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ABSTRACT

The purpose of this booklet is to offer some guidelines for inservice educators who are interested in teaching human relationships and communication skills in nursing homes. Getting It All Together (GIAT) was developed for people to improve their basic communication skills through a new approach to communication and interpersonal relationships. It consists of a series of inservice discussion sessions which focus on the individual facets of human relationship. These sessions have been divided into six categories: Listen!, See!, Speak!, Touch!, Cherish!, and The Sound of Silence. The sessions are summarized in the final chapter. Each contains general notes for the inservice educator, lesson plans of the overall objectives, teaching methods and feedback/evaluation. Appended to the document are two appendixes--a partially-annotated 12-page bibliography, and sample reaction forms. (Author/BP)

GETTING IT ALL TOGETHER

TEACHING HUMAN RELATIONSHIPS AND COMMUNICATION SKILLS IN NURSING HOMES

Nursing Home Trainer Program
United Hospital Fund of New York

A NOTE TO INSERVICE EDUCATORS

This GIAT material has been prepared for insertion into a three-ring binder. It is recommended that the users of this material add their own notes, as well as any newspaper and magazine clippings, and other illustrative items and examples that will make these guidelines more useful in teaching human relationships and communication skills in nursing homes.

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PREFACE

This booklet is a supplement to the final report of a demonstration project conducted by the Nursing Home Trainer Program of the United Hospital Fund of New York. The project was funded by a grant from the New York Metropolitan Regional Medical Program, Health Services and Mental Health Administration, U.S. Department of Health, Education and Welfare.

The purpose of the booklet is to offer some guidelines for inservice educators who are interested in teaching human relationships and communication skills in nursing homes.

Whatever distinguishing features this document may have, owe their presence -- in large measure -- to the commitment and cooperation of a number of nursing homes in the Greater Metropolitan New York area. These homes range in bed capacity from 51 to 499; they represented both the voluntary and the proprietary sectors.

A special note of appreciation is expressed for the direct involvement of the personnel of the Florence Nightingale Park and Willoughby Nursing Homes, all in New York City.

Profound thanks also to the project staff, members of the Project Advisory and Operational Committees, and to all those others who made notable individual contributions during the various stages of the booklet's development.

Members of the project staff trust that the booklet will be useful to personnel who care for chronically ill, aging persons in nursing homes throughout the country.

Celeste Nodell, M.P.H.
Director
Nursing Home Trainer Program

New York, N.Y.
December, 1972

An Introduction to GIAT

"Communication is not a tool of organization, something to be grafted on those thriving organizations able to afford this rather expensive luxury. Instead it is the very essence of all organization."

Even though this comment appears in a brochure on employee-management communication in hospitals, published by the United Hospital Fund of New York, it is equally relevant, equally valid, for staff-patient relationships in nursing homes. It is precisely because nursing home administrators and staff alike felt that better communication was a necessity, and not a luxury, that they gave so high a priority to the creation of GIAT.

But because the problems and programs of nursing homes are different from those of other settings, they asked also for a new approach to communication. GIAT -- Getting It All Together -- is a pilot effort at finding that approach.

It offers no "great new discoveries". Its newness lies only in its application of generally accepted concepts and techniques to the conditions and relationships within nursing homes.

GIAT offers not revelations, but relevancy.

When a GIAT planning group asked why patient care needed to suffer because of a breakdown in communication, they were not thinking of an abstract "problem", but of a specific incident "last week" between an aide named Agnes and "the lady with the broken ankle". "Accurate messages" involved the patient who almost got the wrong medicine; no one needed the textbook definition of a "lonesome patient"; everyone had his own nominee.

There was a feeling that some of the people needed to improve their basic communication skills. GIAT's component sessions do focus, therefore, on individual facets of human relationships. On some "how-to's". On the difference between hearing and listening. Between looking and seeing. On the various "languages" which make up nonverbal communication -- on how to see what a patient is saying.

But more than skills were needed. "In a narrow sense," the United Hospital Fund brochure comments, "communication involves skills such as reading, writing, listening, speaking; in a larger sense, it involves attitudes, psychology, environment, and perhaps the entire range of business and personal relationships.

"It involves the sending and receiving not only of information, but of attitudes and feelings as well. When effective, it helps an organization reach its goals. Ineffective, it does the opposite."

GIAT sought therefore to identify the common threads which run through all communication relationships. The basic concepts, the underlying motivations.

Time: why it must take time for real communication to happen. Heart. Feelings. Attitudes: why you do communicate better with someone you like. And whether you can really communicate with a patient you don't like. Why you're not "getting through" sometimes when you think you are -- and how to check whether you are. Why patients don't say what they mean, and why "misunderstandings" between co-workers occur. Why the "line of communication" between two human beings is so much more complex -- and difficult to "fix" -- than a telephone wire or a radio circuit.

Yet all of these abstractions were dealt with in concrete terms. For that was why GIAT was created: when the Nursing Home Trainer Program brought together a group of administrators and inservice educators at a planning workshop, it was they who gave a high priority to the need for a practical method of teaching human relationships and communication skills in their homes.

And just as the initial spark of GIAT's life came from nursing home professionals, so it was nursing home personnel -- at all levels -- who helped to flesh and mold it into its final shape, the content of this brochure. Those who helped to field-test GIAT and its methodology included not only administrators and inservice educators, but all levels of nursing personnel, occupational and physical therapists, social service workers, recreation specialists, aides and orderlies and even food service workers. A staff member of the Nursing Home Trainer Program was assigned to work closely with the pilot groups. And a deliberate attempt was made to constitute these groups according to the same "mix" the inservice educator was planning for her other inservice programs.

Group discussions seldom revolved around a "Miss X" or a "Mrs. Y" or a "Mr. Z". Usually it was more meaningful and rewarding to talk about "Mrs. Brown in 619" and "Miss Julie, who aggravates me every time I go into her room" and "that lady who looked so happy when by mistake I gave her a whole chicken leg to eat instead of her strained baby food." Real people and real problems in real homes.

But it would be a mistake for the inservice educator to think, because GIAT may be effective in solving problems at this level, that stories and anecdotes -- or even the analysis and discussion following them -- can entirely take the place of careful advance planning. The deliberate effort to break GIAT down to its simplest elements--and even to simplify its language --should not be allowed to obscure the fact that it is a program which deals with some highly complex aspects of human behavior.

GIAT should not be treated as a program apart, but should rather be integrated into the home's overall inservice education plan, which should in turn be related to the home's objectives and programs. Not only will GIAT's usefulness increase, but the support you receive from your administrator and program planning committee will depend largely on the contributions they see this new approach making to the home's total program.

To make sure GIAT related in this way, in the homes which had offered themselves as laboratories, at every stage of planning the emphasis was on the involvement of as many people as possible. Any member of the staff who was interested and available was invited to participate, to contribute ideas about what could and should be said and done with and in GIAT.

As a result, while there is only one GIAT in this brochure -- and it is hoped that it is the best of all possible GIATs -- no two programs, no two sessions were ever exactly alike. Even if they had the same starting points and the same lesson plans.

The good sessions acquired a life of their own. In the view of inservice educators it was a mark of real acceptance when staff members began referring to GIAT discussion groups as "rap-sessions" -- they had integrated the program into their own world, and related it to what they already knew.

The good sessions, therefore, depended as much on the participants as on the inservice educator. Spontaneous, unplanned, responsive. Just schedule a session and let 'er rip! Not so.

Digging deeper, it was almost always the inservice educator who had chosen the participants for each group, who knew them and their educational backgrounds, their ability to handle English, their special difficulties, what each could contribute to the group. That was a major ingredient in the recipe for a successful session.

Plus listening -- and watching -- for feedback. In the sessions, between sessions. Not only for the impact GIAT was having on participants, but for any impact on staff-patient relationships, staff-staff communication, on the program of the home, on feelings and attitudes about patients.

A word about the lesson plans presented in the next six chapters of this booklet: they are models which condense and restate the content and methods of teaching which were tried -- and tested -- during the GIAT demonstration.

Any educator can testify that the only good lesson plan is his/her own lesson plan. Take these, therefore, as suggestions, ideas, hints -- a springboard from which to design a lesson plan geared for your home, your program, your people. When you make notes to yourself about the lesson plan, use words that have a meaning for you and your own participants -- whether or not they have the same meaning -- or any meaning -- to any other person/educator who may happen to read your plan.

Not only that. As far as the sequence in which the lessons are presented: not necessarily so. You might want to begin at the lesson on "The Sound of Silence" and go backward -- or skip around. Your decision will be determined by your knowledge and understanding of your home, and the immediate concerns and needs of the personnel you work with, and in particular those who have been chosen to participate in GIAT.

In a way, the lesson plans are presented reluctantly -- not because they do not present the essence of GIAT, and not because they fail to serve their purpose. Rather it is because of GIAT's special quality.

In this series, it is our experience that the best inservice educator is sometimes the least vocal inservice educator. The most rewarding sessions have invariably been those in which "the spirit moved them"; in which participants broke through their reserve, began to speak of themselves, their attitudes, their feelings.

As a method of solving the problems of a nursing home, GIAT is designed precisely to deal with feelings and with attitudes, to bring them out into the open.

You may have a lesson plan, with your objectives clearly indicated. And suddenly -- as in all informal settings -- the discussion takes off in a totally unforeseen direction. It begins to deal -- on the gut level -- with attitudes and feelings about one of the home's most acute problems in caring for patients.

What do you -- as inservice educator -- do?

Use your judgment. Consider your alternatives: a) to let the discussion go on, even though it isn't going toward the objective in your plan; b) to cut it off, perhaps promising to get back to it at a later session; c) to see whether it is possible to guide it back toward the session's intended objectives.

Use your judgment. None of the alternatives is right for every occasion. None is always wrong.

One thing you might perhaps want to do even in advance of the scheduled sessions, since you are dealing in such a sensitive area of human relations: talk to potential participants, individually or in groups, about some of the areas to be covered.

This will give you a chance to identify the "touchy" areas. It will also give you an opportunity to identify those staff members who are likely to be more cooperative, and those likely to resist. This in turn will help you to work out a "mix" of participants most likely to succeed, which will interact well.

You will also find the "feedback" you get in this informal way very useful to you in determining both objectives and methods. If you feel your participants will not be inhibited by the presence of a tape-recorder, it is very much worthwhile to have all sessions taped, for later analysis.

Some Suggestions on Pre-Planning

There are a number of aspects of the GIAT series which should be discussed and clarified by the inservice educator in advance of the sessions, either with the administrator or with a program planning committee, if the administrator is a member of the committee or has given it decision-making powers. Among the items which should be settled at such a meeting are:

a) support from administration
b) audience to whom session will be directed
c) release time for employees to attend session
d) definite date and time of sessions (should be set on a regular basis)
e) length of sessions
f) adequate space for group
g) making of posters
h) budget money for film and other necessary materials
i) evaluation of sessions and series

General Check-List

1) Environment and Audience:

   a) room with adequate lighting and ventilation, and conducive to informal learning
   b) small groups (10-15) of participants
   c) select "mix" of participants most likely to succeed
   d) repeat sessions as necessary to cover all shifts, total personnel of nursing home

2) Media Selection:

   a) must always be timely, therefore will always require updating
   b) should be relevant to audience
   c) may include records, film strips, films, tape and videotape cassettes, transparencies, clippings, photos, drawings (to be passed around or projected)

3) Special Posters:

   a) To create an interest level or an anticipation of the scheduled inservice program
   b) can be created by patients in art class with assistance from activities leader

General Evaluation of Series

At the close of each session, a single-page reaction form is given to each person. There are four questions which relate to interest, knowledge, understanding and skills. In addition, every fourth person will receive a second page, which measures attitudes toward content and process of the GIAT program.

One month following the final session, a group discussion should be held, whose purpose is to attempt to evaluate the impact of the sessions, both on the individual participants in the GIAT sessions and on the program of the home, particularly as evidenced in improved patient care.

LISTEN!

Notes for the Inservice Educator: LISTEN!

"Nobody listens to me. Nobody cares."

The elderly patient sat on her bed, rocking back and forth. The tears were streaming from her eyes. She was crying so quietly that it was obviously from the heart, and not for "demonstration" purposes. So that it was almost no accident that a passing aide happened to notice it, and came in to ask what the matter was.

For some time, the old lady continued to repeat only: "Nobody listens. Nobody cares." Yet when the aide finally persuaded her that she was listening, there didn't seem to be anything special the lady wanted to say.

Yet when the aide finally left -- after 15 minutes -- she left the patient quite happy. Temporarily, at least. The old lady had wanted, had needed, a human listener. The medium -- talking and listening -- was the message.

Because in a nursing home -- only emphasizing what is basically true of all human relationships -- the mere act of listening is often equated in the patient's mind with caring.

Not caring for him or her. Caring about him.

And in an era when the philosophy of nursing homes involves care for the whole patient, improved communication relationships can become the keystone to better patient care.

Sometimes the problem may be that the appearance of a relationship has been substituted for a real relationship. There was an aide who would often sit and "listen" to one of her patients for long periods at a time. Another aide asked her what the patient always found to talk about. "I really don't know what she's saying any more," the "listening" aide answered. "In the beginning I tried to pay attention, but she really didn't make much sense. So now I just sit. It's a chance to get off my feet."

The aide had turned off her mental receiver. She was hearing the sounds the patient was making, but not listening to the words. If an act of communication was actually taking place, it was on the non-verbal level.

Sometimes that too is valuable. But often words are important -- and the only way you can find out how important a patient's words are is to listen to them.

One patient kept mumbling something while the aide was in her room cleaning up. The aide was in a hurry; besides, she had her mind on other things. Finally she burst out in exasperation: "Why do you keep mumbling? Why don't you put your teeth in so I can understand you?"

"Listen!" the patient mumbled, at the top of her lungs. "That's what I'm trying to tell you! I can't find my teeth!"

Too often busy personnel in the home don't take the time to listen. They hear the words, or at least some of the words, of patients and other staff members, but they don't really take the time and the trouble to listen for their meaning, to understand them. Yet listening can often provide important information on a patient's physical condition; it can also provide valuable insights into his mental and emotional health, his inner needs.

At one inservice session, the discussion got around to a patient named Nellie. "Yeah, I listen to her," one aide said. "I listen to her all day, griping about every little thing. What a headache she is." Almost everyone in the group had moaned at the mention of Nellie's name -- they all reported that they couldn't pass Nellie's unit without Nellie stopping them, asking for some totally unimportant service, or reciting an endless list of complaints.

Except for one aide, who suddenly spoke up: "Nellie doesn't bother me. She used to complain to me too. But one day I decided that what she really wanted was someone to talk to, so I started putting her in her wheelchair and taking her along with me to the rest of the rooms."

Occasionally Nellie would practice making a bed; but mostly she would just talk -- to the aide, or to the other patients, who seemed for their part also to enjoy her company. By the time the aide was ready to take Nellie back to her room, she'd heard all the news of the day and was perfectly content to settle down with her newspaper until lunch.

That aide had done what none of the others had -- she'd listened to Nellie long enough to find out not what she seemed to be saying, but what she was really saying -- and what she really wanted.

How many Nellies are there in nursing homes? In your home? "Do we hear the loneliness of the elderly through their talk? Through their silence?" The questions are asked in a High Holy Day Message in the New York Times of September 8, 1972. "And when we hear, do we turn in understanding?"

How do you listen with understanding?

On the simplest level -- in order to get specific information -- it becomes a matter of focusing ears and attention. No one needs to emphasize the importance of giving and receiving messages and instructions fully and accurately in a nursing home. The story of the patient who was supposed to get procaine is now a part of nursing home lore. The nurse telephoned the doctor, who approved a verbal order. Unfortunately, it was a different nurse who phoned the order in to the pharmacy, so somewhere along the line procaine was transformed into cocaine. Result: a $65,000 malpractice suit.

That doesn't happen every day. But at one inservice session, a nurse told a story that does happen often. She had called out to an aide. "Mrs. K. isn't feeling well. Will you go in and check her pulse, please?" A few minutes later, the aide came out and reported: "It's 101.2."

The difference between the cocaine incident and the pulse incident is one of degree, not of kind. In both cases, the "listener" had tuned out the speaker in mid-sentence. In the case of the nurse and the aide, you can almost point to the precise word where the tuning-out took place -- at the word "check". .

This particular species of non-communication is common everywhere; but in a nursing home it becomes a luxury you can't afford. A message hasn't been communicated if it's only been sent out over an open circuit. Communication takes place only when another human being listens to the message -- and understands it.

Breakdowns between staff members are usually a joint responsibility -- the listener "knows" how the message is going to end; or the message is important only to the speaker, not the hearer.

But with patients, the responsibility devolves almost entirely on staff people. And often, when the "communication failure" is broken down into its component parts, , you will find one component missing: time.

"When I have time to listen," an aide says, "I can usually make out what she's saying, even though she doesn't speak much English. But I hardly ever have the time." "Only the aides can communicate with the patients" -- this was an aide speaking -- "because the nurse never has the time. She's got so many other things to do."

But on the positive side, one orderly reported what he had learned from GIAT: "If I was really going to listen to people, I found that I had to slow myself down. So lately I'm not so inclined to race from one job to another gettings things done. I try to be more considerate toward the patients now. I listen; they talk to me; I understand better how they feel."

How people feel often comes out in what they say, especially if they're speaking to someone they think they can trust, someone they think likes them. Yet often -- and this is particularly true of elderly, withdrawn, timid patients -- what they say isn't what they mean. Because of this, the GIAT session needs to focus not only on what patients say, but sometimes on what they don't say.

As soon as her daughter had left, Mrs. Kane began snapping at the aide about the "sloppiness" of the room. The aide listened, did some straightening out of no consequence, but remained cheerful. "Didn't you mind being called sloppy?" she was asked. "Oh, Mrs. Kane wasn't really calling me sloppy," she answered. "She was really hurting because her daughter left."

At another session, an aide asked: 'What do I do about Mrs. O'Neill? She won't go to the day-room, keeps making remarks about 'those people', as if they're not good enough for her."

The home's administrator was there. "Maybe Mrs. O'Neill isn't really a snob. Maybe she just doesn't want to be told what to do, to be regimented, like the army. Maybe if you give her time, make it clear to her that it's perfectly O.K. for her to be 'out of step' if she feels like it, then one day she'll ask to go to the day-room on her own.'

Two sessions later the aide reported success: Mrs. O'Neill had been going to the day-room on her own for three days. And had been warmly accepted by the others, with no coldness on either side.

Why hadn't Mrs. O'Neill been able to express her true feelings? Perhaps because she was timid, because they were "socially unacceptable", because she was afraid she'd only receive more pressures, because she had never been able to say what she felt, and it was more difficult now, among strangers.

There is no home without its Nellies, and without its Mrs. O'Neills. Their communications are often on an inarticulate level. When they do speak, what they say can often be understood only after it is translated and interpreted by the listener. That takes time; it takes the desire to understand.

Listening begins with wanting to listen. If you hope to understand, you must want to understand.

Notes for a Lesson Plan: LISTEN!

Overall Objectives: a) to demonstrate the difference between hearing and listening; b) to recognize that listening and responding to the patient -- especially the geriatric patient -- will give him the attention/understanding/acceptance he needs; and c) to demonstrate listening-with-understanding: what is the patient really saying?

Methods: "The Rumor Game", tape/cassette recordings, demonstration, discussion.

Note: It is worth reemphasizing, in connection with a specific topic: in this and all succeeding lesson plans, more suggestions are given -- deliberately -- than can possibly be incorporated into a one-hour session. This is to provide choices: take what's best for you.

Feedback/Evaluation: In addition to the summary at the end of the session, inservice educator should be on lookout after the session -- and after the entire GIAT series -- for changes in the home, as they may reflect the impact of the sessions.

* * * * *

Objective: To demonstrate how each of us hears/listens differently; how messages change between the mouth of the speaker and the ear of the listener.

Method: "The Rumor Game" (see page 25), followed by group discussion.

Note: If they do not come up spontaneously, inservice educator may want to guide discussion toward incidents/situations which may recently have taken place in the home.

Objective: To demonstrate how the emotional involvement of the listener affects his "reception" and understanding of messages.

Method: Just as though it were something she had actually heard (but being careful not to let the situation go too far) the educator mentions a "vague" rumor she has "heard" which could affect jobs of many in room.

Note: The point to be made -- after discussion -- is that people react not only to rumors, but to everything they hear, in proportion to how what they're hearing will affect them.

Objective: To demonstrate how the patient feels when a staff member "doesn't listen".

Method: Role-playing: putting the shoe on the other foot. A "nurse" bawls out an aide (both are participants playing roles) for something the aide did, but never gives the aide a chance to explain. Various people to play the "aide".

Note: Educator begins by asking "aides": How did it feel when you were "catching it", and the "nurse" wouldn't listen? Suppose you were a patient, and the aide wouldn't listen -- would that be the same feeling?

Objective: To demonstrate some listening/communication skills.

Method: Educator illustrates eye-to-eye contact, hearing better by looking at speaker, listening with extraneous noises in room, dropping voice in mid-sentence, mumbling/articulating, and so on.

Note: If the educator wants to take notes the week before the session -- and thinks the method can be used in the session without hurting any feelings -- she might illustrate: "Who speaks like this?"

Objective: To demonstrate why/how we listen better when we're not thinking about something else.

Method: Educator reads a list of figures for participants to add. (If literacy is problem, she may instead ask everyone to try to recall the precise menu of a recent meal.) As soon as group members are absorbed in task, educator announces (without warning) time and place of next session. Later asks if everyone heard announcement. Discussion: when you're thinking about "something else", and patient talks to you, you've really "tuned him out."

Objective: To explore the difference between what patients say and what they mean.

Method: Tape-recording/role-playing/description by educator, to be followed by discussion.

Note: Educator prepares several incidents she has witnessed, or has heard from others: a) Patient has just had visit from daughter, shouts at aide for dirty towel: is she really complaining about being abandoned by family? b) Patient suddenly refuses favorite dish, complains about "same food all the time": is she really asking for some of the freedom-of-choice she had before entering home? c) Patient suddenly complains of "pains", but they seem to shift: is she just hungry for attention, lonely?

Objective: To demonstrate/reemphasize that the actual "message" often has nothing to do with the words spoken.

Method: Tape-recording. In advance of session, inservice educator should record a thirty-second speech in an angry, emotion-filled tone of voice (not her own voice). The content of the recording should be as bland and innocuous as possible: the effect has been achieved at various times with a reading from the telephone book or a "message" in double-talk. Educator should open discussion with: What did he say? How do you know?

Note: Ask in advance that those who get the idea quickly not spoil the experiment for the others. In a group where understanding of English makes this an unfair experiment, the educator may want to use a variant: record the same bland message three times, in three different ways -- angry, happy, sad to the point of tears. Distinguish how you say something from what you say -- and how to listen for feelings.

SUMMARY: Before the end of the session, educator should ask for comments and feedback from participants, and should summarize lessons/accomplishments of the session. Educator also distributes reaction/evaluation forms (see Appendix), uses them to assess results, work out objectives/methods for future sessions.

Lesson Plan: "The Rumor Game"

When people come into room, they take chairs arranged around a large table.

Coordinator: Our session today is going to be somewhat different We are going to play a game called "Rumor". I have a message on this piece of paper, which I am going to whisper to Miss Y, on my right. She will whisper it to the person on her right, all the way around the table until it gets to Miss Z, on my left -- she will say it aloud. This is a game, but it isn't just a game. The idea of it is to find out the difference between hearing and listening.

The coordinator, having indicated the objective of the session, now whispers the message -- which should actually be the sort of rumor heard around the home. For example: Have you heard the new policy about giving patients showers? The room has to be warm, and the water too, because too many patients have been coming down with colds lately. I wonder how often they will be getting showers now -- you know how cold those bathrooms usually are.

The coordinator gives the written message/rumor to the person on her right (Miss Y) to read aloud, after the message has traveled around the entire table. Reactions will be immediate and spontaneous. "I didn't say that!" "Yes you did!" and the discussion has begun. The coordinator must remain in control; she must be careful to guide the discussion, to intervene when necessary, while still permitting maximum participation and involvement.

The points to be made are: that each person normally injects or omits or changes a word or two -- to make up for what he didn't hear, to "clarify" the message, to drop what he doesn't consider important; and each little change alters the tone/meaning of the entire message. The coordinator should also point out the additional factor -- that this particular rumor (like many real rumors) might involve jobs and working conditions in the home, might therefore have created anger, fear, frustration and tension in some of the participants.

Following up on this, once the problems of "listening" have been clarified, the coordinator should deliberately relate the game's "rumor" to actual work-situations in the home.

Coordinator (in closing): We all think we're listening, but what we're really saying is that our hearing is O.K. Usually, though, we only half-listen, because we're thinking about something else. We can all remember when we "goofed" because we didn't pay attention to what someone said -- we heard the sounds, but we didn't really listen to the words!

If all of us can really begin to listen, patients will benefit, we'll get along better with our co-workers, very soon even our social relationships will improve. Try it. Try listening!

(Final note: Leave a few minutes for more "feedback". Let the participants have the last word.)

SEE!

Notes for the Inservice Educator: SEE!

"Look at me. What do you see?"

In a general way, in English the words "look" and "see" are usually thought of as meaning more or less the same thing. As a matter of fact, in speaking informally we sometimes do interchange them: see who's coming/look who's coming - would both be understood. But even so, one of those statements doesn't sound exactly right. And in the sentences at the top of this page -- well, try substituting:

"See at me. What do you look?"

The point is: it is not just a matter of language, of semantics, of the way we use words. It is the difference between the two acts or processes: looking is not seeing.

Looking is simpler: all it really takes to look is to open your eyes. It takes more to see. And the more it takes is a brain -- the part that interprets and thinks. The English language acknowledges that fact: what's another way of saying: "I understand"? "I see."

You might say therefore that looking plus understanding equals seeing. The eyes plus the brain -- on active duty. This session -- to simplify -- is designed to get the brain into the act.

Question: how is it possible to look without seeing?

There is an apocryphal story -- about a nursing home which shall remain nameless -- about a nurse who one day looked into a patient's room and saw her sitting up in bed with her tray of food in front of her, but not eating. A bit later when she looked in, she saw the same tableau, so she called the aide over: "Did you try to feed Mrs. G.? I see she's not eating." "No, I was in a hurry. I just put the tray down and ran."

All this time the two of them were looking at Mrs. G. from the doorway; she still hadn't moved, so nurse and aide went in to see what was wrong. She had of course expired.

It isn't only in the home that people may be "too much in a hurry" to see what they're looking at. On the contrary, with so much happening in the world -- particularly in an urban society -- most people don't have the time -- or take the time -- to see. It is not only patients who are being overlooked, instead of looked over; it may also be family and friends; social relationships, as well as work relationships, may be suffering.

But there is a special responsibility upon personnel in a nursing home, whose daily routine involves the well-being -- and the lives -- of others. For them, learning to see is as important as learning any other job skill.

In one home, a "lovely" patient suddenly turned uncooperative, almost overnight it seemed. She no longer reacted and responded as she had done ever since she came to the home. One of the aides went into Miss R.'s room one afternoon, because she was concerned about her, and began to chat. The answers were slow in coming, and the aide noticed that as she spoke Miss R. was staring at her lips: she was trying desperately to lip-read! Miss R. -- it turned out -- was nearly deaf. She had apparently had a second stroke and no one had noticed -- and there had been no murmur from Miss R. herself.

When aides, orderlies, other personnel in the home, look at patients, are they instructed to watch for changes in vital signs? Do they know what to look for, and how to determine whether the information should be reported immediately? It is not simply that a trained eye can tell a great deal about the way patients feel from the way they look; before you can tell anything about the way someone looks, you must see him as a person. See how he's changed since the last time you saw him; note "wrong" details.

That beautiful bracelet Mrs. Martin's son gave her last week -- is it pushed too far up her arm, so that it blocks circulation? There's Mr. Harding, sitting in his wheelchair as usual on sunny afternoons -- pity he has to be restrained. But is that just a loose tuck of cloth, or is one of the knots becoming untied? And Miss Gower is back in bed; shouldn't her side rail be up? After all, she's already fallen out of bed once.

At one inservice session, an orderly mentioned something else worth seeing. One day he noticed some tiny round holes in a patient's sheet. He went out to find the patient and spotted similar holes in his pajamas. It took a little while to get the patient to admit that he'd taken to smoking in bed again; the clue -- to the orderly -- was that the patient wouldn't look at him while he was denying the charge. "I had to find out," the orderly said. "After all, there were lots of other people involved."

Because the patient kept denying that he'd been smoking, the orderly's eyes were more reliable informants than his ears. In a nursing home, where one must often deal with aphasic, CVA or withdrawn patients, the eyes must often play this role.

Mrs. T. was a withdrawn patient. So withdrawn, as a matter of fact, that in the month she'd been in the home she had never spoken. One day she had been wheeled into the rec room in her wheelchair, and placed on the edge of the circle of chatting patients, where the aide could keep an eye on her. Usually Mrs. T.'s eyes had a faraway look. The conversation turned to the best way of raising

children, and a fairly brisk argument developed. The aide noticed after a while that Mrs. T.'s eyes were suddenly focusing, that they were darting back and forth from one speaker to the other. There was no instant miracle; but the report of the incident did give the home's psychologist a clue -- and one day Mrs. T. did begin to talk about her own children.

"You can learn a lot more about what patients like and don't like," an aide said at one session, "from the way they look than what they say."

"I'm always surprised," another aide said, "by the things you have to find out for yourself. My God! you think -- why didn't she tell me that she hurt herself? But she didn't; if I didn't notice the blood, I wouldn't have known until a long time later."

Most people think of seeing as something you do, and not something you learn to do. Like breathing. It is therefore most important, in the context of inservice education, to emphasize that there are skills involved -- if it helps, you may call it seeing details, seeing clearly, seeing and observing, seeing and evaluating. Just so long as your participants do understand that it is a learned skill, which can be taught.

"I didn't think I was above average as an observer," one administrator said, "but I didn't think I was below average either. Just by accident I happened to sit in on the GIAT session on seeing, and afterward I decided to test myself.

"So I thought of Mrs. V., because she's a patient I probably see every single day. And I tried to remember all the details I could about the way she looked -- hair, eyes, whether she wears a ring on her finger -- what you'd put down if you were writing a description of a person. And I did write them down.

"Then I tested myself by going to see Mrs. V. This wasn't a test -- fortunately for me -- that you could pass or fail. Because when I wrote down just the things worth remembering about Mrs. V. that I didn't write down before, the second list was bigger than the first one."

As an inservice educator, you're aware that while we speak of seeing as a skill to be learned, it is not a skill which can be tested in the same way as such other learned skills as transferring patients, for example. Given the fact that each participant will be starting from his own level, with his own degree of visual acuity, his own perceptual abilities, what you will be attempting is some improvement in everyone's seeing-ability.

You may need to emphasize that this is not an exercise designed to improve anyone's eyesight, but to improve his brain-sight. Afterward, you may want -- in relation to specific problems -- to talk about what to see; at this session you're dealing with how to see, the meaning of what they see.

"I don't really know where you draw the line between seeing and doing," an administrator said, about a month after the GIAT sessions were concluded. "It used to scald me when I'd see someone walk right past a wet spot on the floor and not do anything about it. Or someone waxes the floor with the cord right across the corridor, where the patients were walking.

"I'd yell about the wet spot, and the answer would always be: 'I didn't see it.' Well, I don't know whether it was GIAT or not, but I don't hear that answer so much any more. More important, I don't see so many wet spots. Or so many electrical cords across the floor."

Notes for a Lesson Plan: SEE!

Overall Objectives: a) to demonstrate the difference between looking and seeing; b) to clarify some of the reasons we don't see what we look at; c) to focus on the special importance of seeing in the daily routine of the nursing home; and d) to begin the process of sharpening individual abilities to see, as a contribution to improved patient care.

Possible Methods: Slides, photographs (either to be passed around, or projected via overhead projector); discussion. Note that methods are always to be taken as optional; inservice educator should use those he/she is comfortable with, and for which materials/equipment are available. This is also true of setting the scene -- the arrangements which follow may be used/changed/adapted for this or any of the other sessions. For SEE! the room might be arranged with the tables in a horse-shoe. A tape/cassette recorder might be playing -- a tune having a relation to the topic.

Feedback/Evaluation: In addition to the items noted in the summary at the end of the lesson, inservice educator should be on the lookout after each session -- and after entire GIAT series -- for changes in the home, in patient care, as they may reflect the impact of the lessons/sessions.

* * * * *

Objective: To demonstrate that each of us sees differently.

Method: Select recent incident in home, involving patient-care crisis, or other situation with emotional overtones. (Alternative might be reference to particularly vivid recent sequence on TV news.) Ask session participants to write description (or tell it, if writing is a problem) with as many specific details as possible. Comparison of written accounts, or discussion will show: a) how one person will see details others miss; and b) how people see the same thing quite differently, particularly in situations with high emotional content.

Objective: To demonstrate that what we see depends on what we think is important, meaningful.

Method: Project -- or show -- a nursing home scene for a limited time. Then ask each participant to write -- or say -- what he saw. Note not only the number of items each mentions, but the order in which items are mentioned, what is left out, even what may be added which wasn't there. Point out why some note one thing, some another -- a nurse would be likely to note some medical details that an orderly would not, for example. Men and women might differ too in what they see.

Objective: To get participants to focus on small, important details.

Method: Project another nursing home scene, choosing one which shows details of patient care. After a few seconds, ask one of participants to come forward, turn his back to screen (slide is still shown) and describe scene. Ask about specific details, not only by area in slide, but by relating to various persons shown. Repeat with other slides, other participants.

Note: Educator is likely to find that after several slides, participants seem to "see" more. He/she can make the point that when you're sensitized to the problem, when you begin to look for more to see, you see more.

Objective: To demonstrate how much we usually do not see.

Method: Ask participant to tell you whether his wrist watch has a "6" on it, or a line. Ask him what number goes with the letter "N" on a phone dial. Ask him to describe a fellow-worker, with details: color of hair, eyes, clothing worn that day, whether he/she wears a ring.

Objective: To focus on role of seeing with relation to patients.

Method: Ask participant to describe patient everyone knows, with emphasis on physical details, appearance, noticeable symptoms.

Note: Educator -- if able -- should attempt to relate patient's physical appearance, symptoms to his condition, and to show how changes in appearance may indicate some change in condition, which requires attention.

Objective: To show role of emotion/attitude to seeing.

Method: Ask participant to describe in detail patient he likes, patient he doesn't like. Jot down items as he talks, point out -- by omissions, choice of details -- role of emotions in description -- and in actual seeing.

Objective: To determine whether you can tell how people feel by how they look.

Method: Project a number of news-photos, in which caption has given clue to situation, feelings of person shown. See how closely participants' guesses match newspaper descriptions.

Objective: To relate this to feelings/emotions of patients.

Method: Ask participant to tell how he knows when a withdrawn/aphasic/problem patient is happy? Sad? Disturbed? Can he tell by just looking? Do other personnel "read" the patient's feelings the same way? Are there indications common to all patients which can be "read" by all? What should you look for in contacts with patients? When should you look for signs?

Note: This is a chance to focus either on a specific problem which has been noted in the home -- lack of attention to decubiti, for example -- or some general indications about watching for changes in vital signs, and so on.

SUMMARY: Before ending session, educator asks for comments and feedback from participants, and summarizes what session has shown/accomplished. Educator also distributes reaction forms, uses them to assess results, problems.

SPEAK!

Notes for the Inservice Educator: SPEAK!

How do personnel communicate with patients? Do they speak to them, with them, or at them? Do they speak to them at all when they don't have to?

"I've got a million jobs to do," an aide says. "If I have to stop and talk to every patient who has nothing to do but talk, I'd never get my work done. Not that I'd mind sometimes" -- with a laugh -- "but I'd sure get hell for all the things I didn't do."

An experienced administrator -- perhaps he's exceptional, perhaps not -- gave a succinct, if somewhat earthy, rebuttal at a GIAT evaluation session, when he said: "Patient care is much more than wiping someone up. Sometimes it requires talking to them."

And sometimes "talking to them" can actually take the place of "wiping someone up." At another home, an aide talked about her experience with an incontinent patient. "I sat down and talked to her about it," the aide reported, "and asked her: 'Wouldn't you like to stop wetting yourself and go to the bathroom?' 'Yes,' the patient said, 'that would be wonderful. But you girls just don't have the time for me.' So I told her I would take her to the bathroom any time she wanted to go, and she said that would be wonderful.

"Now this patient is dry and goes to the toilet regularly. It took about a week before she was continent, but now she's happy -- and I'm happy. Just that talk has made my job easier -- I don't have that particular messy job to clean up four times a day."

That was an instance when talking with a patient about a problem not only meant better care for that patient, but for other patients whom the aide could now give some of the time that formerly went to the four-times-a-day cleanup. And of course it also made the aide's life -- and her job -- that much pleasanter.

Some recent studies have shown that people spend about 75% of their waking time talking and/or listening. Yet we never appreciate what the sound of other human voices means to us until we're cut off from it. Like a prisoner in solitary confinement. Or a castaway.

Or the patient with a broken leg, who couldn't even get into a wheelchair because he was in traction. All day, almost without stopping, he kept calling for the DNS, whose office happened to be across the hall from his room: "Miss G! Miss G! Come in here! I'm lonesome; nobody is here that I can talk to."

But how could the DNS leave her work, and spend the day talking? An article by Irene M. Burnside, R.N., in the July 1971 issue of "Mental Hygiene" describes a similar situation. "A student of mine," Mrs. Burnside writes, "described a 79-year-old man who had been hospitalized and placed in isolation at the end of the hall... (She) assessed part of his problem as sheer loneliness...

"He was isolated for a staph infection; he was restrained for an intravenous. She talked to him and found he was upset at being restrained, so she untied his hands, and explained that he must not try to pull the intravenous out. She talked to the staff and explained his plight, and they designed a nursing care plan to mitigate his loneliness...Staff alternated in brief visits. Each time someone passed his door, they stopped momentarily at the threshold of his door to at least say 'Hi'."

A concerned person -- it might have been any staff member -- took the time to speak to the patient, and to find out that his problem was "sheer loneliness" -- longing for the sound of a human voice. Then she spoke to the rest of the staff. Once they became aware of the problem, they worked out a plan which shared the responsibility of care among a number of people. And possibly the most important aspect of the plan was the people stopping to say "Hi" as they passed his door -- speaking to him when care/routine did not require it.

All staff members will speak to patients -- and to each other -- when they have to. It is important therefore, in connection with this particular inservice session, to point out how important it can be -- to the happiness of the patients -- for staff to speak to patients even when they don't have to, even when there is no problem. Especially when there is no need to; especially when there is no problem.

When people take a moment to chat with patients, to exchange small talk, they are making an important contribution not only to improving their own relationships with individual patients, but to raising morale in the home generally.

The old idea that talk was talk and work was work is beginning to disappear. At one inservice session, an administrator told his people: "You can talk to the patient whenever you're around him. You can talk to him while you're making the bed, or fixing the drawers. Some people don't have to be told this -- I see it happen all the time.

"And I for one appreciate the time you spend talking to the patients. It is all part of the job. You are their family; not too many of them have any family left."

In mentioning "the time you spend," this administrator was raising one of the key questions involved in the process of speaking, from the point of view of the home as well as the staff member: Is talking with patients wasting time -- or using it?

An aide brings Mrs. S. her tray, and Mrs. S. snaps out: "Same old Thursday night supper -- creamed chicken that the chicken ran through quick." Maybe Mrs. S. has a legitimate gripe; maybe no one had ever asked her if there was something else she might prefer Thursday nights that could be prepared; maybe she was just kidding, trying to get a reaction from the aide. But there are fifteen other trays, and fifteen other hungry patients waiting. So the aide slams down Mrs. S.'s tray and exits -- possibly with some such exit line as: "I don't cook it; I just serve it."

With some patients it won't help a bit for the aide to say sweetly: "Mrs. S., I can't stop with you now, because the other trays are waiting. Why don't you eat the creamed chicken now, and I promise to come back later and talk to you, to see what we can do about it from now on." With some that won't help -- but suppose all Mrs. S. wanted was to be noticed?

Because it is difficult to determine how many of the "problems" patients raise are the real problems, and how many are simply a device to get staff members -- anyone -- to speak to them, to spend time with them, to give them that bit of extra attention that gives definition to the word "family", that makes them feel part of things.

What the aide says to Mrs. S. about the creamed chicken may not be as important, many times, as the way in which she says it. Mrs. S. may be complaining aloud about the food, but inside her she may be voicing her need for an extra portion of TLC -- tender loving care. And when the aide brushes her off, or says nothing, Mrs. S. may (perhaps correctly) interpret that as the aide's answer: "I'm not giving you that TLC because I don't really love you."

There are some patients who won't ever be satisfied with a promise -- who insist that the aide stop and talk right now. But there are others for whom promising to come back -- and keeping the promise -- is most important. The patient -- even the grumpiest -- is more likely to accept the promise instead of immediate performance, if with it there is a smile, or a pat on the hand, or just an extra moment's pause. Will accept it not only because of the words, but because of the emotional content -- the attitudes and feelings -- conveyed through and in and around the words. In today's parlance, what might be called "good vibes".

A patient will get a different feeling from your talk --and respond differently -- if you talk with him, rather than at him. There was a man who wouldn't take a bath when he first came into the home, nor change his clothes. The first day he was there, the orderly asked him several times to take a bath; the answer was always no.

But the next day, after another no answer, the orderly had an inspiration; he asked whether the man might perhaps prefer to take a shower. He didn't get a yes -- but there was a slight wavering. The wise orderly decided not to press the patient; instead he told him he'd come back in a half hour to see how he felt about it then.

Sure enough, a half hour later the patient went to the shower without objection, and changed his clothes as well. He now takes a shower several times a week, but always according to the same ritual. Each time the orderly has to ask him whether he might prefer a shower to a bath, and give him a half hour to consider his decision.

At a time of life, and in a situation where this patient has lost nearly all possibility of making decisions, when he is emotionally oppressed by what one administrator described as "a feeling of regimentation like the army," speaking with him, offering him a choice of something, not rushing him, gives the man some feeling -- some vestige -- of control over his own destiny.

Speaking with him, accepting his action and his reaction, gives that patient the dignity of choice. In a small way he can feel that he is more than a piece of furniture, to be moved from his room to the shower and back at someone else's convenience. An orderly substituted a question for an order -- though the content, and the final effect, were in the end identical -- and a patient thereby regained some part of his manliness, his lost personhood.

Talk did it; a way of speaking.

Notes for a Lesson Plan: SPEAK!

Overall Objectives: a) To demonstrate the role of speaking/not speaking in the care of patients; and b) to teach participants how to speak/respond to patients in a therapeutic manner.

Method: Prepared skit, discussion and questions. Equipment needed: wheelchair, cassette recorder, smile and frown masks.

Note: In the first two sessions of GIAT, emphasis was on participants' role -- in the communication process -- as receivers. Listening and seeing are both essentially passive acts. At this session, the emphasis is on a more active role, as the senders or originators of the communication.

* * * * *

Objective: To demonstrate that words are weapons -- that they can hurt, anger, irritate, destroy.

Method: The room is arranged with chairs and tables in a circle. Possibly a rock tune is coming over the intercom, or from the cassette recorder. While group is assembling, a person who is not a member of the regular staff, but who is an authority figure, is arguing with the inservice educator about the unconventional way the room is set up, and the "strange" teaching techniques being used in GIAT. Experience with this technique indicates that you will soon begin to get a response from the assembling staff: most of them are likely to support "their" inservice educator, because the other person is considered an "outsider". The two finish their argument, and put up the smile and the frown masks in front of their faces. This relaxes the tension; it also leads into the topic when the educator asks the group: "How did you feel when you walked in and found us arguing? Were you angry? Embarrassed? Feel like leaving?"

Objective: To demonstrate that words can not only hurt and destroy, but that they can also comfort and heal.

Method: Ask participants to nominate "most difficult patient" in the home. Get participants to describe in words why patient is so hard to handle. Then, using "Goodmouth/Badmouth" skit as a general guide (see end of lesson plan), role-play various ways in which "most difficult patient" might be handled. Have various participants play and exchange roles.

Objective: To demonstrate what happens when response to patients is made in a therapeutic manner.

Method: Discussion of specific incidents. Start by asking whether any of participants can recall incident in the home when a "soft word" succeeded in turning away a patient's wrath. Educator might prime the pump by beginning with an incident from own experience, or based on discussion with supervisors/administrator. If someone happens to remember "negative" incident, one in which answer made situation worse, educator can follow up by asking participant whether he can now think of a different/better way in which he might have handled it. Also -- depending on the situation in the home -- it is possible to expand the scope of the discussion to include relationships between staff members.

Objective: To provide specific examples of therapeutic and non-therapeutic responses.

Method: Take sample situation. From the list of Interpersonal Techniques which follows, and which you may have distributed to participants, ask each person to select the one he might have used, and to explain why.

SUMMARY as in previous lesson plans.

INTERPERSONAL TECHNIQUES

THERAPEUTIC TECHNIQUES	EXAMPLES
1. Accepting	Yes. Uh hmm. I follow what you said. Nodding.
2. Giving Recognition	Good morning Mr. S. You've tooled a leather wallet. I notice that you've combed your hair. I like your bright blouse.
3. Offering Self	I'll sit with you awhile. I'll stay here with you. I'm interested in your comfort.
4. Giving Broad Openings	Is there something you'd like to talk about? What are you thinking about? Where would you like to begin?
5. Offering General Leads	Go on. And then? Tell me about it.
6. Making Observations	You appear tense. Are you uncomfortable when you...? I notice that you're biting your lips. It makes me uncomfortable when you...?
7. Encouraging Description of Perceptions	Tell me when you feel anxious. What is happening?
8. Exploring	Tell me more about that. Would you describe it more fully? What kind of work?
9. Giving Information	My name is... Visiting hours are ... My purpose in being here is ... I'm taking you to the ...
10. Presenting Reality	Today is Monday. It is lunch time. This is July 1972.

NON-THERAPEUTIC TECHNIQUES	EXAMPLES
1. Rejecting	I don't want to hear about ...
2. Disapproving	That's bad. I'd rather you wouldn't.
3. Disagreeing	That's wrong. I don't believe that.
4. Defending	No one here would lie to you.
5. Requesting an Explanation	Why do you feel this way?

THE DEMANDING PATIENT

Cast: Mrs. Grunch, Miss Badmouth and Miss Goodmouth.*

Mrs. Grunch: Where is everybody? Miss Badmouth! Where are you? Miss Badmouth! My clothes have been stolen. Somebody took my blouse. Miss Badmouth!!!

Miss Badmouth: (Comes stamping into room) You are making too much noise! (Angry and impatient) You're always yelling. What are you yelling about now?

Mrs. Grunch: It's about time you got here. Whenever I want you, you're in Mrs. Sweetlady's room! For your information, someone took my blouse. It isn't with my clean clothes where I put it.

Miss Badmouth: That old blouse? Who'd want it? Anyway, it was all ripped. Forget it.

Mrs. Grunch: It was mine and now it's gone! It was my best blouse and I want it back, or I'm going to the Administrator.

Miss Badmouth: Oh be quiet! All you ever do is complain.

Mrs. Grunch: Nobody here cares about me; that's why.

(She continues to complain as Miss Badmouth leaves; eventually Miss Goodmouth passes, hears her, and comes in.)

Miss Goodmouth: Good morning, Mrs. Grunch. What's wrong?

Mrs. Grunch: My blouse is gone. Somebody stole it. I want it back, and I'm going to report Miss Badmouth.

Miss Goodmouth: Maybe it wasn't stolen. Maybe it just got into the wrong package when it came back from the laundry. (Inspired) Maybe it went to your old room by mistake!

Mrs. Grunch: (Considering) Well, that did happen once.

Miss Goodmouth: Why don't you go down to breakfast while I check on it.

Mrs. Grunch: (Still angry) I don't want breckfast. I want my blouse!

Miss Goodmouth: Yes I understand, and I'll look for it. Why don't I come to the dining-room and have a cup of coffee with you after I find it. Then you'll know I found it.

Mrs. Grunch: (Leaving and already forgetting) Do they have prunes today?

(*Note: If "neutral" names are preferred, the patient can be Mrs. Green, the two nurses Miss Brown and Miss Gold.)

TOUCH!

Notes for the Inservice Educator: TOUCH!

"I had been on vacation," an aide recalls, "and had just gotten back. One of my patients is blind, and I went up to her, took her by the shoulder, and said hello to her.

"A big smile came out on her face and she said to me, 'I'm so glad to have you back. I knew it was you even before you said anything. Just the touch of you feels different from the other aides.'

"I can't tell you how good that made me feel," the aide added. "I know that that lady got good care while I was gone. But it gave me a nice feeling to be recognized that way, and a nice feeling to be missed."

Blind people are of course particularly conscious of being touched, and particularly sensitive to the language of touch, to the messages which touch conveys. But this sensitivity is only a matter of degree: touching is a form of communication which all human being use to a greater or lesser degree. It is another language patients will understand.

Traditionally there has been a taboo in the United States--and in "Anglo-Saxon" cultures generally -- against most forms of interpersonal touching, unless the two people were on fairly close, if not intimate, terms. Perhaps, therefore, one reason that the taboo seems now to be disappearing is our ethnic-cultural mix. But in addition the "fallout" from the proliferation of T-groups, sensitivity training and other forms of contact-communication has impinged on the consciousness of all groups in American society.

There is therefore increasing awareness of touch as a form of communication. But even if this were not the case, all nursing personnel know of the therapeutic effect of a touch in time -- as a way of calming, of comforting, of reassuring, of showing concern and affection. Touching may not be the most efficient way of giving the answer to a problem in physics or mathematics, but it is nevertheless a method of communicating. Communicating information, that is.

To a doctor, a nurse, a therapist, an aide, touching can provide very specific information about the state of a patient's health, his approximate temperature, pulse-rate and so on. But touching can also reveal much about the patient's attitudes and his emotional state; and it can also provide a means for communicating attitudes and feelings to the patient as well.

With regard to specific information, one aide told this story at an inservice session: A few days earlier she had walked into a patient's room to find her holding her abdomen. When the aide asked whether it hurt, the patient nodded, then took the aide's hand and squeezed it against her abdomen. The aide wasn't sure she

could tell what was wrong, so she asked the patient whether she'd like the nurse to come in, and again the patient nodded. The nurse came in, looked at the patient, felt her abdomen, and knew immediately that the patient needed an enema.

"That little experience," the aide noted, "showed me again how patients can express themselves with their hands, and how I communicate with my hands without realizing it.

"You know," she added, "before we started this inservice, I'm not sure that I would have paid any attention to that patient, because she wasn't saying anything. Or I'd have figured she was just generally complaining. The difference was learning about touching, getting used to the idea of touching people. I was glad I understood."

When you speak of touching, you're usually speaking of touching with your hands, though there are all sorts of other ways in which people touch each other. What can a nurse's or an aide's hands tell her about the state of a patient's health, physical or emotional?

It takes no special background or training to suspect that something may be wrong with a patient if his hands feel cold and clammy. Or if -- for the first time you can remember -- they are trembling violently.

But hands can convey other kinds of personal intelligence. Without consciously thinking about it or analyzing it, you can easily think back to occasions when merely holding a patient's hand has conveyed to you his anger, or his helplessness, or hopelessness, his love or despair or dependency.

By the same token, helping personnel can in their turn convey to the patient -- by the touch of their hands -- certain of their feelings and attitudes -- anger, impatience, acceptance, affection, involvement, concern. This can be done consciously; what is even more important is that personnel should be aware that such emotions and feelings are also conveyed unconsciously, and sometimes even when we make an effort to conceal our true feelings.

But to change what we reveal unconsciously we have to change our feelings. Let us here therefore concentrate primarily on the conscious language of touch. Here is a dialogue-without-words: an aide enters a patient's room to find her looking at a photo and sobbing bitterly. The aide reaches out spontaneously and takes the patient's hand. After a moment or two, still sobbing, the patient reaches out with her free hand, and enfolds the aide's hand with both of her own. The aide in turn covers the patient's hands with her free one.

A simple handshake can reveal a great many things about someone -- his emotional state at the moment, certain general personality traits (does he grab your hand and try to overpower you, or are you squeezing a limp sock?), and possibly something

about the general kind of work he does -- are his hands rough, calloused, carefully manicured?

But in addition to this kind of incidental information conveyed through hand-to-hand contact -- incidental because it is not deliberately designed to provide information or convey a message -- we do use our hands and touch deliberately to communicate our feelings, sometimes in a very forceful way.

You grab someone to restrain him; you pat a child on the head -- and an adult on the shoulder -- to show your approval. And it isn't only a matter of who is making the gesture, but to whom. You put your arm around the shoulders of a person your own age and of the opposite sex, and that is generally interpreted as a sign of affection; the same gesture around the shoulders of an elderly patient -- of either sex -- would signify support and comfort.

Another interesting aspect of touching is that while everyone touches, even when it is done without design or conscious thought, it is usually done according to a set of careful rules. We don't touch strangers, as a rule, in any of the ways just mentioned, because that would be too intimate -- or too threatening. We don't even touch all the people we know well -- we are aware that even some close friends "don't like to be touched"; it may be that unconsciously this represents to them an invasion of their privacy.

Among certain cultural groups, however -- and perhaps you can see this among some staff members in your home -- touching has always been socially acceptable. And today it is becoming more accepted throughout society generally.

But having indicated some of the more general aspects of touching, the inservice educator should then attempt to focus on the specific relevance of touching -- first of all -- to improved patient care in the home; second, within the context of patient care, to identify certain kinds of touchings and their meanings; and third, to encourage the use of touch as a form of communication with patients. And what needs to be stressed is that touch is a method not only of obtaining information about the patient's physical well-being, but about his spiritual and emotional well-being as well. It is a method which provides information about the whole person, to help care for the whole person.

But it is a form of care that must be used with care. Individual patients will have their individual reactions, their feelings about touching and being touched -- "different folks have different strokes."

If the nurse came on duty in the morning and as she said good morning to Mrs. Smith, took Mrs. Smith's hand in hers, would Mrs. Smith be pleased or shocked? Would

she understand it -- from her own background -- as a gesture of affection, or would she resent being "handled"? Perhaps it might make a difference -- if the nurse doesn't know Mrs. Smith's attitude -- for her first to announce what she's doing: "Mrs. Smith, do you mind if I take your hand?" And then -- whether or not -- "I do understand."

But let's apply the concept of the "advance announcement" -- which may seem a little silly with regard to holding a patient's hand -- to a more common real-life situation in the home -- the transfer of patients. How many times does this take the form of a "rush job", where the patient is left in no doubt that personnel are in a hurry? Two people come dashing into the room, do not explain anything (after all, this is done so often), certainly don't ask the patient's permission or his help but just grab him under the arms and move him bodily from his bed to the wheel-chair. Like a sack of potatoes.

The difference between a "sack of potatoes" and the dignity of a human being may be between ten and thirty seconds. Think of how many emergency situations there really are in the home when thirty seconds of staff time are that valuable.

It is no exaggeration to say that -- whether we do so consciously or not -- when we touch a patient and how we touch a patient tells him, to some extent, what kind of people we are and what kind of person we think he is; but to a much more revealing extent, how we feel toward him and the help we're giving him.

Yet having said this, it is possible to modify and control the language of touch, and to use it in a therapeutic way. There are certain universally-understood gestures which translate simply as "I do care." They come naturally and spontaneously with those we love -- friends, family, patients.

Yet even with patients whom we do not necessarily love -- or even like very much -- but whose care has been entrusted to us: a pat on the arm may be more valuable than a pill.

And a smiling touch may be super-therapy.

Notes for a Lesson Plan: TOUCH!

Overall Objectives: a) to understand the role of touching in communications/ interpersonal relationships; and b) to recognize the therapeutic role of touching in patient care.

Method: Series of demonstrations, followed by discussion. Equipment needed: pillowcase, bed, wheelchair.

* * * * *

Objective: To demonstrate how much information can be obtained by the use of touch alone.

Method: Place a number of small objects -- fruit, instruments, tools -- into a pillow-case. Ask participant to put hand into case, name the object he's feeling, then describe the particular qualities of the object which led to conclusion. Change objects in pillow-case, repeat with other participants.

Objective: To demonstrate that information about people can also be obtained by touching.

Method: Blindfold a volunteer, have him/her touch face of another participant, guess who it is. But most important: have him describe characteristics -- shape of face, shape of nose, hair, glasses -- which led to guess.

Objective: To show how much can be learned about physical condition of people/ patients by touch alone, or touch in combination with observation.

Method: Ask participants to give examples from own experience, and draw up a list: feeling forehead for temperature; cold, clammy hands; trembling hands; rigid limbs; distended abdomen; puffy ankles.

Objective: To show that in addition to physical symptoms or condition, touching can also sometimes indicate emotional/mental state of patient.

Method: Have a small role-playing demonstration, with one participant, playing himself, and taking the hand of a "patient", and the "patient" demonstrating the varying reactions of a patient who is: withdrawn, disturbed, anxious, frightened, responsive, happy, affectionate.

Objective: To demonstrate the language of touching as a form of person-to-person communication.

Method: Inservice educator will demonstrate following gestures, where relevant indicating setting, and who is being touched by whom; and in each case ask individual participants to describe meaning/content of gesture:

Holding hands (mother and child)
Holding hands (lovers)
Holding hands (nurse and patient): which other hand-holding relationship does this most resemble? Why?
Pat on cheek and cheek-to-cheek.
Arm around shoulders -- lovers, mother-and-child; nurse-and-patient.
Pat on head -- mother-and-child, teacher and pupil.
Pat on rear -- coach to player entering game, mother burping baby, lovers.
Cradling baby in arms.
Stroking hair -- lovers, mother-and-child, nurse-and-patient.

Note: It is not to be expected that all participants will understand "language of touch" equally well, though all will readily understand simpler gestures. Inservice educator may therefore have to provide additional input relating to cultural backgrounds, home environments -- it might even be interesting and valuable to explore some of the different interpretations given to the same gestures by people from various cultures. Similarly, how do the various participants feel about the "proper body space" -- the correct social distance people should maintain between them in normal conversation? Do Latin-Americans have a different estimate of this "proper distance" than blacks, "Anglo-Saxons", people from Eastern Europe?

Objective: To discuss and analyze manner in which patients use touch (and being touched) to communicate their feelings to personnel.

Method: The inservice educator demonstrates a series of common gestures patients use, ask participants to interpret. These may include: tap on back or arm, holding/clutching aide's hand(s), touching own body, especially repeated, compulsive; fondling objects.

Note: The emphasis here should be on what these gestures reveal about the patient's mental/emotional state, not his physical condition: when a patient touches/clutches your arm, is he trying to say something? asking a question? protesting? disturbed?

Objective: To demonstrate that the way in which personnel respond to patient's touch is often equated in patient's mind with feelings of staff member toward him.

Method: One participant is "patient", reaches out to touch another (acting as staff member, of course), and second must respond in therapeutic manner. Other participants translate this "dialogue" into words, suggest alternative meanings and alternative responses by staff member. Inservice educator should herself be prepared to demonstrate various possible responses to same overture by patient, clarifying different meanings each may have to patient.

Objective: To demonstrate different kinds of "touching" and handling of patients in everyday life of home: transfer of patient from bed to wheelchair.

Method: Demonstration: a) the limp transfer -- making the patient feel insecure by not really helping him, but just pushing him around a little; b) the rush transfer -- not explaining anything to patient, just grabbing him under arms, and removing him from bed to chair like sack of potatoes; and c) the firm/supportive transfer, with good use of body mechanics.

Note: Using this routine operation, inservice educator should make the point: how you do something with patient will often indicate to him not how you feel about your job, or how you are feeling about the world in general at that moment, but how you feel specifically about him. More than any other form of interpersonal communication, touching is a one-to-one relationship.

SUMMARY and EVALUATION as in previous lesson plans.

CHERISH!

Notes for the Inservice Educator: CHERISH!

It used to be thought that if a nursing home provided adequate physical care for its patients, that was enough. Everyone knows better today. Yet vestiges of the old approach may still exist in the home, in practice if not in theory. And it may still be necessary to convince some staff people that every person in the home can make a contribution to the treatment of the patient as a whole person.

If this concept is occasionally difficult for one or another staff member to grasp, it is perhaps because it is not something a physician can put into an RX. Tender loving care -- TLC -- doesn't come in bottles.

Up to now, in this series of GIAT sessions, we've been taking one human sense, one facet of communication, at a time. In this session, we begin to discuss interrelationships and intangibles. Perhaps the best way to show these relationships is to point out that all the sessions have had a common component -- heart.

For when we've said: listen! we've really been saying: listen -- with heart! And see! has been shorthand for see with heart! And touch with heart, and speak with heart. Without heart...

This incident came up at one session: A patient offered an aide a piece of his fruit; he had already taken a bite out of it. The aide refused; the patient cried. The aide thought that was funny; he laughed. When the patient offered the fruit -- and especially with a bite out of it -- he was saying to the aide: You're my family; this is O.K. in families. And when the aide laughed at him, without any words, the aide was saying scornfully: But you're not my family.

Those involved in nursing home care are aware that no matter how much such a setting does to improve or safeguard the patient's physical condition, it may actually worsen his mental state. The patient pays for that better physical care in part with emotional currency -- by being cut off from his family, his friends and neighbors, his familiar surroundings, whatever social contacts he may still have retained.

He no longer belongs. And what makes it far worse, he has no real hope or expectation of ever belonging again.

Instead of family, friends, neighbors, surroundings, all that the patient has left to him is -- you, the personnel of the home. And it is only to the extent that everyone in the home understands that they now represent every past, present and future relationship in the patient's grasp, they will also understand his acute and intense need to cherish and to be cherished.

"With personnel whom they like," an administrator relates, "patients make them part of their own lives. They won't make a move without consulting 'their' nurse. When we want to change an assignment, the patient and his family come screaming -- they don't want anyone else. They want the one they've adopted."

And another aspect of the patient's feeling toward staff: At one session the question is asked: Suppose two aides get into a fight during coffee break and then have to work in the same area -- does this affect the patients? "Oh yes," an aide answers, "the patient will come up to you and ask - 'Are you fighting? What is wrong? What did I do?' Yes, that's right -- 'What did I do?' They feel as though it had to be something they did."

Any experienced staff member in the home will tell you that his or her first and most important tool in dealing with patients is his/her personality. The ancient Chinese philosopher Lao-Tze once said: "One who loves humanity as he loves himself can be entrusted with the world." But it isn't easy to be philosophical about all of the patients you deal with. Every staff member has patients he likes, patients he can accept or tolerate, patients he "can't stand," or doesn't like to care for.

Yet in every home there are people who seem to "have the knack" of getting along with even the most difficult patients. What these sessions have been designed to do, and especially this one, is to help participants understand that this "knack" is actually a number of specific attitudes translated into specific acts.

Do you remember Nellie, the difficult patient in the lesson on Listen? And the aide for whom Nellie was no problem? The aide's "knack" was really the willingness and the understanding to analyze the problem; after that the solution was easy. The aide took the time to ask herself: What does Nellie really want? And answer: Not to be left out. So she took Nellie along while she did her work.

In his book, "On Growing Old," A.L.Vischer has some comments which would seem to apply to nearly all patients in the nursing home:

> "Apart from security as such, old people also need to feel that they are safely enclosed within a warm and loving circle. What they are looking for, in fact, is the warmth of the nest. For old people to live in a cold and impersonal environment where nobody wishes them well and where they receive neither love nor attention is quite unbearable. An old person who still has somebody to 'make a fuss of him'...is fortunate indeed...
>
> "Sometimes old people can be quite tiresome with their constant complaints. But if we enquire more closely into such behavior and try to establish its underlying causes we find that in many cases what they are really trying to do when they complain is to make people take notice of them."

> And -- remember Nellie? -- "Old people develop feelings of inferiority due to the debilities and deprivations which come with old age. Because of this, they want to be acknowledged, they want to be made to feel that they are still needed and still useful. And often it takes very little..."

There will be many patients -- perhaps most -- who want what Nellie wanted -- to be included in life. It may not always be possible; it is not often easy. And since you cannot possibly cover all situations, what you will be dealing with in this session are attitudes.

If you have to boil everything down to one sentence for staff people, to tell them how to deal with patients, wouldn't it be likely to be the Golden Rule? "Do unto others as you would have them do unto you."

(At this point in one of the sessions, an orderly born in the British West Indies asked if he could quote a poem he learned as a child:

"Little children love each other
Never give another pain
If our brother speaks in anger
Answer not in wrath again.")

Or an enlightening modification of the Golden Rule which has occurred to many. An aide was talking about a bedridden patient: "I understand better now. I put myself in the patient's shoes, sitting there day after day, never getting the chance to go out of the room; I'd be angry and demanding too." An orderly: "You really need patience to handle patients. I now have more understanding. And besides, I'm going to be old someday myself." And an aide: "My feelings carry over to the nursing floor because my motto is: 'Treat the patient kindly -- you'll be old someday yourself'."

For which of us knows what illnesses and debilities may yet be in store for him; or where or how he will spend his own old age?

O.K.; you're thinking Golden Rule. Now what do you <u>do</u>?

The first step is easy: you give <u>time</u>. Time to see and listen and speak. And if you, as inservice educator, know that giving time isn't possible for an aide if the supervisor or the administrator doesn't accept/approve it, here is what one administrator said at a session: "Do you stop and listen every day? They think you've got to listen to them...cause you're their family. You belong to them.

"You were walking by and someone tried to stop and tell you something. You didn't have time; besides, you already <u>knew</u> what they wanted. You just couldn't wait for them to spit it out, so you went ahead and did it. But that didn't really satisfy them. Because they wanted to express themselves. They wanted to get it off their chest."

An aide who takes time to listen to a patient shows she is interested in him and his welfare.

When you take time to respond to him in a therapeutic manner, you show him that you are ready to accept him as he is.

When you take time to use a firm, kind touch, you are showing understanding and consideration; in turn you get trust from the patient.

When in all these ways you show a patient that you cherish him, perhaps at a time when he is having great difficulty accepting and liking himself, think of how much comfort and reassurance you are giving him. Aside from you -- the staff of the home -- there are only things.

When Mrs. O'Brien refuses to move out of her room without her rosary beads, keeps fussing when they can't be found in her drawer, the rosary is far more than a thing -- it is a religious symbol, it is the remnant of everything Mrs. O'Brien used to cherish. It is much harder to accept the patient -- as in one home -- who chose two eggs to cherish -- which an aide finally discovered in a bureau drawer when they went rotten.

Old people do cherish things -- because people are impermanent. It is this overwhelming sense that people keep disappearing that colors the feelings of the elderly -- an all-pervading sense of loss.

It is a tall order -- probably an impossible order -- to expect nursing home personnel to take the place of family, friends, neighbors. The fact is: it is not their choice. It is the patients who make the choice -- because there is no one and nothing else. None else to cherish.

So long as they are in the home, therefore, the decision which staff people have to make is a limited one -- how to play the role already chosen for them.

For in a nursing home surely it can be said: I am my brother's keeper.

Notes for a Lesson P' : CHERISH!

Overall Objectives: a) To show how listening, seeing, speaking and touching are aspects of cherishing; b) to emphasize that you care for patients better when you care about them; c) to stress patience with patients -- and giving time -- as a contribution to better patient care.

Method: Demonstration and discussion.

* * * * *

Objective: To determine the variety of acts by which staff show concern for patients, and patient reactions.

Method: Ask for volunteers to tell "success stories" about success with difficult patients. (Inservice educator might prime the pump by summarizing anecdote(s) from Speak!) Permit anecdotes from other homes, and even from personal/social relationships, if relevant. Try to extract from each incident -- and from all of them together at the end -- the essential ingredients of success -- both as the participant sees it and as the others in group see it.

Objective: To spotlight the "glow of success"; to emphasize that making the patient feel better inside makes the nurse/aide/staff member feel good inside too.

Method: Ask how people felt at time of "success" -- unless they've already volunteered the information. Go on from there to discuss the Golden Rule, the modifications cited in the "Notes" for this lesson, the concept of empathy ("putting yourself in the other fellow's place"), patience and time, whether knowing the patient's life story/case history makes you more sympathetic in dealing with him.

Objective: To discuss (without necessarily trying to resolve the question) whether it is possible to be sympathetic/affectionate -- or at least appear to be so -- toward a patient whom one doesn't like.

Method: Discussion.

Note: The inservice educator must begin by establishing a climate and an understanding that participants can freely talk about their feelings toward patients -- even specific patients -- without feeling guilty, or feeling that their behavior is to be criticized or censured. On the contrary, the educator must stress that no one likes everyone, but that we can begin to feel differently by behaving differently, as for example: "Can you recall some time in your life when you had to be nice to someone when you didn't feel like being nice?

To a teacher or a boss, or even your father or mother? What did you do then? And how did you handle the situation? If it was a boss or a teacher whom you never ever got to like, how did you manage to force yourself to get along? What specifically did you do? And did you convince him? If it was your mother or father, how did it make you feel inside when the things you did helped you to get along better?"

Objective: To list some specific "methods that worked", which staff members might begin to explore in dealing with patients they find difficult to get along with.

Method: Going back to earlier "success stories", ask each participant to relate specific ingredients of success. Since you're attempting to change attitudes, ask not only for such specific acts as listening, chatting, holding a patient's hand, but for intangibles -- a different attitude, spending a little extra time, chatting when there was no need to. If possible, have participants write the lists on paper, without checking with each other -- so you can then distill out the common ingredients, if any. Otherwise, write the items on the blackboard, and then ask for a show of hands as to which participants feel are most important.

Objective: To see whether "cherishing" works in real life.

Method: A field test. Go back to the patient chosen by the participants at an earlier session as "most difficult". Ask participants whether they would like to try an experiment as a group. If they agree, have them work out an approach to this patient based on the "ingredients of success" which they have just listed. Agree that between now and the next inservice session, anyone having dealings -- or even coming into contact -- with this patient will deal with him/her in strict accordance with the approach and the methods which the group has just chosen. The next session is to discuss the results -- from two points of view: a) any modification in the patient's behavior; and b) how participants felt about "turning the other cheek" with patient.

SUMMARY and EVALUATION as in previous lessons.

THE SOUND OF SILENCE

Notes for the Inservice Educator: THE SOUND OF SILENCE

An orderly noticed that a patient was not eating, though he should have been quite hungry. Not only wasn't he eating, but he had taken his napkin and used it to cover the pork on his tray. On a hunch, the orderly went and got a serving of chicken. The patient smiled his thanks, and ate the chicken with evident delight.

The patient was aphasic, like the nurse in the film, "The Inner World of Aphasia". That nurse, and the patient who didn't want pork, are, however, extreme examples: in a nursing home in particular it is important to recognize the extent and general validity of nonverbal communication.

From the point of view of inservice education, the problem has two aspects: first, to make participants aware that the "eloquent silence" of patients is often a form of communication; and second, the correct interpretation of this type of communication, so that a response may be given.

You are an aide talking to a patient about her incontinence, hoping to get her to control it. You keep talking, but she sits there saying nothing. Question: What is she saying? You persist. You ask her whether she is making the attempt to have a regular BM before bedtime, and she keeps quiet, telling you nothing. What is she telling you?

Another aphasic patient was not eating; she was always sending food back on her tray. Even though she couldn't talk, one aide was finally able to take the time to sit with her during an entire meal, and to figure out what was taking place. It turned out that the patient was actually hungry all the time -- she was a slow eater, and they were taking the tray away too soon for her. They hadn't known -- after all, she'd never said a word to protest...

But an aide at one inservice session protested: "You can't just spend too much time with any patient like that, because you have your work to do." It was another aide who gave the answer: "Some patients you just have to spend time with. There's just no other way."

"One cannot NOT communicate. When a response is expected, silence communicates..." The quotation is from a special study by the United Hospital Fund of New York on communication in hospitals. "(Silence) may communicate fear, stubbornness, uncooperativeness, etc.," it goes on. "Thus our choice is not between communicating or not communicating, but between communicating effectively or ineffectively, between contributing or not contributing to reach the goals of the organization."

The essential point to be made during the inservice session is that whether the silence is the patient's or the staff member's, it is the staff member whose responsibility it is to initiate and sustain communication.

Granted that a patient unable or unwilling to talk makes communication difficult -- nonverbal "conversation" is a lot harder for the "listener" to understand. A cartoon in The New Yorker once pointed this up: a little girl is trying to convey by gestures to her class that she is a flower. But they -- as shown in balloons over their heads -- are variously interpreting her to be portraying a bird, a tree, a fish, an octopus, a sailboat, a bee, a deer, a horse, a cat and an airplane. The Communication Issue of the Scientific American, which reprinted the cartoon, rightly referred to it as a "skeptical view" of nonverbal communication.

It was because of the inherent difficulties of this method that in silent films all the gestures, all the emotions, were always "writ larger than life". The silent film director -- in his role not as an entertainer, but as a professional communicator -- had to make certain that his audience understood each step in the plot's development, before he could go on to the next.

Yet in one major respect that director's problem was more difficult than that of nursing home personnel -- he had no way of getting feedback from his audience in time to change, correct or reinforce his approach, no way to determine whether communication was actually taking place (and so there were some very obscure "silents"). In a nursing home, the patient's face tells you (except, of course, where the physical condition makes it impossible) when communication has been achieved. And there are other nonverbal signals: "I now have more understanding," a participant in one session said. "Patients that lose their speech, when you deal with them every day, you begin to know what they want by their grunts and groans. They let you know all right when you get the idea."

And an administrator tells an anecdote about a patient who would often come up alongside the home's switchboard "and keep on moaning, as if she was in great pain.

"But it only sounded that way," he went on. "Eventually we figured it out -- it wasn't that easy -- that she was really asking what time it was, on the clock that was there. But until the switchboard operators took the time to figure out what she was really doing, to understand what she was asking, she'd keep repeating and repeating -- and never get tired."

The aphasic patient may be the most dramatic -- and the most tragic -- demonstration of the need for nonverbal communication in the nursing home. He is certainly not the only patient for whom it is important. Aside from words, all human beings communicate -- in part -- nonverbally. And quite often -- particularly with patients -- the words are the least significant part of the total communication.

We are not speaking here of the aphasic's "grunts and groans," or his "moans," his other overt gestures -- though we all use them to augment and supplement our normal verbal communications. These represent what Jurgen Ruesch and Weldon Kees, in their "Nonverbal Communication" call "behavior as a form of language".

There is yet another, involuntary form of communication, familiar to all nursing home personnel, which Ruesch and Kees describe:

"There are many surface manifestations of excitement...pallor, the pouring out of 'cold sweat'...the dilation of the pupils...the hurried respiration, the trembling and twitching of the muscles, especially about the lips -- all these bodily changes .. inform the observer by visual means...

"...emotions reflect the inner state of the organism...(which)...may be expressed in a great number of ways, among which nonverbal actions figure prominently... Sometimes they enable the onlooker to predict future events more accurately than if he relied upon words alone. And, if he is familiar with the individuals...he observes, the possibility of accurate prediction of subsequent behavior becomes even more likely...Gestures differ in that they are consciously intended for communicative exchanges...

"All expressions of an individual, when perceived by another person, must be interpreted if they are to be understood...we have today come to realize that any form of action, whether verbal or nonverbal, has communicative function. As soon as another person interprets a signal with some degree of accuracy, it must be codified in terms that qualify as language."

We have now described two kinds of nonverbal communication which the staff member in a nursing home must be prepared to recognize, understand and interpret -- the language of behavior, and the language of what might be called "signals," or symptoms. There is yet another occasion on which he must be prepared to interpret -- for "foreign-born aged who have not mastered the English language," and for whom, in the words of Mental Hygiene, "there exists real isolation.

"I recall a Russian-born woman," the writer notes, "who walked about a nursing home carrying a doll in her arms and smiling plaintively at those who passed her. No one was ever able to communicate with her in her native tongue as there was neither staff nor patient who knew any Russian."

Yet there are ways to communicate under such circumstances. At one session an aide described one of her patients, "a patient who doesn't talk. That's because she's Italian, the only one in the whole home.

"But," the aide added, "she can understand what I say to her. And if I keep trying, I can understand what she wants. Because if it isn't right, the patient just keeps shaking her head. Until I finally do figure it out. And it feels to me like I'm getting better at it all the time.

To "figure it out," three things are required. First, staff members must be convinced of the importance of better communication in the home (between staff members as well as between staff and patients, of course); second, that whatever the problem may be in communicating with a patient, it is the staff member, and not the patient, who has the responsibility for breaking through to communication; and third, that opening this line of communication is likely to take time -- and patience. "If I keep trying," the aide said, "I can understand..."

Being able to communicate with another human being is always satisfying. There is a special satisfaction in establishing communication on the nonverbal level, especially with someone like an aphasic.

But it is likely that achieving that kind of breakthrough will require an extra measure of "patiencewith patients."

Notes for a Lesson Plan: THE SOUND OF SILENCE

Overall Objectives: a) To understand that nonverbal communication is true communication; b) to learn to recognize nonverbal languages, and some of their specific meanings.

Method: Film dealing with aphasia, followed by discussion, plus illustrations of difficulty of communicating nonverbally.

* * * * *

Objective(s): To understand some of the frustration, anguish and torment the patient with speech deficit endures; to have empathy for the patient who does not communicate verbally; to become aware of some nonverbal "cues".

Method: Film, "The Inner World of Aphasia," about the emotional world of the aphasic, illustrating how professionals work with patients who cannot communicate verbally.

Note: This film must be previewed by the inservice educator to determine best way to introduce and present it. It can be a moving, disturbing experience; it can also be a most effective educational tool. In commenting on the film during the discussion period, the inservice educator should point out all the ways the patient attempts to communicate, and which the staff does not recognize. She should also highlight the indications of anxiety or frustration or impatience on the part of the patient, before any understanding takes place. As for the specifics of communicating with aphasics, the following points should be made: 1) their attention span is short; 2) they are easily distracted; 3) they are adults: do not use baby talk; 4) they have a visual deficit; 5) they can hear: do not shout; 6) they must be allowed to maintain their dignity, to do things for themselves; and 7) they need understanding, to know someone is "on their side".

Objective: By having each participant attempt nonverbal communication, to put him "in the other fellow's shoes": to help him understand the frustrations of unsuccessful nonverbal communication, especially in the nursing home.

Method: If appropriate, inservice educator writes on cards a series of statements/questions/requests of patients, to be conveyed nonverbally by participant to rest of group. Each participant gets card -- with most difficult reserved perhaps for those who need lesson most.

Note: Some sample statements might include:

I didn't sleep at all last night.
When is the doctor coming?
I would like to get off the bed and walk.
I have a heartburn.
Isn't it time for my medicine?
Is my daughter coming today?
My pants are too tight.
Someone stole my nice blue blouse that I always liked.
I want my pill now!
My shoulder hurts when you do that.
I have to go to the bathroom again.

GETTING IT ALL TOGETHER

Notes for the Inservice Educator: GETTING IT ALL TOGETHER

Now that you've seen the parts of GIAT, you know the whole of it -- a new approach to communication and to interpersonal relationships in nursing home inservice education, a promising approach to improved patient care.

"What is communication? A working definition might be: a process that involves the sending and receiving not only of information, but of attitudes and feelings too." Again the quotation is from the United Hospital Fund of New York's study on communication in hospitals. And it goes on to add that "to communicate effectively... helps the hospital (read nursing home as well) to reach its objective of the best possible patient care...

"Many methods are used in communicating...the spoken word...the written word... And we communicate also by nonverbal means:...by gestures (raised eyebrows, a chuckle, a hostile expression, body posture). Finally, very effectively and commonly, by silence...with 'more than words'. Instead, we use all parts of ourselves. And if we are skillful and sensitive to others, we can receive from others a wealth of information:

* From the words they use or don't use.
* From the way they use words (tone).
* From the expressions of their faces and bodies, and so on..."

As to the importance of this activity, the survey declares that "...communication should not be regarded as a tool or 'helping' aspect of the organization, but as the essence of organized activity and the basic process out of which all other functions derive."

As a process, communication requires four elements: a message, a sender, a method and a receiver. When you communicate face-to-face with another human being, you can send -- by speaking or touching or the way your body posture and your gestures speak. You can receive -- by seeing and by listening, and by evaluating and understanding what it is you are seeing and hearing. And you can, as in most one-to-one communications, do both sending and receiving, alternately (talking and listening) or simultaneously (seeing and touching).

In its individual sessions as well as in its totality, GIAT has demonstrated that it is possible for people not trained as communicators to improve their communications skills, and therefore to communicate better, particularly with patients.

But GIAT's sessions weren't really directed toward skill-improvement, as much as they were an attempt to get people to look at their feelings, attitudes, emotions. Particularly their attitudes toward their work in the home, their feelings about their patients.

It cannot be emphasized too strongly: the underlying philosophy in GIAT is that caring for people can be improved if you care about them.

The best natural (i.e., untrained) communicators usually have one quality in common---they like people. But not everyone who likes people is a good communicator -- it helps to understand the process, to know its values, to give it its proper importance in the total plan for patient care.

What were GIAT's objectives? The first has just been stated: to make people aware that improving communication will help improve patient care. Another was to show that people -- patients -- communicate at all times; that some of the languages people use to communicate are not thought of as languages at all -- that there is not just word-language but gesture-language and expression-language and body-language and even the languages of symptoms and of the aphasic's silence.

Whatever happens during GIAT's sessions -- whatever lessons appear to have been learned -- GIAT (like all inservice education) will be judged and measured in another arena. It is what takes place outside the classroom that is the true index of GIAT's worth -- at the bedside, in the corridors, in the dining-room, throughout the home.

At an impact evaluation session, an administrator asked an aide: "What did you get out of the GIAT sessions? What did you learn?" "Well," said the aide, "I did learn some new ways of saying and doing things. But if I had to mention just one thing, what I got out of this was that now I'm more aware of other people and what they're thinking and feeling."

Another aide, the mother of a little boy, chimed in: "Usually I don't listen to my son very much, because he doesn't speak too clearly. But the day after we had our session on Listen! I did listen to him for once -- and he was telling me a story about pigeons. Other times I don't even try to make out what he's saying, just give him a cookie and tell him to go play. This time -- I just can't tell you -- he was so pleased that I took the time to listen to him!

"And these classes have helped me to understand my patients more too. Some of them aren't as crazy as you think. But the only way you can find that out is to take time with them and listen."

The little boy was pleased that his mother "took the time" to listen; and the only way she could find out that her patients were not crazy was "to take time with them." There was no single session devoted to "taking time", but there was no session in which the phrase did not occur again and again.

Listening means paying attention to what you're hearing, for example. And that takes time. One of the commonest causes of communications breakdowns in the

home is when someone is "in too much of a hurry" to listen. If anyone felt that "The Rumor Game" was just a game, here's what one aide reported: She was instructed to take a patient's temperature, but as she went off to do so, she realized that the nurse had also said something else -- what it was she wasn't sure, because she'd already tuned the nurse out.

But the lesson on listening had stuck, so she took the time to go back to the nurse and ask again. Sure enough, what the nurse had been saying after the aide stopped listening was that the patient had hemorrhoids, so she was to be sure to use the oral, not the rectal, thermometer. The patient never even knew how grateful he should have been to "The Rumor Game" and a lesson on listening!

GIAT has something valuable to teach about listening. And about seeing, speaking, touching. Yet when participants were asked what they felt they had gotten from GIAT, they often referred not to specific topics or specific sessions, but to GIAT's total impact.

"The sessions have given me insight into the problems of the patients," one aide said, "I am now aware of my feelings and how I treat them." "I have one very demanding patient," another said. "I understand her better now that we have had these sessions. It's because of her sickness and how she feels about herself."

"Are you more aware now of patients?" a third aide was asked. "Sure," she answered, "you learn more about patients when you sit and rap. Then you see that somebody else cares about the patient and it makes you feel good. And you learn from other people who take care of them."

Question: "How do you feel about these rap sessions?" Answer: "It gives me a better understanding of the patients' behavior." "Made me more observant." "I now have more patience." "I understand better now -- I put myself into the patients' shoes."

Yet it would be foolish to attribute the power to produce "overnight miracles" to GIAT, or even over-six-sessions miracles. Attitudes and emotions do not change that quickly. But with GIAT's help they can begin to change -- as one aide's heartfelt comment indicates: "After some of these sessions, I used to go into Miss Jackie's room and tell myself: Miss Jackie isn't going to get me aggravated today. I'm not going to let it happen.

"But it happens," she sighed. "Not as fast though. Then I have to walk out of the room."

And the cry of still another aide, with the ring of truth: "You know, I try hard to change, especially after these classes. I really try hard, honest to God I try. But when you have been this way for a long time, it's hard to change. These sessions have helped me to understand better how to be, but it's still hard to change!"

All of these were the comments and opinions of participants. Some time after the GIAT sessions had been concluded at one home, therefore, the home's administrator was asked for his comments. "There is no question," he said flatly, "that GIAT made people in the home more aware of patient's problems and feelings."

As a matter of fact, he added, he had been so impressed by the changing attitudes and feelings of his staff that he had added a psychiatrist, in part to continue the process. Later a psychologist was brought in. But when he began to approach the subject via the lecture method, the group resisted.

"They said flatly that they preferred rap-sessions," the administrator reported. "They said they liked the GIAT way better."

And if the staff liked the GIAT way, so did the administrator. Without really paying attention to it, I've noticed something interesting that's been happening here. Now when people come in for work in the morning, I notice them saying good morning to the patients. And I see them doing something else -- coming over to the patients and touching them on the arm, or the shoulder. And smiling. And taking an extra second with them.

"Maybe it isn't on account of the sessions. But the fact is I never saw those things happening before."

Notes for Impact Evaluation: GETTING IT ALL TOGETHER

The following discussion guide was developed for use with groups of ten to fifteen participants, in order to assess the effect of the GIAT inservice education experience on nursing home programs. It was felt by the Nursing Home Trainer Program that GIAT - Getting It All Together -- required some such evaluation-in-depth because it represented an innovative departure from the more standard methods of inservice education usually undertaken in nursing homes.*

The objective of the session was to obtain feedback from groups exposed to GIAT, to see whether there had been any changes in their knowledge, understanding and behavior, in their relations/interactions with patients and with each other. In effect, answers were being sought on two levels: a) had GIAT improved the ability of staff members to communicate, particularly with patients? and b) had such improved communications improved patient care?

To some degree, the method and form of the impact evaluation was dictated by necessity. Time limitations, for the inservice educators and other personnel, precluded individual interviews-in-depth with each participant. Questionnaires were considered, but rejected because some of the participants were known to have a limited ability to read and write.

On the positive side, the method of small group discussion recommended itself because the format was nearly identical with the earlier sessions in the GIAT series. The GIAT process was intended to encourage maximum group participation and involvement in the discussion -- what many of the participants referred to as "rap-sessions".

This impact evaluation session is opened by the inservice educator, or by the administrator of the nursing home, with the comment that, as the participants know, GIAT -- Getting It All Together -- was the name given to a new kind of inservice education program in nursing homes. It had been developed as part of a demonstration project of the Nursing Home Trainer Program of the United Hospital Fund of New York, which is anxious to get your opinion on several things:

+ Do you feel that you personally are dealing differently -- better -- with patients as a result of the GIAT sessions? Do you understand them better, communicate better with them?

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* The impact evaluation session was tested during the Fall of 1972 with groups in three nursing homes which had completed the full series of GIAT sessions.

+ Do you think there have been any changes in the home's program because of the GIAT sessions? Have you noticed any of your fellow-participants doing anything differently than they used to? Have any of the patients commented to you?

+ Some of you have participated in other inservice education programs. What do you think of GIAT as a method of education, compared to the other types you've had?

In his/her preliminary remarks, it might also be worthwhile for the discussion leader -- depending perhaps on how long it has been since the last GIAT session -- to summarize very quickly the titles and content of the sessions. He/she might lead into the general discussion, draw the participants out, by asking some detailed questions about listening (the first session) -- has their way of listening changed, has the new way helped them to get along better with patients/with other staff people, do they feel they're doing their jobs better now, and so on.

As with the GIAT sessions themselves, the discussion leader should allow the discussion a certain amount of latitude, of "drift". Not merely to keep it moving, but because spontaneous comments are often the most interesting and instructive. He/she should also solicit examples, anecdotes, illustrations; he/she is likely to find these more fruitful than adjectives and analyses. It's another case where showing is better than telling.

A final suggestion: this is a particularly valuable occasion to have the cassette/tape recorder in operation, as in earlier sessions. The comments of the participants may be very much worth analyzing in terms of the home's program and objectives. They may give valuable clues to the "problem areas" which should be covered in future inservice education programs.

APPENDICES

NURSING HOME TRAINER PROGRAM
United Hospital Fund of New York

December, 1972

The following list of source materials was compiled for inservice educators who are interested in improving human relationships and communication in nursing homes and other long-term care facilities.

The selections reflect a wide range of old and new information for inservice educators who are planning and conducting sessions on this subject. This list is by no means complete, because the subject area is one which permeates every aspect of the teaching-learning process.

HUMAN RELATIONSHIPS/COMMUNICATION

Selected References

1. Books, Parts of Books, and Pamphlets

    1. Adult Education Association of the U.S.A. "Leadership Pamphlets". Washington, D.C., The Association, 1955.

        A series of 18 pamphlets designed to help leaders in any group situation work with insight and skill. Following is a list of titles:

        - How to Lead Discussions
        - Planning Better Programs
        - Taking Action in the Community
        - Understanding How Groups Work
        - How to Teach Adults
        - How to Use Role Playing
        - Supervision and Consultation
        - Training Group Leaders
        - Conducting Workshops and Insiitutes

Human, Relationships - Books, Parts of Books, and Pamphlets (cont.)

1. Adult Education Association. op. cit.

   - Working with Volunteers
   - Conferences That Work
   - Getting and Keeping Members
   - Effective Public Relations
   - Better Boards and Committees
   - Streamlining Parliamentary Procedures
   - Training in Human Relations

   These pamphlets are available at minimal prices from The Association, 1225 Nineteenth Street, N.W., Washington, D.C.20036.

2. Berne, E. Games People Play: The Psychology of Human Relationships. New York, Grove Press, Inc., 1964. 192 p.

   This book reduces psychological jargon to colloquial language. It presents a series of situational "samples" in which transactional analysis technique is used to develop self-awareness and ability to interact more constructively with significant others, in one-to-one and small group encounters.

   Transactional analysis technique is based on the concept of three "ego-states" which persist throughout a person's life, and which may fluctuate in terms of dominance as determinants of behavior:

   - child ego-state
   - adult ego-state
   - parental ego-state

   The dominance of a given ego-state at any point in time depends on the individual's priority need for satisfaction of any of three "hungers":

   - stimulus hunger
   - recognition hunger
   - structure hunger

Books, Parts of Books, and Pamphlets (cont.)

3. Bernstein, L. and R. H. Dana. Interviewing and the Health Professions. New York, Appleton-Century-Crofts, 1970. 170 p.

   Provides a simple, teachable framework for therapeutic use of self via verbal and nonverbal communication with other members of the health team, as well as with patients.

   Applies information from research in behavioral sciences. The authors use "real, live" people to illustrate their messages -- the reader becomes actively involved with the feelings of these "people" very early in the text.

4. Cohen, L. K. Communication Problems after a Stroke. Minneapolis, Kenny Rehabilitation Institute, Publication No. 709. 1971. 23 p.

   An explanation of language problems after a stroke and suggestions for helping the patient to cope with them.

5. Fabrin, D. Communications: The Transfer of Meaning. Beverly Hills, The Glencoe Press, 1968. 48 p.

   One of many slim volumes that are packed with information an inservice educator can use to promote better communication for better patient care.

6. Fitts, W. H. Interpersonal Competence: The Wheel Model Research Monograph No. 2. Nashville, The Dede Wallace Center, 1970. 99 p.

   Top notch. Readable, down-to-earth, well illustrated with examples of interpersonal interactions. Includes a short, carefully selected reference list.

   For information as to how to obtain this document, write to The Center, 2410 White Avenue, Nashville, Tenn. 37204.

7. Group for the Advancement of Psychiatry. Toward Therapeutic Care: A Guide for Those Who Work with the Mentally Ill. New York, Springer Publishing Company, 1970. 125 p.

   Lay persons involved with mental health activities as well as professionals will find this book most helpful. Many clinical examples of problem areas in patient care are presented, along with methods of resolving them.

8. Hall, E. T. The Silent Language. New York, Fawcett World Library, A Fawcett Premier Book, December, 1966. 192 p.

   A paperback edition of a book which was originally published by Doubleday

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Books, Parts of Books, and Pamphlets (cont.)

8. Hall, E. T. op. cit.

and Company in 1959. The author, an anthropologist, believes that beyond learning to read and speak the "language" of other people, an understanding of their culture (and one's own) is essential to effective communication. The book contains information -- and implications -- for administrators and supervisory personnel concerned with developing inservice education as a factor in improving patient care in the nursing home.

9. Hays, J. S. and K. H. Larson. Interacting with Patients. New York, The Macmillan Company, 1970. p. 21-23, 36-37.

These pages provide two lists of verbal interpersonal techniques. The list contains samples of therapeutic and nontherapeutic responses, with examples of types of statements personnel are most likely to use in responding to patients.

10. In Milieu Therapy: Training Series, Publications, Film and Film Strips, Residential Institutes, Workshops. Ann Arbor, Institute of Gerontology, The University of Michigan- Wayne State University, 1971. 8 p.

This catalog describes a comprehensive range of publications, A-V aids and staff training programs available through the Institute. The therapeutic milieu model -- and the concepts and techniques associated with it -- are applicable to rehabilitation of disturbed persons of all ages; including aged persons served in multi-purpose and day care centers, nursing homes, other long-term care facilities.

The cost of materials listed in this catalog are low to moderate. An inservice educator planning a series of sessions on human relations and communications will find an abundance of useful source materials in this collection.

11. Johnston, M. K. "Nursing the Geriatric Patient Who Is Mentally Ill." Mental Health & Mental Illness. Philadelphia, J. B. Lippincott Co., 1971. p. 237-247.

Describes the physical changes and emotional problems associated with aging. Under psychological needs emphasis is placed on the need to convince the elderly psychotic patient that somebody cares about him. Two ways of establishing communication with a patient are to: a) gain his confidence by respectful acceptance of him despite his regressed functioning and b) help him to feel that he is a worthwhile person.

12. Keyes, K. S. Jr. How to Develop your Thinking Ability: A Guide to Sound Decision. New York, McGraw-Hill Paperbacks, McGraw-Hill Book Company, Inc., 1963. 246 p.

    General semantics in readable prose, illustrated by a talented cartoonist and written by a reasonable man. Indicates how the words we use not only reflect our ideas, but also determine our attitudes toward ourselves and toward other people.

13. Lee, I. J. and J. L. Lee. Handling Barriers in Communication: Lecture-Discussions and Conferee's Handbook. San Francisco, International Society for General Semantics, 1968. 149 p. and 60 p.

    The course outlined in the first portion of this handbook was originally designed for supervisors in business and industry. However, the content is basic -- and applicable to teaching human relations and communication in virtually any adult education program. As the authors say, "It is hoped that wherever this material finds profitable application it will be used and adapted by creative leaders to meet their own needs and purposes."

    A separate 60-page Conferees Handbook is also available from the Society. It gives direction to students in such manner as to dynamically involve them in each of the sessions in the course. Both volumes are inexpensive paperbacks. Both are highly recommended by teachers and students who have used them.

14. Likert, R. New Patterns of Management. New York, McGraw-Hill Book Company, Inc., 1961. 279 p.

    Presents theory derived from research done at the Institute for Social Research Center for Group Dynamics. Focus is on business management; however the information is applicable to management in health service settings:

    - . leadership
    - . group process/influence
    - . communication
    - . measurement/function and effect
    - . interaction-influence system

    Contains an excellent bibliography and an adequate subject index.

Books, Parts of Books, and Pamphlets (cont.)

15. Looking into Leadership Series: The Executive Library. Washington, D.C. Leadership Resources, Inc., 1972.

A collection of monographs by different specialists. The titles are:

- Styles of Leadership
- Authority and Responsibility
- Individual Motivation
- Improving Performance Through Job Design
- Decision Making
- Group Effectiveness
- The Consultative Process
- Planning for Change
- The Use of Time
- Personal Communication
- The Art of Listening
- The Learning Climate
- Appraisal of Personnel
- Self-Development

16. Ruesch, J. and K. Weldon. Nonverbal Communication: Notes on the Visual Perception of Human Relations. Berkeley, University of California Press, 1959. 205 p.

The authors use the word .. "Communication" to include not only written and oral speech but also body language, music, the pictorial arts, the theatre, the ballet, all human behavior. Disturbance of mind, speech, perception are also dealt with.

This book might be useful to inservice educators in setting up a variety of role playing and other interactions to teach personnel how their facial and body language affects the messages they send to others.

Books, Parts of Books, and Pamphlets (cont.)

17. This, L. "Communicating within the Organization." Leadership Resources Inc. Management Series, Washington, D.C., n.d. 28 p.

The four most frequently found communication systems are:

. the formal communication system

. the work relationships communication system

. the informal communications system

. the external communication systems.

18. United Hospital Fund of New York. Improving Employee-Management Communication in Hospitals: A Special Study in Management Practices and Problems. New York, The Fund, Training, Research and Special Studies Division, 1965. 62 p.

Emphasizes the importance of good upward, downward and two-way communication. A practical guideline for health facility administrators. Suggests specific means of improving communications between management and employees.

II. Articles and Other Sources of Information

19. Batten, J. D. and J. V. McMahon. "Communications Which Communicate." Personnel Journal, July-August, 1966. 4 p. Reprint

Gives tips on effective communication as bases for checking to see if what "they" heard was what you meant "them" to hear and understand.

20. "Communication." Kaiser Aluminum News, 23:1-39, 1965.

Don't be put off by the date of this item. It is a gem and as good today as it was when it first came out. The content is magnificently illustrated by Saul Steinberg and others. The content represents just about everything we now know from findings of research on human communication (but, presented "painlessly").

In addition to using this as source material for planning a series of sessions on communication and human relationships; you might want to consider making it available to your students. It's so inexpensive -- single copies are free. On an order for quantities up to 100 copies (of any issue of the News) the price is $.50 per copy.

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20. "Communication." op. cit.

    Direct your purchase orders or letters of request to: Editor, Kaiser News, Kaiser Center 765, Kaiser Building, 300 Lakeside Drive, Oakland, California 94604. A bibliography of the sources used in preparing this booklet is also available on request.

21. "Communicating under Stress." Geriatric Care, 4:1, April, 1972.

    The person who is seriously ill often can't talk at all or he may speak softly and be hard to understand. A patient who is not so seriously ill may speak in a very different manner under stress. Gives clues as to how to respond to these patients and to master some therapeutic ways of communicating in return.

22. Hartbauer, R. E. "Hearing Aids and the Aging." Geriatric Care, 4:3, May, 1972.

    In addition to giving specific information on how to help patients accept and adjust to using a hearing aid; this author gives five directives for verbal communication which are applicable to virtually every conversation one might engage in with any older person.

23. "Listen - What Do You Hear?" High Holy Day Message, New York, The Jewish Theological Seminary of America, Friday, September 8, 1972. 1 p.

    This message contains information from the behavioral sciences -- and from theology -- presented in a poetic, exhortative form. It might be used to stimulate an exchange of ideas and feelings in a group of personnel responsible for care of persons of all ages, including residents of nursing homes.

    The message was published in The New York Times, Friday, September 8, 1972. Reprints may be obtained at nominal costs for reproduction and mailing -- from The Committee for The Greater Seminary, Jewish Theological Seminary of America, 3080 Broadway, New York, N.Y. 10027.

24. Shore, H. "The Current Social Revolution and its Impact on Jewish Nursing Homes." The Gerontologist, 12:178-180, Part I, Summer, 1972.

    Discusses the impact of social revolution on patient care in nursing homes, homes for the aged and hospitals. Indicates some ways in which inservice education can help to improve interracial relationships between members of staff, as a step toward improving patient care. Mentions reality orientation technique as a method of helping every employee to feel that he is an

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Articles and Other Sources (cont.)

24. Shore, H. op. cit.

essential part of the team.

The feelings of minority groups giving care to patients in nursing homes are described in down-to-earth prose. This article could be useful in helping personnel to ventilate feelings -- and then discussing how to keep negative feelings from hurting others, including patients and their families.

III. Some Films on the Subject of Communication

25. BNA Films. Leaders Guide to Accompany...The Berlo Effective Communication Film Series. Rockville, Md., The Cinoconference Center, 1965. 29 p.

Provides the leader with lesson plans for each of the films. Includes how to:

. prepare for the session

. introduce the film

. discuss the film

26. Changing Attitudes Through Communication. New York, The American Journal of Nursing Company. n.d. 16 mm. Color. 24 min.

Deals with some insights into human behavior, as bases for helping people to change attitudes which interfere with ability to care for, with, and about others.

27. Inner World of Aphasia. New York. American Heart Association, 1968. 16 mm. Color. 24 min.

Dynamic film portrayal of the frustrations, anguish, and torment of the patient with a speech deficit. Emphasizes the importance of understanding patient's needs.

28. Instructions or Obstructions. New York, American Journal of Nursing Company, n.d. 16 mm. B&W. 15 min.

Offers some helpful suggestions for giving instructions.

Some Films on the Subject (cont.)

29. Listen Please. Washington, D. C., Modern Management Films, BNA, Inc., 16 mm. Color. 10 min.

    Could be used with supervisory personnel. Good leadership needed to present it on all levels. Emphasizes importance of listening to what people are trying to tell you.

30. More Than Words. New York, ANA-NLN Film Service. 1959. 16 mm. Sound. Color. 14 min.

    This is an animated film about verbal and non-verbal communication. It is highly recommended as an effective medium for helping a group to learn how communication affects interpersonal relationships.

    "Return shipping charge" is the only cost to borrowers in N.Y. State. Available from The Film Library, State Department of Health, 84 Holland Avenue, Albany, N.Y.12208.

31. Mrs. Reynolds Needs a Nurse. Philadelphia, Smith, Kline and French Laboratories. 1963. 16 mm. Sound. B&W. 38 min.

    The heroine of this film is an older patient who is unable to express her fears and anxieties. Shows how hospital staff learn how to understand her, and to give her the care she needs.

    "Return shipping charge" is the only cost to a borrower in N.Y.State. Available from The Film Library, State Department of Health, 84 Holland Avenue, Albany, N.Y.12208.

32. New York State Department of Health. Health Film Catalog, 1972. Albany, New York, p. 195-199.

    This section of the catalog lists and describes a number of films which appear to be useful for inservice sessions on human relationships and communications: The ones that are probably most pertinent are:

    . Effective Listening (for all personnel)

    . How to Conduct a Discussion (for teachers)

    . Instructions or Obstructions (for teachers and supervisors)

    . Manager Wanted (for administrative and supervisory staff)

Some Films on the Subject (cont.)

32. Health Film Catalog, 1972. op. cit.

. More than Words (for all personnel)

. Person to Person Communication (for all personnel)

. That's Not My Job (for all personnel)

. Tips for Teachers (for teachers)

. Visual Aids (for teachers)

The catalog can be obtained by writing to the Film Library, State Department of Health, 84 Holland Avenue, Albany, N.Y.12208.

The first section of the Catalog includes tips on using films effectively, using equipment wisely, and how to order and return films listed in the catalog.

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PLEASE DO NOT PUT YOUR NAME ON THIS FORM

Aide _____
Orderly _____
L.P.H./R.N. _____
Supervisor _____
Administration _____
Other _____
(Specify) _____

"GETTING IT ALL TOGETHER"
Reaction Form

Nursing Home Trainer Program (NHTP) Demonstration Project
United Hospital Fund of New York

AS USUAL, WE NEED YOUR HELP.

PLEASE TELL US HOW YOU FEEL ABOUT TODAY'S INSERVICE PROGRAM.

WE TRIED TO DO SOMETHING:

Tell us how we did it by putting a circle around the answer that best describes your feelings. (Use the code listed below.)

YES (means very much)
yes (means good)
? (means no opinion)
no (means fair)
NO (means not at all)

1. How interesting was today's session to you?

   YES yes ? no NO

2. Did today's session fit in with your ideas about giving good patient care?

   YES yes ? no NO

3. Did the session help you to understand more about why your patients act the way they do?

   YES yes ? no NO

4. Did the session give you any ideas about ways you can act with patients?

   YES yes ? no NO

5. Please list the things we talked about today that YOU would like to know more about:

1. CHECK ONE OR MORE STATEMENTS THAT TELL HOW YOU FEEL ABOUT THIS KIND OF AN INSERVICE SESSION.

_____It was a complete waste of time.

_____I didn't learn a thing.

_____I am not taking any new ideas away.

_____I was somewhat disappointed.

_____It was neither very good nor very bad.

_____I think it will help me in my job.

_____It helped me personally.

_____I hope we can have this kind of inservice often.

_____It was one of the most interesting inservice programs I have ever been to.

2. What did you like best about this session?

Why?

3. What would you do to improve this type of session?