric Nurses" Canadian Nurse.

3. Remove the item closest to the bottom of the list. Discuss.

4. Reach over (without reading your neighbour's list) and cross off one item on the list of the person sitting on your left. Discuss.

5. Cross off the two most valuable items that remain on the list.

6. Discuss the effect of such losses if your health and independence were also taken away.

7. Describe your feelings throughout this process.

- The facilitator may list feelings solicited in small group discussion on blackboard/flipchart.
- Following this, each participant will review the history of a resident (preferably in Palliative Care) known to her/him and count the losses that individual has suffered.
- One member designated in the small group, will compile a list of losses identified by the participants.
- The master lists are collected from each group and losses are itemized on the flipchart/blackboard.

Note: Participants may become tearful. Anticipatory guidance may be indicated.

Facilitator's Comments

The facilitator will relate the exercise to the experience of people in palliative care/nursing homes, who have suffered multiple losses of spouse, home, role, community, friends and finally health.

STAGES OF GRIEF

Objectives

- To recognize that coping with death is a process of adjustment
- To study the feelings which accompany the stages of mourning and grief

Time Required

Approximately ten to fifteen minutes

Group Size

Twelve to fifteen participants

Materials

Handout: Stages of Adjustment to Death and Dying (Appendix Q)

Physical Setting

Room large enough for group discussion

Process

- The facilitator distributes the handout on the stages of grief or mourning.
- The group collectively reviews the grief stages theorized by Elizabeth Kubler-Ross.

Group Discussion[2]

Q . Kubler-Ross suggests that patient, family and caregivers all go through the cited mental adjustments in coming to terms with mortality. Are these observations valid?

- Does the experience and expression of grief stages take into account time frame, cultural expectations and uniqueness of the individual?

2. Questions derived in part from Ajemian, Ina (1982). Time for Caring, A Documentary on the Volunteer as Part of the Palliative Care Team, Resource Handbook. National Film Board of Canada.

- "There is a danger that Kubler-Ross 'stages' may become prescriptive rather than descriptive, that preoccupation with psycho-dynamics ... may not be helpful, and that the diagnosis of a patient's 'stage' may become an end in itself rather than a means to an end." (Ajemian 1982).

  From your personal experience with the dying patient/relative, would you agree with this statement? Why? Is there a right way to die? a right way to mourn?

Predicted Outcome

The grief stages are familiar to most participants and little time is required in their review. This allows the facilitator to move to a more in-depth study of the dynamics of grief.

APPENDIX Q

STAGES OF ADJUSTMENT TO DEATH AND DYING[3]

With all stages, Time varies from a few hours to weeks, days, years.

These stages apply to adjustment to dying and death. Adapted from E. Kubler-Ross "On Death and Dying".

First Stage: Denial and Isolation

Usually a temporary defense and a lack of acceptance of reality. Isolation may occur for various reasons, such as fear of revealing emotions or lack of ability to relate to others. Each individual is unique.

Second Stage: Anger

When denial and isolation have passed, the logical next question is "Why me?". This is a difficult stage for helpers. It may manifest itself in profanity and other disturbing behaviours. Everything will seem to cause anger. Tolerance by helpers is essential.

Third Stage: Bargaining

This combines with anger. For example, someone who is angry about pain or about loneliness may bargain with the helper:

"I'll stop shouting if someone gives me a pill" or
"If my son comes to visit, I won't be so lonely"

It is an attempt to postpone reality and sometimes covers a feeling of guilt.

Fourth Stage: Depression

At this point, reality can no longer be denied or bargained away. People should be allowed to express this depression. Companionship during silent times of grief can be comforting. Cheering up is not usually helpful.

Fifth Stage: Acceptance

When anger and depression are no longer necessary for coping and the person has been able to express previous feelings, acceptance of impending death or loss occurs. This stage does not necessarily mean happiness, often it includes hope.*

* Brainstorming: Hope - How might a patient or family have hope in the face of dying? Hope is always present even in dying - hope that one dies peacefully, goes to heaven, dies without pain, hope that family will carry on.

3. Adapted from Kaplan, Leslie S. (1980). Using Developmental Loss Workshops in the Classroom. Unpublished text, Eric Search Ed. 199593. University of Manitoba.

FILM "REFLECTIONS ON SUFFERING"[4]

Purpose

- To gain insight into anticipatory grief/mourning from one person's perspective
- To extrapolate key concepts in the dynamics of the grieving process

Time Required

Viewing time (twenty minutes) plus group discussion (thirty to forty minutes), total of one hour

Group Size

Twelve to fifteen participants

Materials

8mm Projector
Screen
Film
Pen/pencil
Notepaper
Blackboard
Chalk

Physical Setting

Room large enough to permit film viewing

Process

- The facilitator briefly and carefully introduces the film (without bias or prejudice).
- Participants will be asked to jot down impressions, comments and incidents to which they particularly relate (both in a positive and negative sense).

4. "Reflections on Suffering" by Malca Gillson, National Film Board of Canada.

- Concepts to look for:

  a) Expressions (Stages) of Mourning
  b) Social Issues
  c) Psychological/Spiritual Issues
  d) Expectations of the Helper/Emotional Needs of the Patient

- Halfway through the film, the facilitator may choose to stop the film and facilitate group discussion around the key concepts presented thus far. In the event that the learning experience is structured in this manner, participants should be forewarned of the mid-point interruption.

Group Discussion

- The participants verbally submit fundamental points made in the film by Jean Cameron, a volunteer social worker in Palliative Care. The facilitator categorically records the main ideas on the blackboard under the concepts earlier outlined.

- The concepts are used as the foci of group discussion.

KEY CONCEPTS

I <u>Expressions of Grief</u>

- SHOCK, DISBELIEF - at diagnosis; at now being a patient versus a volunteer visitor (role reversal).

- ISOLATION - sense of loneliness and feelings of rejection; physical and emotional withdrawal.

- ANGER - at being neglected, at not having support when it was most needed.

- DEPRESSION - inevitable in the face of loss; self-doubt, of helplessness and hopelessness initially; day to day sadness associated with illness (i.e. physiological losses of mobility; physical and mental capacities).

- ACCEPTANCE - gradual acceptance of cancer and the inevitable, sees growth in adversity and in suffering; acceptance different than resignation; sense of peace.

  - Acceptance of the inevitable can free one to sharing remaining life with loved ones.

II <u>Social Issues</u>

- STIGMA OF CANCER (DYING) - social isolation; friends' embarrassment, rejection and fear of infection, physician's withdrawal.

- ATTITUDE TO DEATH/DYING - reflected in societal rejection and conspiracy of silence ("death-denying society").

III Psychological/Spiritual Issues

- QUALITY OF LIFE - sees each day as an opportunity; enjoys being useful as able to forget one's own suffering by helping others; cannot be cured but can lead a worthwhile life in the face of declining resources.

  - Sees self-worth and value in being, as opposed to doing.

- PATIENT TO PATIENT SUPPORT - elements of commonality that must be respected and encouraged (underutilized support system).

  - Lessens sense of loneliness and feeling that no one understands.

- HOPE - hope is always there, just changes somewhat. A desire for longer life gives way to other hope:

  - Hope for dying in peace, without pain.
  - Hope to be with loved ones.
  - Hope for memory continuing on in flowers.

- LOSS - must say goodbye to everything.

- MEANING OF LIFE

  - Sees cancer in the order of things; life and death are in the cycle of regeneration, i.e. nothing is wasted.

  - Loves nature (birds, flowers, plants, animals); sees her counterpart in nature; expresses a wish to leave her legacy in her garden of flowers (existence after life).

  - Both fair and unfair things make up life; acceptance of meaning and purpose of life.

  - Reconsiders metaphysical questions and re-examines belief: Is suffering a punishment from God? Sees death instead as an ultimate gift from God, an opportunity to grow spiritually in faith and trust.

  - Suffering with terminal illness is a task that demands:
    1) adaptation to symptoms and diminished capacities
    2) acknowledgement of loss and separation
    3) consideration of transition into unknown state
    4) review of one's life and its significance

- EXPECTATIONS OF HELPER

  - Sharing, caring, understanding, openness, acceptance, patience, sensitivity, "professional" helping is not required.

- Creative listening - ability to listen to not only what is said but what is not said, i.e. things that are hinted at, implied or alluded to (figurative "symbolic" language). See Handout "Creative Listening".

- Love, concern - conveyed nonverbally through touch of a hand or arm (always respecting the individuality of the person).

- Meet the patient where she/he is, not where we think she/he "should" be. Death is a unique experience and reactions vary (avoid categorizations or stages).

- Hopeful, positive, and calm, open attitude (willingness to confront painful issues).

Variation

The facilitator may structure group discussion around specific questions posed after the film viewing.

Example of Exercise Question:

Using what you have learned from interpersonal skills training, identify ways of providing support for the patient in the film or a patient you are familiar with who may be dying. Keep in mind that these skills are appropriate and generalizable to <u>all</u> your visiting.

Facilitator's Comments

The film illustrates nicely the concepts earlier introduced. However, it is essential to point out that the film focuses on <u>one</u> patient's perspective of anticipatory grief/mourning. The uniqueness of each individual must be emphasized.

Predicted Outcome

Participants are impressed by the "real life" quality of the film. Group discussion is essential to the learning experience to facilitate awareness of self and others. The significance of the spiritual component of total care of the dying patient must not be ignored and invites discussion.

RECOMMENDED ALTERNATIVE LEARNING EXPERIENCES:

Mount, Balfour N. "The Last Days of Living", National Film Board, film and resource handbook (discussion guide).

Ajemian, Ina "A Time for Caring: A Documentary on the Volunteer as part of the Palliative Care Team", National Film Board, film and resource handbook (discussion guide).

CREATIVE LISTENING *

"The first duty of love is to listen," says Paul Tillich. Because listening seems to be purely passive, we often don't see it as an act of kindness. Yet, in reality, listening to someone involves more than the ears; it requires the heart and the intellect as well. Too many genuinely compassionate people make poor listeners. In their haste to respond and help the situation causing the pain, they break in with advice and solutions before they have heard the whole story. They fail to realize that part of the benefit gained through a discussion of problems and fears lies simply in their verbalization, in confronting and expressing the fact of their reality. A creative listener is neither critical nor judgemental ... but instead accepts you as you are ... reckless, ill-tempered, joyful, pensive.

Active listening does not come naturally. It is a skill to be learned, an art to be developed. It improves with training and practice.

Some guidelines for creative listening:

- Look at your attitude and how you feel about the person who is talking to you. Are you looking up or down at them? Can you accept the person totally?
- Listen for feelings behind what is being said, to the tone of voice, and the body language as well as the words themselves.
- Be attentive and try not to let your mind wander in your own thoughts and reactions. Good listening requires a quiet atmosphere without distraction.
- Test your understanding by "feeding back" what you have just heard and felt. This helps focus and clarify thoughts and feelings.
- Don't stereotype the patient. Assume nothing. Don't assume that the patient feels "like all dying patients" or that the patient's goals in life are the same as yours.
- Interpret questions as door-openers. If any answer is really being sought, the question will be repeated. Most questions require no answer except to share the feeling behind them.
- Remember that the patient is in control, and that the listener can help only as much as allowed. If you follow the mood of the patient, you will have no difficulty laughing together over the absurd events of the day, or seriously considering some of the mysteries of life.

* From Ajemian, Ina (1982). A Time for Caring: A Documentary on the Volunteer as Part of the Palliative Care Team: Resource Handbook. National Film Board, pp. 36-38.

- Examine your own feelings. Too often we are sympathetic to the other, focusing on how we feel in response to the situation of the other. Sympathy in the listener is self-centered, and is not helpful to the patient. In contrast, an empathetic response hears the feelings of the other and seeks to understand. It is centered in the patient and can lead to further understanding.

- Are you projecting your own feelings onto the patient? Projection distorts the accuracy and depth of understanding, and leads to many errors in listening.

- Remember that a conversation with a patient is privileged communication. It should be received with confidentiality, respect and a nonjudgemental attitude. On the other hand, it must also be remembered that the volunteer is present as a member of a team and that some of the material surfacing in discussion with the patient may have relevance to others. It can assist in their understanding of the patient and the patient's problems and thus influence future care. In general, the boundaries of confidentiality regarding information of this nature include those on the care-giving team who will be of greater assistance to the patient/family if the information is shared. It is useful to ask in each instance whether information sharing is for this reason or simply to satisfy curiosity or some other unacceptable end.

SESSION V

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SESSION VI

Family Dynamics
Saying Goodbye

Objectives

The participant will:

- Gain increased knowledge about family dynamics and the aging/dying patient
- Acquire introductory skills in dealing with the patient's family
- Examine the place of unfinished business in terminating a relationship
- Practice a skill technique for terminating a relationship

Agenda

- Introduction

  - brief overview of Session V
  - feedback and homework tasks (as required)
  - statement of objectives for Session VI

- FAMILY DYNAMICS - a lecture
- Interpersonal skills in dealing with the patient's family
- UNFINISHED BUSINESS
- SAYING GOODBYE - a technique in terminating a relationship
- Formative Feedback for Session V
- Verbal summative feedback of the training program and its goals
- Evaluation
- Presentation of Certificates
  Wine and Cheese Reception
- Closure

LECTURE: FAMILY DYNAMICS

Purpose

- To study some fundamental concepts of family dynamics in relation to the impact of serious illness and dying on the family life cycle
- To explore strategies and skills in dealing with the patient's family

Group Size

Twelve to fifteen participants

Time Required

Approximately sixty minutes

Materials

Overhead projection depicting main concepts and/or
Handout at facilitator's discretion

Physical Setting

Room large enough for small groups of three to four for discussion exercise

Process

- The following lecture is given (see Appendix R)
- The participants break into small groups of four

Group Discussion

Q . Think back to the family depicted in the film "Peege". With the exception of the grandson, have your perceptions/feelings/reactions changed toward the family? If so, in what way? What are some of the tasks facing them right now? What are some of the strengths demonstrated by this family?

Assign to the first two groups the following task:

- Assume for a moment that Peege's son, the father, has come in while you were visiting. He appears saddened by the deteriorating state of his mother and openly acknowledges that it is difficult for him to visit her. Using your interpersonal helping skills and strategies, explain how you might help him under the circumstances.

Assign the second two groups the following task:

- Take a hypothetical situation in which Peege's elderly husband, who lives alone, has come to visit. He stops you outside the room. He states that he is unable to visit frequently due to his own failing health and he worries about his wife. Explore in the group some basic helping strategies that could be utilized in the situation.

- Have a selected group leader make a list of strategies and present them to the whole group for later discussion.

APPENDIX R

"Family Dynamics"

Introduction

From time to time, you are or may be called upon to extend instrumental and emotional support to the patient's/resident's family members.

To enhance the quality of this relationship, it is essential to grasp a few basic concepts in family dynamics, focusing on the middle-aged and older family. Incorporating this knowledge with the interpersonal skills training you have thus far received will enable you to become more effective in your volunteer visiting.

KEY CONCEPTS

I Family

- Individual's fundamental unit of socialization
- System of reciprocal relationships providing social, emotional and instrumental assistance in coping
- Generally operates to keep emotional tension down and family equilibrium stabilized.
- Constitutes context in which illness occurs and is resolved; serves as a primary unit in health and illness

The occurrence of serious illness/impending death occurs in tandem with developmental tasks in the family life cycle, often causing stress which can result in disorganization and crisis in the family.

II Family Life Cycle

MIDDLE-AGED FAMILY (prime of productivity)

Tasks

- Serve as a bridge between younger and older generation, known as "sandwich generation"
- Child-raising, parenting issues
- Career, vocational pursuits
- Seeking financial security and planning

Coping Tasks

- Re-assessing life achievements and goals (come to terms with middle life)
- Launching children, accepting "new" family relationships (in-laws, grandchildren)

- Focus on mid-life marriage and career issues
- Shifting concern to disability and death in older generation
- Increasing awareness of own mortality

Stresses

- Overtaxing of resources (physical, emotional, finanical)
- Neglect of own personal needs

Stresses in Relation to Older Generation

- Caretaking role (especially middle-aged daughter/daughter-in-law)
- Unresolved tensions
- Lingering authority/power/status conflict
- Indebtedness, obligation, loyalty
- Communication breakdown
- Isolation of elderly from family

OLDER FAMILY

Tasks

- Acceptance of shifting of generational roles
- Coming to terms with aging process (physiological decline of physical and mental functioning)
- Dealing with loss of spouse, siblings, peers
- Resolution and achievement of integrity versus despair regarding the acceptance of one's own life and death (Erickson 1950)

Stresses

- Multiple change and loss
- Fear of illness and dependency

III Serious Illness/Dying

The family as a unit must adjust to illness and dying. This involves many physical, social, emotional, behavioural and cognitive challenges. Difficulty in meeting these challenges may impede resolution of life tasks earlier outlined.

Stresses

Physical: Physical and sexual limitation; debilitation, pain, side effects of treatment, altered body image.

Practical/Instrumental: Care of sick/dying, reorganization of employment/education; financial considerations, transportation, child care arrangements.

Intellectual: Getting information re illness and treatment; understanding medical jargon, information about hospital regulations and routine, participation in own care.

Emotional: Coping with isolation, stigma, separation from supports; acceptance of dependence, passivity and vulnerability; finding love, nurturing and affirmation; dealing with grief/loss/change; guilt and uncertainty.

Interpersonal: Change in social roles (relinquishment by patient; increased roles by other family members); diminished support systems; closed communication.

Spiritual: Seeking meaning and explanation for illness; creating new social identity; reordering life plan/dreams; acknowledging/accepting mortality; relating to God/Spiritual Being.

IV Helping Strategies

1) Interpersonal helping skills

2) Provide instrumental tasks if appropriate without overfunctioning for family

3) Point out strengths in family/patient coping (relieve guilt and tension)

4) Respect/hope for life and living

5) Share positive feedback with the family regarding your visits with the patient/resident (exercise discretion re patient consent)

6) Referral (if coping capacities are inadequate)

UNFINISHED BUSINESS

Purpose

- To clarify the role and place of unfinished business in terminating a relationship

Group Size

Twelve to fifteen participants

Time Required

Twenty minutes

Materials

Pen/pencil
Paper

Physical Setting

Room large enough to allow ample spatial movement of the participants

Process

- The facilitator distributes pens and paper and introduces the exercises.

  The group is instructed as follows:

  Think of a person (preferably a patient) with whom you have had a relationship and to whom you said or did something you could not take back or undo <u>or</u>

  to whom you would have liked to have said or done something but have not had the opportunity (as in a death or separation).

- Mentally put the person's name at the top of the page.
- Write down what you would do/say if you had the chance.
- The group will break into small groups of four to <u>voluntarily</u> share the "unfinished business" of their relationships.

Small Group Discussion

Q • Is your unfinished business similar to others' unfinished business?

- What keeps you from doing or saying these things in real life?
- What reactions/feelings are created when you do not complete such unfinished business?

Exercise Closure

- Participants are given the option of "finishing business" with other members in the group.

SAYING GOODBYE *

Purpose

- To practice a structured technique for terminating a relationship
- To increase understanding of the application of the goodbye technique in validating personal relationships

Group Size

Twelve to fifteen participants

Time Required

Approximately twenty to twenty-five minutes

Materials

Pen/pencil
Handout guide (Appendix S)

Physical Setting

Room large enough to accommodate eight pairs of participants

Process - Validation: Terminating a Relationship

- The participants are asked to pair off with a partner they will have limited contact with or are unlikely to see after the training session.
- Each group participant is given a sheet with the headings:

  I learned from you that ...
  I appreciate you because ...
  What I remember most about our experience together is ...

- In paired activity, each participant completes the open-ended phrases and gives the handout to their partner. The partners exchange feedback and reactions.
- If time permits, participants can pair off with a total of up to three partners in the group and repeat the process.
- When the group is reassembled, the facilitator addresses the group using the format phrases to validate <u>her/his own</u> relationship to the group. Feedback is solicited from the participants.

* Writer's variation adapted in part from Kaminski, Robert C., "Saying Goodbye: An Example of Using a Goodbye Technique and Concomitant Psycho-Drama in the Resolving of Family Grief".

Group Discussion

Q . How are you feeling about yourself right now? about others in the group?

- How does this affect your relationship with others in this group?
- What keeps you from doing this outside the group?
- Can you think of other situations with personal friends, family and patients where this technique could be applied?

Facilitator's Comments

If growth of group has evolved, this exercise will evoke tears and ambivalent (happy and sad) feelings in closure.

APPENDIX S

I LEARNED FROM YOU THAT............

I APPRECIATE YOU BECAUSE..............

WHAT I REMEMBER MOST ABOUT OUR EXPERIENCE
TOGETHER IS................

SESSION VI

BIBLIOGRAPHY

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Kaminski, Robert C. Saying Goodbye: An Example of Using a Goodbye Technique and Concomitant Psychodrama in the Resolving of Family Grief. Unpublished text, Eric Search ED 184020, University of Manitoba, Winnipeg, Manitoba.

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TRAINING PROGRAM APPENDICES

Opinion Survey

Session I AGING

Impact Evaluation
Process (Program) Evaluation } Formative

Session II PHYSIOLOGICAL CHANGES IN THE ELDERLY

Impact Evaluation
Process (Program) Evaluation } Formative

Session III COMMUNICATION SKILLS

Impact Evaluation
Process (Program) Evaluation } Formative

Session IV THE HELPING RELATIONSHIP

Impact Evaluation
Process (Program) Evaluation } Formative

Session V YOUR GRIEF AND MINE; A LOOK AT LOSS, DYING AND DEATH

Impact Evaluation
Process (Program) Evaluation } Formative

Session VI FAMILY DYNAMICS
SAYING GOODBYE

Impact Evaluation
Process (Program) Evaluation } Formative

Final Impact Evaluation (Summative)
Final Process (Program) Evaluation (Summative)
Observer Evaluation (Outcome Evaluation)

OPINION SURVEY

NAME ______________________________ M ☐

ADDRESS ______________________________ F ☐

CURRENT VOLUNTEER PLACEMENT ______________________ AGE ____

NO OF HOURS SERVED: WEEKLY ____ HR

MONTHLY ____ HR

LENGTH OF VOLUNTEER SERVICE ______________

WORK EXPERIENCE AND SPECIAL LIFE EXPERIENCES

PARTICIPATION:

a) REASONS FOR YOUR INTEREST IN THIS TRAINING PROGRAM

b) EXPECTATIONS FOR TRAINING PROGRAM

SKILL KNOWLEDGE DEVELOPMENT

Identify skills/knowledge you feel you have or don't have or which you feel you would like to develop below in your visiting relationships:

1. Increased knowledge about:
   a) dying
   b) aging
   c) specific illness
2. Interpersonal skills with:
   a) the patient
   b) the family
3. Listening skills
4. Communication
5. Helping skills

   Other

   If other, please describe:-

	Yes	No	Would like to develop
1.			
a)			
b)			
c)			
2.			
a)			
b)			
3.			
4.			
5.			

IV PERSONAL AWARENESS

I would describe myself as:-

V ANY ADDITIONAL COMMENTS OR CONCERNS ABOUT THE TRAINING SESSION:

S E S S I O N   I
Aging

1) Impact Evaluation
2) Process (Program) Evaluation

} Formative

SESSION I

1) Stereotypical Attitudes to the Elderly

LEVEL OF UNDERSTANDING	Before the Class		After the Class
5 Very High			
4 High			
3 Average			
2 Low			
1 Very Low			

TIME

2) Social and Psychological Changes in the Elderly

LEVEL OF UNDERSTANDING	Before the Class		After the Class
5 Very High			
4 High			
3 Average			
2 Low			
1 Very Low			

TIME

EVALUATION OF SESSION I

1) Attitudes to the Elderly
2) Social and Psychological Changes in the Elderly

1) Did the session meet its objective(s) as stated?

YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1	2	3	4	5	6	7
-						+

Circle as appropriate

3) The overall pace of the session was:

TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

a) Facilitator's Presentation	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
Content	____	____	____	____	____
Organization	____	____	____	____	____
Thoroughness	____	____	____	____	____
Professional Delivery	____	____	____	____	____

b) Learning Techniques (As applicable for each session)

Learning Techniques	0	1	2	3	4
Lecturette	____	____	____	____	____
Role Play	____	____	____	____	____
Learner Participation	____	____	____	____	____
Small Group Discussion	____	____	____	____	____
Film	____	____	____	____	____
Audio Tape	____	____	____	____	____
"Expert" Guest Speaker	____	____	____	____	____
Overhead Projection	____	____	____	____	____
Self Instructional Aids	____	____	____	____	____
Handouts	____	____	____	____	____

.../Cont'd

5) How would you rate today's program on an overall basis?

_____ EXCELLENT
_____ GOOD
_____ FAIR
_____ POOR
_____ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

SESSION II
Physiological Changes in the Elderly

1) Impact Evaluation
2) Process (Program) Evaluation

} Formative

SESSION II

Physiological Losses of the Elderly

L E V E L
O F
O W L E D G E

5
Very
High

4
High

3
Average

2
Low

1
Very
Low

Before the
Class

After the
Class

T I M E

EVALUATION OF SESSION II

Physiological Losses of the Elderly

1) Did the session meet its objective(s) as stated?

   YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1	2	3	4	5	6	7
-						+

   Circle as appropriate

3) The overall pace of the session was:

   TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

   a) Facilitator's Presentation

	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
Content	___	___	___	___	___
Organization	___	___	___	___	___
Thoroughness	___	___	___	___	___
Professional Delivery	___	___	___	___	___

   b) Learning Techniques

(As applicable for each session)

Lecturette	___	___	___	___	___
Role Play	___	___	___	___	___
Learner Participation	___	___	___	___	___
Small Group Discussion	___	___	___	___	___
Film	___	___	___	___	___
Audio Tape	___	___	___	___	___
"Expert" Guest Speaker	___	___	___	___	___
Overhead Projection	___	___	___	___	___
Self Instructional Aids	___	___	___	___	___
Handouts	___	___	___	___	___

.../Cont'd

5) How would you rate today's program on an overall basis?

______ EXCELLENT
______ GOOD
______ FAIR
______ POOR
______ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

SESSION III
Communication Skills

1) Impact Evaluation
2) Process (Program) Evaluation

} Formative

SESSION III

I Communication Skills

Active Listening

1) Attending

LEVEL OF ABILITY/ SKILLS				
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			
		Before the Class		After the Class

TIME

2) Encouraging

LEVEL OF ABILITY/ SKILLS				
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			
		Before the Class		After the Class

TIME

3) Behaviour Description

LEVEL OF ABILITY/ SKILLS				
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			
		Before the Class		After the Class

TIME

SESSION III

I Communication Skills

4) Perception Checking

LEVEL OF ABILITY/ SKILLS

	Before the Class		After the Class
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

5) Paraphrasing

LEVEL OF ABILITY/ SKILLS

	Before the Class		After the Class
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

II Knowledge/Understanding

1) Life Review

LEVEL OF ERSTANDING

Very High			
High			
Average			
Low			
Very Low			
	Before the Class		After the Class

TIME

EVALUATION OF SESSION III

Communication Skills

1) Did the session meet its objective(s) as stated?

YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1	2	3	4	5	6	7
-						+

Circle as appropriate

3) The overall pace of the session was:

TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

a) Facilitator's Presentation	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
Content	____	____	____	____	____
Organization	____	____	____	____	____
Thoroughness	____	____	____	____	____
Professional Delivery	____	____	____	____	____

b) Learning Techniques

(As applicable for each session)

Learning Techniques	0	1	2	3	4
Lecturette	____	____	____	____	____
Role Play	____	____	____	____	____
Learner Participation	____	____	____	____	____
Small Group Discussion	____	____	____	____	____
Film	____	____	____	____	____
Audio Tape	____	____	____	____	____
"Expert" Guest Speaker	____	____	____	____	____
Overhead Projection	____	____	____	____	____
Self Instructional Aids	____	____	____	____	____
Handouts	____	____	____	____	____

.../Cont'd

5) How would you rate today's program on an overall basis?

_____ EXCELLENT
_____ GOOD
_____ FAIR
_____ POOR
_____ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

SESSION IV
The Helping Relationship

1) Impact Evaluation } Formative

2) Process (Program) Evaluation }

SESSION IV

I Helping Skills

1) Active Listening

LEVEL OF ABILITY/ SKILLS		Before the Class		After the Class
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			

TIME

2) Self-Disclosure

LEVEL OF ABILITY/ SKILLS		Before the Class		After the Class
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			

TIME

3) Feedback

LEVEL OF ABILITY/ SKILLS		Before the Class		After the Class
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			

SESSION IV

Interpersonal Skills in Helping

LEVEL OF ABILITY/ SKILLS		Before the Class		After the Class
	5 Excellent			
	4 Good			
	3 Average			
	2 Fair			
	1 Poor			

T I M E

EVALUATION OF SESSION IV

The Helping Relationship

1) Did the session meet its objective(s) as stated?

YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1 2 3 4 5 6 7
\- +

Circle as appropriate

3) The overall pace of the session was:

TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

	a) Facilitator's Presentation	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
	Content	___	___	___	___	___
	Organization	___	___	___	___	___
	Thoroughness	___	___	___	___	___
	Professional Delivery	___	___	___	___	___
	b) Learning Techniques					
	Lecturette	___	___	___	___	___
	Role Play	___	___	___	___	___
(As applic-	Learner Participation	___	___	___	___	___
able for	Small Group Discussion	___	___	___	___	___
each	Film	___	___	___	___	___
session)	Audio Tape	___	___	___	___	___
	"Expert" Guest Speaker	___	___	___	___	___
	Overhead Projection	___	___	___	___	___
	Self Instructional Aids	___	___	___	___	___
	Handouts	___	___	___	___	___

.../Cont'd

5) How would you rate today's program on an overall basis?

- ______ EXCELLENT
- ______ GOOD
- ______ FAIR
- ______ POOR
- ______ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

S E S S I O N V
Your Grief and Mine:
A Look at Death and Dying

1) Impact Evaluation
2) Process (Program) Evaluation

} Formative

SESSION V

Dying and Death

LEVEL OF DERSTANDING/ KNOWLEDGE

	Before the Class		After the Class
5 Very High			
4 High			
3 Average			
2 Low			
1 Very Low			

TIME

SESSION 7

I Death and Dying

1) Loss

LEVEL OF UNDERSTANDING

	Before the Class		After the Class
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

2) Feelings Associated With Loss

LEVEL OF UNDERSTANDING

	Before the Class		After the Class
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

3) Stages of Grief

LEVEL OF UNDERSTANDING

	Before the Class		After the Class
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

SESSION V

II Death and Dying

1) Interpersonal Skills
Supportive Techniques

LEVEL OF UNDERSTANDING	Before the Class		After the Class
Very High			
High			
Average			
Low			
Very Low			

TIME

EVALUATION OF SESSION V

Dying and Death

1) Did the session meet its objective(s) as stated?

YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1	2	3	4	5	6	7
-						+

Circle as appropriate

3) The overall pace of the session was:

TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

a) Facilitator's Presentation

	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
Content	___	___	___	___	___
Organization	___	___	___	___	___
Thoroughness	___	___	___	___	___
Professional Delivery	___	___	___	___	___

b) Learning Techniques

(As applicable for each session)

	0	1	2	3	4
Lecturette	___	___	___	___	___
Role Play	___	___	___	___	___
Learner Participation	___	___	___	___	___
Small Group Discussion	___	___	___	___	___
Film	___	___	___	___	___
Audio Tape	___	___	___	___	___
"Expert" Guest Speaker	___	___	___	___	___
Overhead Projection	___	___	___	___	___
Self Instructional Aids	___	___	___	___	___
Handouts	___	___	___	___	___

.../Cont'd

5) How would you rate today's program on an overall basis?

_____ EXCELLENT
_____ GOOD
_____ FAIR
_____ POOR
_____ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

SESSION VI
Family Dynamics
Saying Goodbye

1) Impact Evaluation
2) Process (Program) Evaluation

} Formative

SESSION VI

I Understanding Family Dynamics

LEVEL OF UNDERSTANDING

	Before the Class		After the Class
5 Very High			
4 High			
3 Average			
2 Low			
1 Very Low			

TIME

II Terminating a Relationship

LEVEL OF ABILITY/ SKILL

	Before the Class		After the Class
Excellent			
Good			
Average			
Fair			
Poor			

TIME

EVALUATION OF SESSION VI

1) Dealing with the Family
2) Saying Goodbye

1) Did the session meet its objective(s) as stated?

YES _____ NO _____ DON'T KNOW _____

2) On a scale of 1 - 7 how would you rate today's session in terms of application and/or relevance to your volunteer duties and responsibilities?

1	2	3	4	5	6	7
-						+

Circle as appropriate

3) The overall pace of the session was:

TOO SLOW _____ TOO FAST _____ JUST RIGHT _____

4) For each of the items below place an X in the appropriate column:

a) Facilitator's Presentation	NOT RELEVANT 0	1	2	3	VERY RELEVANT 4
Content	____	____	____	____	____
Organization	____	____	____	____	____
Thoroughness	____	____	____	____	____
Professional Delivery	____	____	____	____	____
b) Learning Techniques					
Lecturette	____	____	____	____	____
Role Play	____	____	____	____	____
Learner Participation	____	____	____	____	____
Small Group Discussion	____	____	____	____	____
Film	____	____	____	____	____
Audio Tape	____	____	____	____	____
"Expert" Guest Speaker	____	____	____	____	____
Overhead Projection	____	____	____	____	____
Self Instructional Aids	____	____	____	____	____
Handouts	____	____	____	____	____

(As applicable for each session)

.../Cont'd

5) How would you rate today's program on an overall basis?

_____ EXCELLENT
_____ GOOD
_____ FAIR
_____ POOR
_____ NOT WORTHWHILE

6) Which part of today's session do you feel was the most worthwhile?

Why?

7) Which part(s) of today's session did you feel was (were) the least worthwhile?

8) Suggestions for future sessions on these topics?

9) Additional Comments

I FINAL IMPACT EVALUATION

II FINAL PROCESS (TRAINING PROGRAM) EVALUATION

Name ______________________________

FINAL IMPACT EVALUATION

Directions: This inventory is designed to measure change in your level of knowledge and/or skill development prior and after the training program. It is not a test; there are no right or wrong answers.

On each graph scale, place an X on the place that best describes your level of knowledge and/or skill development before the training program, then after the training program. Kindly return the form to me at the end of the session.

Your identity will remain anonymous and confidentiality is assured.

Thank you, Gen Henderson

FINAL IMPACT EVALUATION

PART I GROUP DEVELOPMENT

1) Group Rapport

LEVEL OF RAPPORT			
Very High			
High			
Average			
Low			
Very Low			
	Before the		After the

Training Program

TIME

2) Group Support

LEVEL OF GROUP SUPPORT			
Very High			
High			
Average			
Low			
Very Low			
	Before the		After the

Training Program

TIME

PART II LEVELS OF AWARENESS

AWARENESS OF SELF

	Before the Training Program		After the
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

AWARENESS OF GROUP

	Before the Training Program		After the
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

AWARENESS OF PATIENT/
RESIDENT

	Before the Training Program		After the
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

AWARENESS OF FAMILIES
OF PATIENT

	Before the Training Program		After the
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

PART III   IMPROVEMENT OF RELATIONSHIP SKILLS

LEVEL OF OVER-ALL SKILL DEVELOPMENT

	Before the Training Program		After the Training Program
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

LEVEL OF OVER-ALL KNOWLEDGE

	Before the Training Program		After the Training Program
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

CONFIDENCE LEVELS IN FORMING RELATIONSHIPS

	Before the Training Program		After the Training Program
5 Excellent			
4 Good			
3 Average			
2 Fair			
1 Poor			

TIME

PART IV KNOWLEDGE BUILDING a) AGING
b) DYING

1) Aging

LEVEL OF KNOWLEDGE

	Before the Training Program		After the Training Program
Very High			
High			
Average			
Low			
Very Low			

TIME

2) Dying

LEVEL OF KNOWLEDGE

	Before the Training Program		After the Training Program
Very High			
High			
Average			
Low			
Very Low			

TIME

FINAL EVALUATION OF VOLUNTEER TRAINING PROGRAM

Primary Goal: To improve the quality of one-on-one relationships with the institutionalized patient in a long-term care facility.

I Training Program

1) Did the training program meet its primary goal as stated?

YES ____ NO ____ DON'T KNOW ____ NO RESPONSE ____

2) How would you rate the training program on an overall basis?

Not Worthwhile	Poor	Fair	Good	Very Good	Excellent

3) How would you rate the training program overall in terms of its usefulness? Circle the number of your response.

1	2	3	4	5	6	7
Waste of Time	No Use	Of Little Use	Uncer- tain	Somewhat Useful	Use- ful	Very Useful

II Adult Learning Model

4) Did you feel you were able to contribute to the planning of future Volunteer Visitor training programs through the:

- [ ] Opinion survey
- [ ] Weekly session evaluations
- [ ] Verbal feedback in class
- [ ] All of the above
- [ ] None of the above
- [ ] No response

Use the following scale to rate items 5 to 12. Circle the appropriate number.

1	2	3	4	5	6
Definitely Not	No	Not Really	Probably (somewhat)	Yes	Definitely

5) Were the handouts helpful in promoting your self-learning?

1 2 3 4 5 6

6) Did you feel the training program was designed for adult learning (that is, did it take into account your past life experience)?

1 2 3 4 5 6

7) Were you able to draw upon your personal life experiences to integrate the concepts presented?

1 2 3 4 5 6

8) Were your expectations regarding this program fulfilled?

1 2 3 4 5 6

9) Has this course sparked your interest in pursuing further education related to the topics presented?

1 2 3 4 5 6

10) Would you recommend this program to other Volunteer Visitors?

1 2 3 4 5 6

11) Do you feel Volunteer Visitors have a valuable role to play in serving the social and emotional needs of patients in the health care system?

1 2 3 4 5 6

12) Would you recommend the primary facilitator to other volunteer groups? If rating is 5 or 6, state why.

1 2 3 4 5 6

If rating is 5 or 6, please state why: No response

III Program Planning

13) For group learning, the group was:

____ too small
____ somewhat small
____ just right
____ somewhat large
____ too large
____ no response

14) In regard to content, the program length was:

____ too short
____ somewhat short
____ just right
____ somewhat long
____ too long
____ no response

15) In future, I would recommend the training program be held in:

____ spring
____ summer
____ fall
____ winter
____ no response

in the following months (check 2 consecutive months)

January___ February___ March___ April___ May___

June___ July___ August___

Sept___ October___ Nov___ Dec___

No Response___

16) Have you been able to use the skills/knowledge acquired in relationships with patients?

- ___ Yes
- ___ No
- ___ Don't know
- ___ No response

With people other than patients?

- ___ Yes
- ___ No
- ___ Don't know
- ___ No response

17) What were the strengths of this training program?

18) What were the weaknesses of this training program?

19) Would you be interested in a future training program?

20) Specific suggestions for future sessions (i.e. topics, format, techniques, exercises, etc.)?

21) Additional Comments:

OBSERVER EVALUATION

OBSERVER EVALUATION

Name: ____________________

The above named has successfully completed the volunteer visitor training program. Using your previous evaluation of his/her level of knowledge, skills and confidence as a baseline prior to training, kindly assess any perceived change in the level of knowledge, skills and confidence after the training.

Use the spaces to rate items A to C. Check the appropriate space to indicate your response.

Since completing the training program, the above named volunteer has acquired the following:

	Lower	Same	Higher	Cannot Assess	No Resp.
A. LEVEL OF KNOWLEDGE					
Aging	___	___	___	___	___
Dying	___	___	___	___	___
B. LEVEL OF INTERPERSONAL SKILL DEVELOPMENT					
Communication	___	___	___	___	___
Helping	___	___	___	___	___
C. LEVEL OF CONFIDENCE IN ESTABLISHING SUPPORTIVE RELATIONSHIPS	___	___	___	___	___

Would you be interested in future training programs for volunteer visitors?

YES ___ NO ___ DON'T KNOW ___ NO RESPONSE ___

Specific suggestions for future sessions?
(i.e. topics, format, techniques, exercises, etc.)

Additional Comments