C.O.N.N.E.C.T.: A Training Program for Volunteers Who Work With a Communicatively-impaired Population

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THE NEED

"I'm a Resident at The Jewish Home and Hospital for Aged.

"I know what I'm thinking. I know what I need. I know who you are. I know who I am.

"BUT

"I can't talk. I may say some words—even a phrase. You can't understand, even though I know you're trying because you like me, because you are my volunteer."

These might be the thoughts of the elderly, communicatively-impaired residents of a nursing home, or any other health facility where one sees victims of stroke, Parkinsonism, Alzheimer's, cerebral palsy—and on and on.

BACKGROUND

Depending upon which research study you read, the percentage of elderly in nursing homes who are communicatively impaired can vary from sixty to ninety-two percent, a very significant statistic. Studies show that the mental health of the elderly is significantly enhanced when communication skills are maintained. As mental health improves, the aged person will often participate more actively in rehabilitative therapy and activities which frequently restore a degree of independence directly related to physical improvement.

When a person becomes older, the social network becomes especially important. It serves as a vital support system. Communication is the main vehicle for making use of this social network. Therefore, it becomes obvious that since communication skills are part of maintaining a social network, and since communication skills are often impaired in the elderly, enhancing these skills is a crucial ingredient to maintaining the highest level of mental health in the individual.

In 1985 The Jewish Home and Hospital for Aged (JHHA) in New York City began to address the need to help residents with communicative impairments. We began to do this by helping those who interact with the residents to improve their understanding of communication and their skills in coping with problems that involve communication such as stroke, depression, memory disorders, etc.

Initially, we designed Communications Need Not Ever Cease Totally (CONNECT) for family members. In the Spring of 1986, 30 family members participated in the first series of workshops.

This program received the 1986 Innovation of the Year Award from the American Association of Homes for the Aging (AAHA). The Home made a commitment from the beginning to offer this communication skills training program to volunteers and staff.

With funding from The United Hospital Fund of New York, CONNECT was then adapted to address the need for training in communication skills for volunteers who work with the communicatively-impaired elderly. Volunteers in long-term care settings play a key role in contributing to the comfort and peace of mind of

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An active volunteer concerned with health and education while raising a family, *Frances Gitelman* became a director of volunteer services in 1972. Professional experience includes directing programs in acute and long-term care health facilities and as Project Coordinator for the Multiple Risk Factor Intervention Trial (MRFIT), a study to test prevention of heart attacks by treating major risk factors. Ms. Gitelman is a frequent contributor to *The Volunteer Leader*. *Theresa Martico Greenfield* is Special Assistant to the Executive Vice President of The Jewish Home and Hospital for Aged. She helped to develop the initial project for Family and Friends Group from which the volunteer training program evolved.

nursing home residents. In addition, volunteers establish friendly relationships characterized by concern and understanding. As "Chief Timegivers," volunteers make a special contribution to the quality of life of the institutionalized chronically ill.

Each volunteer understands that there are no miracles working with this population. The volunteer's satisfaction comes from mini-miracles—a smile, a song, a response, a CONNECTion with a resident.

PROGRAM OBJECTIVE

To provide communication skills training to strengthen the volunteer's ability to reach the communicatively-impaired.

WORKSHOP FORMAT

CONNECT consisted of a series of three workshops to address the following topics:

1. causes and nature of impaired communication in later life;
2. consequences of this problem for the older person in relating to others;
3. practical strategies to cope with specific problems which enable volunteers to improve communication with the residents.

Each workshop was two hours long and was designed to combine lecture, question/answer and role playing.

It should be noted that these skills also enhance volunteers' ability to communicate in other areas of their lives as well.

Role of Rehabilitation Nursing Team

This team coordinates all rehabilitation disciplines, giving team members firsthand knowledge of residents' communication and other problems. The team selected residents who, upon consent, could benefit most from visits by the specially trained volunteers. Team members attended the workshops and helped the volunteers identify the residents' communication problems. Then the volunteer would know which newly-learned tools to try to use with each resident. The Rehabilitation Nurses consulted and provided continuing support to volunteers and residents. They also served as liaisons between these volunteers and other staff and worked closely with the Director of Volunteer Services (DVS), particularly on follow-up and reporting results of when residents were helped most.

THE PROGRAM

Phase One

In the Summer of 1986, as part of their Summer Youth Program, twelve high school students were carefully selected to participate in the program. Their schedule of twenty-four hours per week for eight weeks was worked out so that they spent eight hours a week intensively implementing the training they received. They reported to the DVS and The Home's Rehabilitation Nursing Team who had referred the residents. Prior to the special training, the students completed The Home's Volunteer Orientation designed to sensitize all volunteers to the needs—emotional and physical—of the institutionalized elderly, basic skills, wheelchair/walker and general safety and management within a healthcare facility, bedmaking and feeding.

Phase Two

During March and April of 1987 all adult volunteers were invited to participate in the three session training. Thirty-seven adult volunteers participated and, as had occurred with the student volunteers, many received referrals from the Rehabilitation Nursing Team for friendly visiting to communicatively-impaired residents.

PROGRAM RESULTS

Youth

"I learned a lot from this resident."

"I'm the only one she (the resident) talks to."

"I can use this information the rest of my life."

"She (the resident) feels like I'm her grandaughter, and I mean a lot to her."

The instructors had anticipated that these high school volunteers, by virtue of their youth, would *not* come to the program with preconceived notions counterproductive to establishing better communication and relationships with the elderly. However, much to their surprise, at the outset they found that these young volunteers held fairly rigid views regard-

ing the elderly. The instructors learned this by reading the volunteers' responses to a 35-item "Yes/No" questionnaire and listening to their impressions during the first session. The volunteers interpreted much of what they saw in the elderly as stubbornness and/or lack of intelligence. Once these attitudes changed, the students were better able to carry out their training. The residents responded to the high degree of respect they were shown for their remaining abilities. There was a positive relationship between residents' renewed self-esteem and the training success rate. Clinical staff often recognized which residents had this additional assistance.

Ten of the twelve student volunteers (83%) selected to participate completed the communication skills training program. At the end of Workshop 3 the same 35-item "Yes/No" questionnaire was administered again to those who completed the program. The instructors analyzed the volunteers' responses in terms of whether they had changed in the desired direction. They found that an average of 71.9% (range 50% to 100%) of the responses indicated a change in the desired direction.

Factual questions were also asked, requesting the matching of terms to definitions. Before and after results were compared, and there was a 31.4% increase in the number of correct responses. We can say, then, that both factually and affectively the workshops resulted in significant positive changes. It was clear that by working with the elderly the volunteers had gained insight and flexibility in viewing them as people who have long, complex and often fascinating histories. They learned that the residents—and all older people—could have something to offer them, and to be more sensitive to individual and cultural differences and needs. They learned a great deal about interpersonal relationships among residents, staff and volunteers, and experienced being needed and feeling increased self-worth themselves.

Adults

After the end of the communication skills training program, the volunteers again showed a great deal of initiative by requesting a wrap-up meeting with the Director of Volunteer Services, the Rehabilitation Nursing Team, and The Jewish Home and Hospital for Aged's Assistant Administrator so that they could spend more time talking about their experiences with the residents. They were eager to share the happiness as well as frustration that accompanied their newly-formed relationships. The volunteers reported that many residents, given the head start by the students, were showing marked progress.

The mutual volunteer-resident positive effects were often the same as with the youth group whose comments ranged from "Mary said hello today" to "Louise said I looked just like her grandson."

During the adult volunteer training the first workshop began with a pre-test of the volunteers' knowledge regarding communicative impairments and ways to cope with them. At the end of Workshop 3 a post-test, identical to the pre-test was administered. The results of the pre- and post-test responses indicated that 75.4% of the volunteers' responses changed in the desired way. From comments written by the participants, it was also found that their patience, insight and flexibility regarding their communication with residents had increased. The volunteers also learned more about individual needs and cultural differences and how these needs and differences pertain to nonverbal forms of communication such as touch, eye contact and gestures. After the program ended, the volunteers established a follow-up support group so that they could continue to share ideas, frustrations and accomplishments that might occur from their daily interaction with residents. This worked so well that volunteers continued to meet informally either over lunch or formally with their own leader to continue the momentum.

Chris's story demonstrates the effectiveness of the program.

Janet (age 84) spoke so softly that no one heard her unless right beside her—as Chris had been doing for a while each day for six months. She continually urged Janet to speak louder; Janet whispered, "I can't." Everyone who had contact with Janet agreed she had a speech problem.

After the first training session, Chris began to use some of the techniques:

raising her own voice, distancing herself from Janet, insisting that Janet must talk louder or she might have to leave. She, of course, didn't leave and, in fact, had to move closer that day.

A few days later, as Chris approached, a loud voice said, "Oh, Chris, you made my day. You're back!" Now everyone knew Janet had nothing wrong with her voice—only her spirit!

Chris's newly-learned technique, her reinforcement, patience—her volunteer spirit—had worked.

After the second session where volunteers were urged to accept residents' limitations but to try to reach a little higher, Chris got Janet to go to the library. Janet looked through magazines. Then Chris pointed up to a print on the wall depicting a Roman scene. "I'll never go to Rome," she sighed. "I'll tell you about Rome," Janet responded, and did so vividly and *without* prodding. She began to talk about other travels, opening a whole new conversation field for both of them.

The training had given Chris the confidence to be a bit tough, to use the techniques, to look for a mini-miracle. From simple questions and answers, Janet now commands real conversation, giving her a sense of her worth.

ADAPTATION OF TRAINING FOR OTHER AGENCIES

Communicative impairment is not limited to the elderly. Neurological impairment, cerebral palsy, retardation, Parkinsons, hearing and speech impairment can strike all age groups. These populations can also benefit from having trained volunteers to reinforce the work of professionals.

Replication or adaptation of CONNECT[1] to one of these groups can be achieved at the outset with simple changes such as word substitutions "elderly population" for the client population, *i.e.*, "cerebral palsy victims." The causes and consequences would be slightly different, but the practical strategies would remain the same. Selections of candidates, task descriptions and general program would be carried out in the same manner. The handouts would be adapted to the population served, whereas the "Glossary of Terms" and "Helpful Hints" would be essentially the same.

The goal is identical for all: to increase knowledge of normal communication skills and the strategies for improving these through social interactions to enhance the volunteers' and/or staff's work. This is particularly important for the mental as well as the physical well-being of the patient.

The volunteers' satisfaction has been apparent here as they report the mini-miracles they witness when the techniques begin to work. It cannot be emphasized too often that the trained volunteers, particularly those in new programs, have most about which to feel good.

The Director of Volunteer Services must convey to volunteers in training that in addition to all of their other responsibilities, they can be communication partners with the people they serve, and in that way contribute to their overall mental health.

The three tapes are designed to address six objectives.

The *first* objective is to highlight the role of communication in daily living, so that everyone knows how important it really is.

The *second* objective is to describe the changes in communication that come with aging, disease processes and institutionalization.

The *third* objective is to define the role of the volunteer as the facilitator of communication.

The *fourth* objective is to increase knowledge regarding normal communication skills. In this way, abnormal communication skills can be better understood.

The *fifth* objective is to increase knowledge regarding communication disorders. Only with a clear understanding of what the nature of the disorder truly is can someone be expected to manage it effectively.

The *sixth* objective and the most important, is to familiarize the volunteer trainer with a series of strategies designed to facilitate communicative effectiveness.

During the training program volunteers received affirmation of what they were already doing correctly, as well as new infor-

mation to help them achieve even greater satisfaction for the residents and themselves from whatever CONNECTions they could make. They saw and heard the connection with a resident. They saw and heard the smile, the song, the gestures—not just the words.

FOOTNOTE

[1]A training kit is available from JHHA, 120 West 106 St., New York, NY 10025 to those who would like to replicate the program. The kit has two components—a manual and three audiocassette tapes—and was designed to train the trainers, primarily Directors of Volunteer Services in health care facilities. Other agencies which rely heavily on volunteers might also offer this training.