TRAINING VOLUNTEERS FOR PASTORAL CARE SERVICE IN A HOSPITAL SETTING

By

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Psalm 119: 11

Dedication

I dedicate this demonstration project to all my Teachers. The first one was my mother Edith Ophelia Maynard-Reid. She inspired me to explore the world of knowledge by teaching us – her sons to love reading. It was through the influence of all my teachers I was able to succeed. Your perseverance and persistence, your insights and intuition, your grace and generosity, your examples and encouragement, your support and sagacity, these attributes and more have helped to mold and fashion me. It is through the foundation you laid and the unfailing constant motivation and support you have given that I am able to earn the title Doctor of Ministry. I have been taught by my wife Earline and my children Andrew, Fahimee, Rodney, Christine and others. I have been instructed and inspired by devoted friends and family members. Sometimes my toughest teachers were the supportive and not so supportive parishioners and co-workers. I am proud to dedicate this work in their honor and with love. I am truly a part of all of you.

ACKNOWLEDGMENT

I am indebted to all those to whom this demonstration project is dedicated but there are some persons who made this doctoral work possible. Without them it would still be a dream.

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My teachers and advisors, Ms. Lynne Jones and Dr. Carol Ochs have given me the benefit of their expertise. They instructed, guided and motivated me. They were indispensable to the process and me. They were patient, sensitive and supportive and for these and more I express my heartfelt gratitude.

My Staff and the Volunteers without you this particular project would not have been realized. Accept my heartfelt appreciation. You were the instruments of testing a tool, which I hope will be useful in pastoral care education.

I am deeply indebt to everyone for the support and encouragement you gave in making this project a reality and as a result my doctorate possible.

ABSTRACT

This is a demonstration project focused on the training of volunteers to serve as Pastoral Care Givers. Volunteers who are from various religious traditions are brought together for training in order that all will be able to effectively serve the patients in the hospital irrespective of the religious tradition of the patient or the volunteer.

The concerns were that they have been serving as denominational and religious volunteers without adequate pastoral or spiritual care giving training. Each came to serve with a motivation driven by their religious tradition. The Roman Catholics were primarily concerned with Roman Catholic patients. They wanted to fulfill the obligations of taking them to Mass, ensuring that those who were unable to attend the service had the sacraments if they so desired. The Baptist, Pentecostal, Jehovah Witness and Muslim sought to minister to the religious needs of patients within their respective traditions.

In some instances the Roman Catholics would visit with and minister to Anglican and Episcopalian patients and Protestants would cross denominational traditions and visit—giving Bibles, offering prayers and sharing of common Traditions. There was a general discomfort among the volunteers with serving others outside their own tradition. This was more difficult for some since a policy is in place

prohibiting proselytizing. To be present with a patient was a new concept to the volunteers.

The focus on religious service and denominationalism prevented the volunteers from effectively serving all the patients. They were unable to network in a mutually supportive manner and focus on the patients needs. Instead of being a source of spiritual support for all, they were providing religious support for those of like mind. The volunteers were disconnected from each other by religious beliefs and practices and the disconnect, was the same with patients.

In order to address this problem, I developed a model training program which consists of —a retreat and seminars. The retreat was to create a climate in which all were together and functioned in a mutually supportive manner. It was a time to identify the feelings we share – especially in times of sickness, pain and distress. The personal beliefs and religious traditions did not interfere with nor regulate the activities engaged in or the experienced shared.

The Retreat took place over a twelve-hour period. It proved to be very effective. All of the participants were able to communicate with each other. Each listened to the other, and sharing his or her experiences and feelings in an empathetic manner. The sharing of life experiences helped us to connect with each other and no one was isolated or disconnected.

There were four seminars, which were held once every other month for two hours. A meal was served and all shared in this fellowship. This was followed by two psycho dramatic presentation and group discussions about the cases and any relevant interpersonal psychodynamics. The session ended with a brief didactic and summary of the things learned during the session.

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STATEMENT OF THE PROBLEM ADDRESSED BY DEMONSTRATION PROJECT

Presenting Problem

Woodhull provides inpatient medical, surgical and behavioral health services, emergency care in three separate areas (adult, pediatric and psychiatric) as well as a wide range of primary and specialty services at over 50 ambulatory care clinics. The Annual statistics for 2002 include: over 492,704 clinic visits, 178,075 which are primary care visits, 79,035 emergency room visits, 18,599 discharge, and 21,650 general dental visits. 171 or 42% of beds are allocated for mental health services including alcohol and drug detoxification. Behavioral health—a major service on the outpatient side as well with 18% of outpatient visits at Woodhull (49,921 of 271,284) and 32% at Cumberland D&TC (46,312 of 142,385).[1] Woodhull operates three—free standing residency programs in Internal Medicine, Pediatrics and General Practice Dentistry and Oral and Maxillofacial surgery.

The Department of Pastoral Care Department at Woodhull Medical & Mental Health Center is a part of the interdisciplinary team serving the inpatients,

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[1] Woodhull Medical & Mental Health Center and Cumberland Diagnostic & Treatment centers Annual Statistic Report.

outpatients and all other hospital staff. There are 420 patient beds. The institution provides the following services. Palliative Care: Chemical Dependency: Detoxification: Drug Rehabilitation: AIDS: Medical: Mental Health: Emergency: Pediatrics: Labor & Delivery: Asthma: Intensive Care: Ventilation patients: Social Services - Medicare: Baby Safe Haven (for abandoned children): Interruption of Pregnancy and Financial Counseling.

The Pastoral Care staff consists of one Roman Catholic Priest, one Roman Catholic Nun, one Jewish Chaplain, one Muslim Chaplain and two Protestant Chaplains. The Roman Catholic Nun; has one unit of CPE and is a Certified Catholic Chaplain. The two Protestant Chaplains, each have 4 and 5 units (Basic and a Year of Hospital Residency) and the Masters of Divinity degree. The director is a Board Certified Chaplain by the Association of Professional Chaplains. The Muslim Chaplain has his Masters Degree and has completed his Residency in CPE. The Jewish Chaplain has her Bachelors degree and 5 units of CPE. She is from the Reform tradition. The department has five full time chaplains and one part time.

There are 36 volunteers in the Pastoral Care Department and they have no clinical training. The volunteers are Roman Catholics, Jehovah Witnesses, Protestants and Muslims. Staff members offer limited volunteer service and play a significant role when Hindu, Buddhist, Sheik or Orthodox patients need special

spiritual care. All volunteers are committed to serving the patients and do so with enthusiasm. The hours of patient contact by the volunteers is significant. When adequately trained they would provide significant pastoral support to the chaplains, patients and the institution.

The patients in the hospital are from different religious backgrounds and traditions. Some are affiliated with religious communities, others are not and some are irreligious. The patient population at Woodhull Hospital is a microcosm of New York City, the many and varied spiritualities are to be respected and allowed to exist as long as there is no conflict with the hospital policies,[2] and the practice of such spirituality is not a threat to the patient's health. The Pastoral Staff are all clinically trained caregivers and reflect the following religious traditions - Islam, Judaism, Pentecostals, Roman Catholics, and Seventh-day Adventists.

Each staff chaplain serves as the chaplain for assigned units. The spiritual needs of the patient on each unit are served by the assigned chaplain. If and when a patient desires to see a chaplain and another staff member is of the patient's religious tradition then a referral is made. Roman Catholics who desire the rites of the church are referred to the priest or nun. Muslim patients are referred to the

[2] Woodhull Hospital Pastoral Care Policy. "Spiritual Care For Our Patients" Section: 2-V: SP/PR 2

Muslim chaplain. Visiting Clergy[3] who are invited by the department to visit with the patient if their minister is not available also assist in meeting patient's needs. With a larger contingent of volunteers, more religious traditions may be reflected and more patients can be served. In keeping with our policy and the Joint Commission Standards the goal of pastoral care is to provide spiritual support rather than religious. It is this broader perspective which the Volunteer Training program is intended to demonstrate.

The invaluable service provided by trained volunteers must not be underestimated. Whereas the ratio of patients to chaplains will always be high, the ratio of patients to volunteers will be lower. There can be a significant pool of volunteers whose help the hospital would always welcome.

The listening presence and the compassionate companioning are all functions the trained volunteers can provide. With time and experience some will also be able to function as challenger, comforter, guide, sustainer and reconciler. Areas beyond the volunteer's expertise or beyond their comfort zone can always be referred to the supervising chaplain. Volunteers on duty will always be under the supervision of a chaplain and are assured of prompt response from the chaplain should they be needed.

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[3] Woodhull Hospital Pastoral Care Policy "Visiting Clergy" Section 2-V: SP/PR-4

Volunteers have played significant roles and will continue to do so. A woman was shot in a random shooting [4] and rushed to the hospital. The Director was paged; he called one of the volunteers who arrived at the hospital within a few minutes. She was the family's spiritual support until the Chaplain arrived. The following day a pastoral visit was made to the home[5] and the volunteer continues to keep in touch with the family who is also a member of the community.

Patients who are ill are not primarily concerned about philosophical discussions; they tend to be more practical in their concerns. The trained volunteer will often be in a position to meet the cry of another heart. Their moving from factual concerns to the underlying feelings of the patient eclipses their intellectual and religious concerns.

The Pre-retreat and Training Questioneer in Appendix A. revealed that the perceived needs of the patients by the volunteers are more religious than spiritual. The Consequence of their perceptions leads them to approach the patients with an evangelist fervor and enthusiasm. They thus bring their agenda to the patient and the patient's needs are often not heard nor focused upon.

When I took up the position as departmental director, the volunteers came and functioned as religious representatives. The Catholics reported to the Nun or the

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[4] Daily News Sunday, December 29, 2002 page 2

[5] New York Times Monday, December 30, 2002 Section B3

Priest, the Protestants reported to the Protestant Chaplains and then each went and visited with patients within their traditions. This had the effect of leaving a large segment of the patients in the hospital without the service of the volunteers. The consequence of such disparity was not known to the patients unless they were in the hospital for a long period of time and were ambulatory enough to observe the volunteers in action on their units. They may observe that the volunteer regularly visited some, while others were not visited.[6]

The Patients

A significant number of the patients in this hospital are disconnected from church, mosque or synagogue but desire a pastoral presence while in the hospital. In some instances the disconnectedness is also, disconnectedness with their own family. These feelings of disconnectedness bring with them feelings of alienation, anxiety and loneliness. The availability of a volunteer or chaplain who can be trusted to share emotionally has been a source of healing to many. Many also experience isolation and economic hardship. Others do not have the extended family support and are often under economic, cultural and social siege. They lack support and also often feel abandoned. It is in situations like these the volunteer is needed and welcome as a pastoral presence. In a succinct manner Fontaine Belford writes –

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[6] Woodhull Hospital Policy – Pastoral Care Policy "Assessment of Patient" Revised 3-2002 p. 2. The criteria for visiting and assessment patients is high

"We find our families, those with whom we can be as God called us to be, with each other and alone. We step out with them, people of the desert, as we are all people of the desert, into silence. We find ourselves there, bearing the other within and the other without, the stranger without whom we cannot live, without whom we cannot be who we are called to be in this holy emptiness in this darkness which is sometimes filled with light, in the presence of God. And as we stay there, resting at peace in emptiness, and silence and darkness, we practice this presence and celebrate the other with whom we share, the other who makes us whole."[7]

There are other patients who are not under economic strain but have questions, which are spiritual in nature, and they often enjoy engaging the chaplain or volunteer. These patients can be very reflective and will rehearse the path their lives have taken. It is this rehearsal of life stories volunteers can so easily listen to and empathize with, once properly trained. The connectedness, which occurs as one tells and another listens to life stories, set in motion transference and counter transference dynamics. Volunteers are trained to recognize these and keep them in their consciousness.

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and medium risk should be see within 48 hours of admission. All other will be seen as time and opportunity dictate.

[7] Belford: 1996 p. 146

The Volunteers

I invited all the volunteers to a meeting and explained to them that they had a greater role to play as volunteers. They were willing to come and visit with the sick and these patients were most grateful for these visits. There was an area, which we needed to address. Instead of seeing themselves as catholic, protestant, Muslim or whatever religious tradition they identified with, I wanted them to see themselves as pastoral care volunteers. This would mean that instead of coming to do volunteer service for patients within one's own religious tradition; all volunteers would serve all the patients.

This idea seemed to ignite a spark. Some said that was impossible. Others said I do not know anything about the other religions. Some said that was really something new. After allowing the volunteers to react for a while I refocused the group and invited questions. The primary concern was how can a person outside of a patient's faith tradition minister to the patient? The level of anxiety was very high. I assured them that the focus of our work was in being with the patient and listening to them. Again the response was mixed. There were those who were concerned about the giving of the sacraments and other religious ritual and they were assured that all who desired such services would be so served. This brought a visible sigh of relief for some. Others wondered aloud how could a non-Christian bring pastoral care to a Christian? It seemed as if there were more and

more issues for the group to get more anxious about. There was no question about unexposed anxiety. It was laid out in the open.

The majority of volunteers in the Pastoral Care Department are members of the Christian traditions. A definite effort is made to recruit other volunteers from other non-Christian traditions. Corresponding with other faith-based organizations and inviting their leaders to encourage their members to volunteer some time each week in the hospital Pastoral Care Department is an ongoing process I am committed to continuing.

The volunteers do not have access to the patient's medical charts but are instructed about privacy, confidentiality and how to communicate with the patient, the chaplain and others.[8] The volunteers however become privy to privileged information in the process of their work. By just being in the hospital and visiting the units they can become aware of information, which is private and personal. Patients who develop a bond with a volunteer may share personal information and feelings as he or she wishes. This is why along with this program of volunteer training, the volunteers are required to attend HIPPA training, where they are instructed in how to deal with issues related to

[8] Woodhull Hospital Pastoral Care Policy "Privacy of Protected Health Information"

handling confidential information. Any information which can be used to identify a patient is considered private and protected information.

Relevance of Project to Ministry

As the Director of the Department of Pastoral Care it is my responsibility to ensure that all who desire are given adequate spiritual care and support. Our staff consists of two Roman Catholic Priests, one Roman Catholic nun, one Jewish Chaplain, one Muslim Chaplain, and two Protestant chaplains serving a 420 bed facility. The staff in the network totals 3,200 persons.

When Moses was called to lead the Israelites out of Egypt into Trans-Jordan, his father-in-law counseled him to get loyal helpers and assistants." Thou wilt surely wear away, both thou, and this people that is with thee: for this thing is too heavy for thee; thou art not able to perform it thyself alone."[9]

The New Testament indicates that the Early Church sought out men of good report to assist the Leaders in carrying out their work.[10] The volunteers will play a similar role of helping the chaplains in pastoral care giving. Clinically trained volunteers can make a greater contribution to the hospital than those who have no training.

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[9] Exodus 18:18

[10] Acts 6: 3 See the Theological principles in Chapter 2.

My focus is on pastoral care, yet the skills learned are valuable in almost all areas of volunteering and ordinary daily living. The presence of volunteers significantly increase the number of contacts made with the patients daily. This one to one contact with the patients plays a vital role in boosting patient's morale. There are many patients who do not fall into the category, which requires them to be seen by a chaplain. Those who do not fall within the required assessment guidelines[11] , will be seen by a chaplain if they make a request or if the chaplain has time to see other patients after he has seen those referred to him. An effort is made to ensure all that all who desire have access to spiritual care – they will be seen by a chaplain or volunteer before they are discharged.

At the beginning of this demonstration project each volunteer was given a sheet of paper with the following sentence – *"My roles and responsibilities as a volunteer in the Pastoral Care Department are."* Each person then listed what he or she perceived as the primary roles and responsibilities. Many expressed that they felt their great responsibility was to "save the souls of the sick before they die." There is a genuine concern about salvation and some even fear the consequence of failing to be an effective witness to the patient. An effective Christian witness is one who seeks to lead others to accept Jesus Christ as Lord and Savior. This is primarily a Protestant concept but it also appears in some Catholic communities.

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[11] New York City Health And Hospital Corporation , North Brooklyn Health Network - Policy and Procedure "Pastoral Care – Assessment of Patients" page 2.

Most of these volunteers are more focused on a religious outreach and their perception of a spiritual concern is almost non-existent.

It is essential for Pastoral Care givers to understand the difference between Religion and Spirituality in order for them to provide the quality care patients are entitled to receive in a setting that is sensitive to the cultural and spiritual diversity of its patients. Recognizing that some very deeply spiritual persons do not profess to be particularly religious came as a shock to some volunteers. These very spiritual individuals may not be members of any organized religious group but have a profound spirituality.

The etymology for "religion" has a Latin root. Religio or re-ligere. This means to re-link, to reconnect, and to bind up again. Thus religion seeks to re-connect us to ourselves, to others, with God and the universe. Here both religion and Spirituality have similar goals. There is also an element of serving out of fear and guilt. This does lead to some uneasiness for some individuals. There is also the division religion brings. The painful history of the past records the story of religious wars and persecutions. The imposing of religious beliefs upon those who held a different set of beliefs often had terrible consequences.

Religion can be described as an institutionalized pattern of beliefs, dogmas, sacred writings, traditions, rituals, practices and ethical beliefs, which are held as part of a structured community. Communities, which can be so defined, can be called

religious communities. Cultural anthropologists often speak of the world's religions. The most prominent are Christianity, Judaism, Islam, Hinduism and Buddhism. These religions all have within them subgroups often called denominations. Within Christianity there are three major subgroups: Catholics, Orthodox and Protestants. Each of these have subgroups. The Catholics have the Roman Catholics, Maronite; the Orthodox have the Eastern, Greek and Russian and Protestants have over 262 different denominations. Some of the more prominent ones are Adventist, Baptist, Church of Christ, Church of God, Lutherans, Methodists, etc. Within each of these there are further subgroups. Adventist has the Seventh-day Adventist, Seventh-day Church of God, Seventh-day Baptist, and Reformed Adventist. Judaism has its subgroup also. There are the Conservative, Orthodox and Reform groups. Here again each subgroup often have other subgroups. The same is true for the other World religions: Buddhism, Hinduism and Islam. Each has many different subgroups and beliefs.

The evolution of different sub-groups continues to grow, as new subgroups or denominations emerge. Each group has evolved its own beliefs, rituals, sacred scriptures and traditions. These are tapped into when answers to spiritual questions are sought and when members desire to find meaning to life and existence. Some of the questions often asked are: Who or what is God? Why am I here? What happens at death? Am I part of a cosmic design? What is the meaning of life?

Spirituality is much more comprehensive than religion. It is also more difficult to define. While religion is part of spirituality, spirituality encompasses more than any one religion. It is the spiritual dimension that gives meaning to life.

Many volunteers are very sincere and bring their judgment to bear down upon the sick, who sometimes feel judged. These volunteers must be taught that the focus has to be on the patient. The volunteer's values, concerns or drives should not be brought to bear upon the patient. It is the patients' concerns that must occupy the room.

This project will develop a program of training to help volunteers to be effective and efficient care givers in the Hospital setting while emphasizing that each patient's cultural and spiritual heritage must be appreciated and respected. The clientele served by the hospital is 95% Theistic but our staff and the training program will seek to reach out and serve all persons.

Process at the arriving at this Proposal

I have always enjoyed teaching and at the same time nothing is more exhilarating than "being" with someone, companioning an individual when they need your presence. Having taught at many levels and having pastored many congregations I have now moved into another area—Hospital Chaplaincy. As Director of Pastoral Care at Woodhull Hospital & Medical

Center I see the need to train volunteers to be Pastoral Care givers rather than being the ambassadors of their religious traditions.

When I accepted the position as Director of Pastoral Care I found out that there was no training for the volunteers as pastoral care givers. I announced that as expected some things may change. Prior to the announcement, it was clear that the non-anxious volunteers were few. The most anxious began triangulating. It was also noticeable that one staff member was also a bit anxious. This was communicated by the raising of the eyebrows. He is also the longest serving member in the department. Change is difficult for him and flexibility is not always easy. He served in the military as a chaplain. In that capacity he worked with a staff, which did everything, and all he had to do was perform religious rites and services. For years while serving as hospital chaplain, his role and functions differed very little from that which he carried out while in the military. This shift from a religious functioning to being a non-anxious presence did not come easy for him. With his influence, the process of triangulation evolves easily. He had volunteers who worked with him and any resistance from him would be observed by his team of volunteers and at worse, hinder my new direction of ministering to the patients

The secretary informed me that I am seen as a change agent, one who is changing the status quo. Some feel that the most important work of the spiritual provider

is to "do for the patient" – bring communion, read scripture, get them to request the priest to make confessions, take them to the chapel for mass and other services and get them to accept Jesus as their Savior and personal friend.

As I talk with the volunteers each week I acknowledge the good work they have been doing and express gratitude for their services. I also begin repeating the phrase of just "being with the patient" as something everyone can do regardless of race, creed, color or religion. The idea of "listening to the patient" was a new concept but as explained, it is something everyone can do. That helped to reduce anxiety.

Most of the volunteers who serve at Woodhull Medical and Mental Health Center are Christians from various denominations. Recently a couple Muslins have joined the team of volunteers. I have been developing a master list of all the churches, mosques, temples/shuls or places of worship, which are within twenty blocks in each direction of the hospital. Invitations will be given to each organization to send interested persons from their religious/secular or spiritual community to take the volunteer pastoral care training.

Since I discovered that the majority of volunteers often are sincere Christians who are only concerned that the sick accept Jesus or are in right standing in the church traditions, I saw that something was missing. It was the volunteer's agenda and not the patient's needs that were motivating these would be

caregivers. Listening to the patient is not their initial concern but I have found that it did not take very much to convince them to "let the patient fill the room", let the patient lead the way. I also envision that with the multi-cultural sensitivity being promoted by the department throughout the hospital and the network and the climate of openness and acceptance, which is now being fostered, this type of training would be valuable.

The support given me by the entire Administration and the encouragement to explore in any direction that could prove beneficial to the institution aided me in working on this proposal. The location of the hospital at the center of four diverse – ethnic and social communities – Williamsburg; Bedford Stuyvesant; Greenpoint, Bushwick; also prompted me to pursue a project by which all could connect. Although diverse all members of these communities share emotional feelings and needs which all can understand. A training, which goes beyond the religious and political divide and taps into the feelings and emotions, is needed. It is my hope that soon we will have many other volunteers from other traditions like – Buddhist, Hindus, Sikhs and other faith communities not yet involved.

Patients may feel more comfortable with community volunteers who share a common space and experience. There is also the potential for long-term relationships developing; such support is desperately needed –especially by those

who are struggling to overcome chemical dependency and drug addiction. These local resident – volunteers, can help the heightening of self-awareness and self-esteem among patients and serve as role models for them. The religious barriers, which often divide, may disappear as patients and volunteers connect and relate to one another. The skills for such experiences will be developed through role-playing during training, seminars, the retreat and workshops.

Chapter 2

THEOLOGICAL AND CLINICAL PRINCIPLES

Theological Principles

Volunteerism is rooted in the basic principles of other's centeredness. It begins with the golden rule, which is a condensation - in one principle, the entire list of ordinances. From it emerge such themes as love, friendship, individual responsibility, loving kindness, good deeds and community. All these go above and beyond rituals. It is noteworthy that volunteers coming from different backgrounds and religious traditions and those which have sacred scriptures can and do share a surprisingly similar theology of service and inter-dependence.

The familiar words of John Donne, "No man is an island." [12] expresses the theological fact that the primary unit of human existence is the group and not the individual. Rabbi Hillel said " Keep not aloof from the congregation."[13] This may also be translated as community, in the teaching of the fathers. The biblical focus began with focusing on the community or group and then on the individual in a

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[12] John Donne, Devotion Number XVII (quoted in Some Poems and a Devition of John Donne: The Poet of the Month [Norfolk, Ct: New Directions, 1941])

[13] Danby: 1972 Pirke Avot 2:5

secondary way. Carol Ochs posit the question –"Can we be human and not be in community?"[14] She then clarifies the intricacies of our inter-relatedness.

> *"Actually, ... we have to ask whether we can exist at all without being in community. Certainly we cannot come into being without community, which is necessary for conception, nurturance, and development; an infant cannot survive without being in a nurturing environment."*[15]

The manifestations of inter-dependency will change with age and maturation, but connectedness is always essential. The expression "once a man and twice a child" is a truism. The dependency seen in childhood will often manifest itself again in old age. The individual who is ill is also dependent on the help of others who are healthy. Thus a theology of community underlies all ethical actions carried out for the well being of others. The concept of holiness as enunciated in the book of Leviticus, is manifested to a great degree in proper ethical behavior.[16] As one interact, and serve others, these encounters reflect a growth in holiness and others' centeredness.

It would seem as if the reverse is now true, because of the way many in our Western society view mankind. The individual and his accomplishments are more highly valued. The hero, the star is sought after as if by himself or herself the

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[14] Ochs: 2000 p. 154

[15] Ibid.

[16] Psalm 71:9 "Do not cast me away when I am old; do not forsake me when my strength is gone." Other passages clarify the need for compassionate caring are : Ecclesiastes 12:1; Leviticus 19:32; Proverbs 16:31

feats are accomplished. Very few are interested in the family from which he or she comes. Little do we know or care to know about their background. While speaking about "team effort" the real focus is on the achievements of the star athlete or gifted individual. Rice states it succinctly "Human beings are essentially social as well as corporeal. We exist as groups, not merely as individuals, and our being together is just as important as what we are by ourselves."[17] In nearly all the scriptures of every religion the Golden Rule or the ethics of reciprocity is found. Caring about the other individual is considered of utmost importance.

In both Judaism and Christianity it is stated, "You shall love your neighbor as yourself"[18]. The New Testament declares "Whatever you wish that men should do to you, do so to them".[19] Hinduism speaks of behavior and approaches it from a negative view; "One should not behave towards others in a way which is disagreeable to oneself. This is the essence of morality".[20] The teaching of Islam is precise, "Not one of you is a believer until he loves for his brother what he loves for himself".[21] Confucius taught "Do not do to others what you do not want them to do to you" [22] and Buddhism declares "Just as I am so are they, just

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[17] Rice p.122

[18] Leviticus 19:18

[19] Matthew 7:12

[20] Mahabharata, Anusasana Parva 113:8

[21] Bishop : Forth Hadith of an-Nawawi 13

[22] Yutang : Analects 15:23

as they are so am I". [23] Among the many Yoruba Proverbs of Nigeria the one closest to the golden rule states "One going to take a pointed stick to pinch a bird should first try it on himself to feel how it hurts".[24] What we do to others and how we relate to community may reflect one's understanding of the self. Rabbi Hillel said, " If I am not for myself, who is for me? If I care only for myself, what am I? If not now, when?"[25] The dance of life has two partners – the individual and the community. It is not either or but both. Each person must be treated with individual respect and at the same time be recognized as part of a larger community. The following theology guides the training and practice of volunteerism as it seeks to serve the most powerless among us – the disabled, the elderly, the poor and the sick.

The deuteronomic command "Follow the Lord thy God"[26] has been elaborated upon in the Talmud. The rabbis ask, "What does it mean? Is it possible for mortal man to follow God's Presence? The verse means to teach us to follow the attributes of the Holy one, whom we praise. As God clothes the naked, so we should clothe the naked. As the Holy One visits the sick, so we should visit the sick. The holy One comforts mourners and you should comfort mourners. The

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[23] Saddhatissa : Sutta Nipata 705

[24] Radin: Youruba Proverbs (Nigeria)

[25]Danby: 1933 Pirke Avot 1:14

[26] Deuteronomy 13:5

Holy One buried the dead, so you should also bury the dead."[27] The service rendered by volunteers in visiting the sick is considered a mitzvah among the Jews and is reinforced in the daily liturgy. Each morning part of the prayers include reading a portion for the Talmud "These are the duties whose worth cannot be measured:...visiting the sick...."[28] , it is also a prescribed duty, as stated in Jewish law: "It is the duty of every man to visit [the sick individual]."[29] The volunteers who serve in the hospital do not see their work as a duty but as a voluntary act of love. While such acts may be classified as moral ethical duties incumbent on all human beings, the injunction is not codified as such in other cannons. In Judaism the Rabbis' discussion concerning visiting the sick – *Bikur Cholim*, states that the visitor who performs this mitzvah, takes away one-sixtieth of a sick person's pain.[30] A debate follows as to the type of visitor. The expression *ben gilo* has been the subject of much debate. Some declare that the visitor would have to be of the same age, social circle, astrological sign; while others recognize any person sharing empathic connectedness, anyone sharing

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[27] Sotah 14a.

[28] Chaim Stem, ed., Gates of Prayer for Shabbat and Weekday (New York: Central Conference of American Rabbis, 1994), 13.

[29] Solomom Ganzfried, Code of Jewish law (Kitzur Shulhan Aruch) trans. Hyman E. Goldin (New York: Hebrew Publishing Co., 1961), 4.87.

[30] Nedarim 40a.

similar emotional feelings[31] – such a person is a *ben gilo*, bringing healing to the sick.

Love

One who experiences true love, delights in the well being of others and works unselfishly for their benefit. This love or compassion is at the core of all the scriptures and the basis for theological beliefs and practices. They all recognize the person who can rise above self-centered attachments and desires as one who cares more for others. In the New Testament of the Christian Bible: 1 Corinthians 13 and 1John 4 describes this love as grounded in Divine love. In Hinduism, the Bhagavad-Gita states, "When a person responds to the joys and sorrows of others as if they were his own, he has attained the highest state of spiritual union"[32]. The classical Buddhist passage on loving kindness is in the Metta Sutra. It states "Let none deceive another, nor despise any person whatsoever in any place. Let him not wish any harm to another out of anger or ill will...let him cultivate a boundless heart towards all beings. Let his thoughts of boundless love pervade throughout the whole world: above, below, and across without any obstruction, without any hatred, without any enmity. Wherever he

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[31] Joseph S. Ozarowski, To Walk in God's Ways: Jewish Pastoral Perspectives on Illness and Bereavement (Northvale, NJ: Jason Aronson Inc., 1995), 23

[32] Easwaran 1985 : Bhagavad Gita 6:28-32

stands, walks, sits or lie down, as long as he is awake, he should develop this mindfulness. This, they say is the noblest living here".[33]

Such love is demonstrated in the New Testament story of the Good Samaritan. This Volunteer went to the aid of the identified patient – the injured victim. He addressed the needs of the injured and so practiced his theology. This practice of loving-kindness as taught by the rabbi states, "The world stands upon three things: upon the Law, upon worship, and upon showing kindness".[34] Kindness may sometimes be self-seeking, but the Pauline epistle declares, "Let no one seek his own good, but the good of his neighbor."[35] This motif of serving others is elevated to be the purest service – seeking the welfare of others without the expectation of reward. In Sikhism it is expressed, "Without selfless service are no objectives fulfilled; in service lies the purest action."[36] The Talmud declares "All men are responsible for one another"[37] , while Jainism states, "Rendering help to another is the function of all human beings"[38]. A similar theology is found among Latter-day Saints, "I tell you these things that you may learn wisdom; that you

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[33] Saddhatissa 1985, Sutta Nipata 143-151

[34] Herford 1962, Abot 1.2

[35] 1 Corinthians 10:24

[36] Kohli 1961, Adi Granth, Manu, M.I, p. 992

[37] Baron 1996 Sanhedrin 27b

[38] Jain 1960 Tattvarthasutra 5.21

may learn that when you are in the service of your fellow beings you are only in the service of your God."[39]

Because of our creatureliness or our humanity, we all can understand and experience all types of feelings. Some lie buried below the surface while others can access their feelings quickly. The patient in the company of a trained volunteer may form a community, which can be more supportive and healing than when the patient is left alone or is in isolation. We are gregarious creatures. "The biblical view of man is not that of individual existence but that of a group. The bible affirms our fundamental sociality in its account of human creation. When God made humanity, he created two persons, not just one".[40] We are our brother's keeper. We owe our existence to other people. The barriers of divisions should be broken down. [41] This is not limited to just our physical origins but includes our intellectual and cultural origins. Our self-concept is derived from the way people - especially our parents treat us during our early years.

Our need for each other and our interdependence is emphasized in many biblical narratives. Moses was a man of talent and experience but was instructed by Jethro, his father-in-Law, to seek out able assistants. People with exceptional abilities and accomplishments are dependent on others. The teacher helps the

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[39] Book of Morman, Mosiah 2:17

[40] Rice 1997 page 123

[41] White 1940. page 399

gifted child excel. The work of others providing life's basic support allow others to perfect skills and abilities they could not achieve without others doing their parts – insignificant though it may seem.

Because many members of the community are willing to serve as volunteers at the hospital, the conducting of a Volunteer training program within the context of Volunteers Retreat will provide a model which will enable individuals of all traditions to come together and connect with each other. The concept of unity and community in diversity is pivotal. The twelve tribes of Ancient Israel - though descendants of Abraham, were diverse in many ways but they served One God.

Our Brothers Keeper

Theology of Volunteerism is exemplified in the New Testament narrative – the Good Samaritan. This narrative illustrates the fact that no type of division is adequate to prevent one human being from failing to respond to the needs of another. The divisions of race, class, education or finance or any other type of division should not stand in the way of helping others. All humanity is united as one. The ethnic or racial identity does not have any merit or value when a human being is in need of another's help. It is interesting to note that the Pauline Epistles speaks of an after life which also reflect a cooperate social structure. The

dead rise together to receive immortality[42], the eternal inheritance is something shared. Eternal life is not given out one at a time but is received by all together.

In the "the good Samaritan" a picture is presented of human compassion operating at the highest level. In spite of the racial divide and the customs of the times, one man volunteered his time, energy and means for the welfare of another; one with whom he had no prior relations. What is more striking is the fact, that due to the prejudices of the time, one would not expect such a response if the victim and caregivers roles were reversed. The Samaritan did for the wounded man what the wounded man would have desired.

Theology of community or corporate personality is more important than that of any individual. On occasions some individuals become the representative of the group – the Priest, King and Prophet, stand out sometimes but in general the individual member participates in the life of the group and partakes of its significance. It is this sense of corporate personality, which lies behind some of stories in which a community suffered for the misdeeds of one member. In the Old Testament - Joshua 7, the family of Achan was punished with him.

Another protestant theological concept that underlies volunteerism is the concept of the Priesthood of all believers. "The most effective ministries maximize available resources. The laity must be involved. The clergy cannot do

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[42] 1 Thess. 3:17

everything."[43] The hospital volunteers have my support and can call on me for assistance at anytime, but with this training program they are able to function efficiently and effectively as pastoral care volunteers.

The concept of being present and listening as opposed to doing is illustrated in the narrative recorded in Genesis. God visits Abraham near the great trees of Mamre [44]. There is no dialogue between God and Abraham. He is visited after his circumcision, when he is ill. God comes to be with him and comfort him. In a similar manner the volunteer or bikur cholim attends the sick with empathy and love; giving spiritual and emotional support thus meeting the deep needs of the patients.

Clinical Principles

The presenting problem is: that with so many different religious and spiritual traditions – practiced and believed by both volunteers and patients, there is the tendency to feel disconnected from those who do not share similar beliefs and practices. Some may even have feelings of hostility towards other belief systems and their adherents. Others may have feelings of estrangement, while some may even fear being isolated. Differences in attire, rituals and languages can

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[43] James W. Ellor and Sheldon S. Tobin, "Beyond Visitation: Ministries With The Homebound Elderly, "*The Journal of Pastoral Care* 39:1 (March 1985): 19

[44] Genesis 18:1

compound the feelings of being alone. These all engender a certain amount of fear and suspicion due to ignorance of the unknown.

It is necessary for all volunteers to make their contribution without denying their identity. The "systems theory" of family, enables all to maintain their individual identity and at the same time to be part of the family community. The goal is to facilitate and to enable the volunteers to reach out and connect. The process of reaching out to others and connecting without imposing one's views, beliefs or religious traditions is worked out within the context of other individuals be it in the family, work environment, or religious community. By understanding families and how they work, the volunteers will be able to accept and respect others who are different from them in any or many ways. As in families, each person is unique but at the same time a valued person.

Understanding how a family and community functions is necessary, in order to understand the process. The principle of how a family or a community functions is based on systems theory. In this theory the focus shifts from the individual to the family. The process is of paramount importance and the reason why information is communicated is of less significance. Rapoport states "Each family displays its own idiosyncratic interactive patterns in the ways in which its members organize themselves into roles, the manner in which power is distributed, the fashion in which power is distributed, the fashion in which

separateness and connectedness are handled"[45]. The climate, which I desire to develop at the retreat, is one of openness, oneness and respect. It can and will be fostered by having regular group and processing sessions with all the volunteers. At these times the focus will be on shared experiences. These repeated interactions would reinforce community and pattern that of a functioning family.

The emotional processes at work as each shares his or her story and experiences of interaction with the patients and each other, could sometimes be overwhelming. The emotional support from others within the group provides an opportunity for debriefing and stress reduction. It is this holding environment, which is needed by all who are caregivers.

The old pattern of each volunteer making a few calls to those of like mind or religious tradition and then going home should be replaced by a group debriefing and interchange at the close of each volunteer's tour of duty. The intensity of feelings may sometimes approximate the intensity felt in families. Edwin Friedman in his practice as a therapist and a rabbi saw a correlation between a family and religious institutions like the church, synagogues and mosques. He saw them as "a prime area for the displacement of important, unresolved family issues. Interlocking emotional triangles between personal family issues and congregational family issues are the natural consequence of such

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[45] Arthur Rapoport, "Introduction," in William Buckley, ed., 1968 : p. xiii

displacements."[46] The volunteers working together become a community, just like a church, synagogue or a mosque. The manner in which each will act or interact with and in the group would be different.

The structure and process are two important factors in systems theory. The member's interactivity in the group often does manifest the same patterns of behaviors, which are typical. One of these is the forming of triangles. These evolve or are formed when two members of a group develop some difficulties. A third member is drawn in and triangles often develop. The focus shifts from the dyad and a homeostatic or state of balance, develops. This occurs often when stress reaches an unbearable level. This rebalancing that occurs by triangulation helps to ensure the system's survival. Thus the " triangle is the smallest stable group."[47] The ongoing interaction with each other and their environmental milieu helps to maintain balance. This can change if any force – internal or external brings about a change in equilibrium.

The bringing together of volunteers from different faith traditions to train them to serve others of faith traditions other than their own is a natural anxiety producing agent. Anxiety is often diffused and undifferentiated and unfocused. The thinking process lacks objectivity and is often blurred. The process of education and the retreat are tools, which are intended to bring about a

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[46] Friedman 1985: p. 197

reasonable level of equanimity. Chapter One presented the varied backgrounds from which the volunteers come and the even greater variety of patients they will encounter. These all have their own stressors and they can produce great stress. One of the objectives of the retreat is to identify what are some of the causes of anxiety as volunteers interact with each other and with the patients.

The value of this process is that it opens the door of fear and introduces trust and greater understanding. The air of distrust and suspicion is discharged along with the inflexible and rigid ways of viewing issues, ideas and concepts. This process will seek to help all to clarify incoherent and vague thoughts and the activities are intended to induce buoyancy and enthusiasm. As anxiety is reduced and diminished, the participants can be more open with each other and begin to appreciate and learn from each other. A failure to get rid of anxiety would lead to the vicious cycle of: Anxiety – polarization – inflexibility – rigidity – more anxiety. This would lead to an unending vicious cycle. The volunteers would then be unable to be that non-anxious presence for each other and the patients.

The exposure of all the volunteers to their own feelings: their pain, grief, sorrow and other such (feelings), will be a shift away from focusing on the cognitive system of beliefs and teachings, to the affective and experiential. It is hoped that the participants in the training program will discover that these feelings are

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[4] Nichols 1986: p. 118

universal and are understood and shared by all. As this is understood each volunteer will become aware of his or her own feelings and will be able to minister or be a non-anxious presence to any patient who is open to be visited. As they realize that feeling is a common denominator in human beings their level of anxiety about ministering to a person outside their religious community will be lessened. They will have greater confidence in their ability to serve anyone because they share similar feelings and experiences. The way it is manifested and expressed may differ due to cultural differences but they are felt and understood.

Another important factor in the systems theory is that of boundaries. It defines the group and or individual. There are degrees of permeability and the degree determines the climate of each group. It also differentiates the system from its environment. The degree of openness or closeness often determines the amount of change a group or individual is prepared to entertain. A system maintains itself through boundaries and triangles, which give it form, and helps to maintain homeostasis.

The initial response of the volunteers is to keep things as they are. They have done the same thing over and over for the patients. Not "to do for the patient" but "to be with the patient" is a shift away from the routine to which they are accustomed and with which they are comfortable. Their work was very predictable, they set the agenda but the shift "to being with the patient" could

present unknowns for which the volunteer might feel unprepared. Any attempt to break the routine or introduce change creates anxiety. The shape and composition of the old system is thus jeopardized.

GROUP PROCESS

The retreat is based on the clinical principles of a training or personal growth group.[48] The aim of this group is to allow for all to participate in the many activities planned, share experiences and thus have self-disclosure, increase expressiveness as they become more comfortable with each other, share the appropriate emotions as they interact with each other in the structured and unstructured sessions. These activities engaged in for this demonstration project are intended to overcome the religious, cultural or social divide and bring about a connectedness among all the participants. The program will foster a spiritual experience as we engage in nature trail walks and as we tell of personal experiences in our lives.

I must keep in mind that even though I am the director of the department, I am seen as an external agent and an outsider. Transitioning in, into a family or system

[48] Hemenway 1996: p. 102 - 105

is under normal circumstances tedious and fraught with unknown expectations. Thus an understanding of the process of a system is necessary. Understanding how communication is maintained, understanding the degrees of separation and differentiation, and not the least is how change is effected, embraced or repulsed.

Because this is a new approach another goal here was to prevent the group from being hijacked by inflexible resentment and overwhelming anxiety. Their perspective had to be broadened rather than becoming constricted. This group was behaving as systems theorists have observed other groups behave. According to Nichols and Everett "the system is not able to repair itself, plan for the future, and find a new direction."[49] There is also another dynamic at work. The new director does not belong to any of the religious traditions represented by the volunteers, he is new and different and that may be reason for a degree of anxiousness. The system has been working well by the volunteer's[50] standards for years they came and went, following the same routine. For any long lasting and effective change to take place, trust must be developed. Any signs of triangulation must be understood and guarded against if growth in the group is to take place.

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[49] Nichols and Everett 1986, p. 43

[50] At least six of the volunteers have been serving the hospital for over four years.

Chapter 3

METHODOLOGY

The Retreat Experience

Because psychodrama has been used very effectively as a learning tool, it will be used in all the training. Psychodrama is an ego supportive directive model, which will be a vehicle for educating and informing both the participants and the observers. The volunteers in training will play the roles of patient and caregiver. This will be followed by exploration of the feelings and emotions and evaluations of the processes. Didactic will be given periodically and learning will be encouraged on different levels.

Some of the dramatic role-playing will be videotaped. The scene will be replayed and the participants will be given an opportunity to evaluate themselves, this will be a type of self-feedback, self-evaluation. After they have given their evaluation, the other observers will share their views and feelings about the interaction. During role-playing the participants often become more self-aware but after awhile each reacts and responds naturally. The participant becomes less self

conscious, feelings are tapped into, a natural dialogue develops and in some cases personal issues may even arise.

The retreat is a time when volunteers get to know each other and the religious and denominational divide is not emphasized. They all connect with each other. They talk and listen to each other and may even cry when moving experiences are shared. It is this greater self-awareness which will enable the volunteers to better connect with the patients, develop a sense of purpose, become non-judgmental and accepting of others.

As the volunteers talk and listen to each other it becomes clear that there is more shared in common experiences and the points of connections are more than was initially thought. My role is that of a facilitator. The communication and dialogue between the participants will help in achieving connectedness and wholeness.

It was my task to broaden their perspective while at the same time assuring them that the needs of the patients would all be met. At every training session I wrote on the flip chart "The patients come first". This is one of the slogans used throughout the hospital. It was further brought to their attention, that, in pastoral care, we do not set the agenda. It is not what we believe, the patients need that is important, it is our task to companion them and let them lead the way. As I spoke I could see many becoming more relaxed. It was at this point the concept of a retreat is introduced. This was presented to the volunteers as an opportunity

to leave the city and go upstate in the Fall and spend the day in the country at a Lodge on the Lake. Transportation and meals would be provided. This was a first for the institution. The volunteers were excited. They were briefly informed about the program. Some activities would include sharing the story of our lives especially when sick in a hospital. The program will consist of sharing the memories during an illness or pain along with role playing and personal reflections. Didactic work would be informal and limited.

This new idea began a positive shift. Instead of collusion of a staff with volunteers and making the director the scapegoat; because of introducing change - the stress from enmeshment and the silent opposition; the blaming and culprit finding is suspended. Listening becomes the new focus. Everyone wants to be listened to. The volunteers are promised a Retreat far from the hospital, out in the country; there they will listen to each other's shared experience. This is what the patients need also. A chance to be heard, to tell their story, expresses their feelings, and emotions. It is hoped that as they understand this, triangles are broken, they get unstuck, and they move from a group, which is bent, on "doing" and free themselves to try "being" with each other and the patients.

Another concept to be shared with the volunteers is that they all can develop the capacity to listen to another individual and empathize in spite of religious differences. The understanding of cultural diversity will not only serve a useful

function when visiting with patients but also at other times when there is human interaction.

I will also assure all the volunteers that a denial of their religious beliefs is not required in order to be effective. It is an understanding of their beliefs and also their own transference and counter transference, which will enable them to be more effective. The patient must not feel under siege or attack by either staff or volunteer. I point out that the slogan, which is repeated often throughout the hospital, is "the patient comes first", but the more appropriate statement from the pastoral care perspective is "it is all about the patient". The trained volunteer, entering the patient's room will facilitate the patient by allowing the patient to fill the room. All these concepts will begin to have meaning when we put ourselves in the patient's place. This we will practice in our psycho dramatic enactments.

It is my objective to help the volunteers to be able to address and confront their own feelings so that they will be better able to be sensitive to the feelings of the patient's. Feelings of loneliness, isolation, abandonment, disconnection or being overwhelmed are a few of the feelings each must understand. Learning to be supportive enables individuals to listen to others as they share their stories, dreams, hopes, fantasies, myths and ritual practices. Patients who find caregivers whom they can trust, connect with and feel supported by will discuss their feelings more easily. They will then be able to function in the role

needed by each particular patient. E.g.: companion; challenger; comforter; guide; sustainer or reconciler. All the volunteers regardless of their religious traditions and beliefs can play these roles.

The Program

There is a 12-hour training curriculum, which takes the form of a retreat. This is followed by a series of seminars and workshops, which will focus on the mechanics of successful communication and interaction with the patients from a spiritual point of view. Each volunteer will then work under the supervision of a Unit Chaplain while in training. There will be on going seminars for Chaplains and Volunteers through the year. When the program is established various guest speakers will give presentations on psychosocial and clinical topics. These may be expanded as the needs arise.

The program will bring together individuals from different religious traditions. It will provide an opportunity for all to learn more about each other and also to develop respect for other spiritualities. Each training group will be a community, which will promote the well being of the group and share skills for good interpersonal relationships. Each participant will share and reflect on his or her life story and will address and reflect on those feelings they experienced when they were ill or endured some pain. Some of theses feelings of loneliness, isolation, disconnectedness, anxiety and grief are the same felt

by patients in the hospital. The goal is to help each participant realize that they can identify with patients because we often share common experiences and the religious or denominational difference which divides – should not be allowed to defraud us of the opportunity of being out brothers keeper. Listening to each person's story and being supportive will aid in creating trust. The greater the trust the more connected people feel. The development of empathetic listening will enable each volunteer to give the patients the respect they desire as they seek to communicate with others. Having a caring, non-judgmental spiritual support is what many desire during their times of illness.

The Retreat

In order to give the volunteers an opportunity to interact with each other in a more relaxed environment a retreat will be conducted for them away from the hospital. In the over twenty years history of the hospital and the department of Pastoral Care this will be the first retreat to be conducted. It is my plan to make this an annual event. By so doing new volunteers will have this opportunity to interact with each other outside of the regular volunteer duties in the hospital.

It is my intention to provide a method for those who will participate in the retreat and an opportunity to connect with each other. They will listen to and hear each other's experiences. Their hopes, dreams and experiences in and out of the hospital, with patients and as patients will be shared. The method seeks to create

a community – the group, in which the members will operate not as religious representatives but as individuals who share and experience all the human emotions.[51]

In order to have an orderly and well running retreat and training seminars, it is necessary to have some ground rules.

1. Each person will indicate by what name they would like to be addressed.

2. All are encouraged to participate in all the activities but if an individual does not wish to participate in a particular activity, he or she is free to do so. All activities are voluntary.

3. The responses made on the note pads and questionnaire will be returned to the director and these will be used as a tool for evaluating the training for the demonstration project. Those who desire the return of the written material should indicate the same and it will be returned after the project is completed.

4. If anyone has any questions at anytime feel free to raise it with the director.

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[51] See APPENDIX 1

The physical setting chosen for this retreat is a lodge in the country. It is away from the hospital and home. The setting is in a nature preserve, far removed from the sound of commercial traffic. The trails and lake provide a placid setting and lends itself to quietude and reflection. The group will consist of 10 to 15 individuals. Normally their only contact with each other is when they come to give volunteer service at the hospital. This 12-hour retreat begins at the hospital where everyone meets at 6:30 am. The half hour before departure is a time of "getting to know you better." The time in transit - on the bus, is an unstructured time. All are encouraged to use this time to get to know others.

This demonstration project is intended to include ten to fifteen volunteers. This is based on the work of Yalom's finding. He writes, "The group range in size from eight to twenty members...large enough to encourage face to face interaction, yet small enough to permit all members to interact."[52] The participants will come from different cultural backgrounds and religious traditions. Some have been serving as volunteers for a number of years while others are new volunteers. All the participants in this project have self-selected. They all are motivated to become better volunteers. With a new director of the department of pastoral care and with new ideas and programs - like the annual retreat, enthusiasm is high and both staff and volunteers feel engaged in the

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[52] Yalom: 1970, page 489

process. "The most important criterion for inclusion in a group is the most obvious one... motivation."[53]

Each participant is given complete information about the program and the process; this is done in a general meeting with all the volunteers and also in one of the one-to-one supervisory sessions before the project begins. The value of becoming more open to understand others as well as ones self is explained. The outcome of developing deeper connections with other volunteers and the developing of a more connected community as well as more intensive self-exploration is elaborated upon. They will have the opportunity to explore their own values and beliefs and also hear and become aware of the values and beliefs of the other members of the group. The group is a microcosm of the patients they will meet and with whom they will be better able to interact.

The retreat begins once we gather at the hospital. The interpersonal relationships begin in an atmosphere of relaxed excitement. All gather, talk, make phone calls to find out who else is coming or not, introductions are made and acquaintances are renewed. It is in this environment that long-term relationships, greater bonding and high esprit are developed.

The social and secular nature of the retreat allows the participants to shift focus from that which divides to that which we share in common and unites us. Many

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[53] Ibid, p. 244

of the feelings[54] we all share and which are a common denominator among human beings are given an opportunity to surface in this environment. Instead of meeting each other as representatives of particular religious or denominational traditions, we come to see each other with shared values. This was elaborated on further in Chapter 2.

This will be an opportunity for all the participants to see themselves and the patients as human beings and not as religious or denominational persons. This experience will provide an opportunity for breaking stereotypical barriers; increase learning, respect and greater appreciation for others.

As this heightened awareness occurs, it is hoped that a shift will occur. Instead of coming as a volunteer to: administer the sacrament; discover who desires to see the priest to make confession; give out Bibles or any literature; seeking to save a "lost soul"; sing hymns and or read scripture and or engage in theological discourses, it is hoped that instead of focusing on doing, the concept of being present with the patient and becoming a more empathetic listener will be the goal of each volunteer. Focusing on the patients concerns rather than the personal agenda of the volunteer is one of the main goals of this demonstration project. It is hoped that they will see themselves as companion, challenger, comforter, guide,

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[54] Appendix 1

sustainer and reconciler when each situation presents itself and requires its unique response.

The volunteers find it natural and easy to operate as small-disconnected groups. They identify themselves more readily by their religious affiliation. There are two significant barriers that the retreat will begin to help overcome. The first is separation because of language and the second is religion or the denominational divide. Because the largest numbers of volunteers speak Spanish, I will provide a translator for all of our group meetings and seminars.

Being together as one in spite of the differences in language or religious traditions we will seek to strengthen the bonds of friendship and develop relationships with others outside our own religious traditions. Instead of controlling or manipulating we shall seek to experience cooperation and companionship. Instead of judging we will seek to respect differences and value everyone's contribution. Instead of defining ourselves in terms of the traditions from which we come, the focus will be on discovering who we are and what we share in common.

The principle of participation and cooperation will become more natural and normal as the bonds of trust and friendship develop. The behavioral shift from manipulating, controlling and demeaning of others who do not share the same theological or ideological views is one of the desired objectives of this demonstration project.

The retreat will provide the participants with a change of environment and create a more relaxed environment, which could enhance their receptivity to new approaches and experiences. The quiet environment is more conducive to individual reflection and contemplation. It is also possible to experience a wide range of emotions in this environment. As the participants go off alone on the preserve, one can experience being alone. It may even be the case that some experience separateness and loneliness while walking through the woods and meadows. Such experiences are similar to those experienced by the sick patients they often visit in the hospital.

Most retreat activities will transpire as the group is arranged in a large circle in the living room or den. There, each participant will choose where they wish to be seated. They will have the option to choose from a sofa, arm chairs with or without cushions, rocking chairs, the rug, cushions, metal folding chairs or wooden straight back chairs – with or without arms.

Prayer is an important shared experience among Chaplains and Volunteer workers. The forms and format for prayer, meditation or reflections are often different from one community to the other. All religious traditions will be given the opportunity to participate in prayer using the form and format, which is unique to the tradition. This will give all an opportunity to become aware of other ways of praying and engender greater appreciation, understanding and respect.

The retreat participants are a microcosm of the patients they visit on the units. The exposure to other styles of praying and prayer on the retreat will create a more open climate that will be non-threatening and prepare all for similar encounters with the patients. The volunteers thus exposed will feel more comfortable in inviting patients to use their own mode of prayer when prayer is requested. The outcome sought by this exercise is to have patients feel comfortable and the volunteers will become respectful of other traditions. The attempt is to be also inclusive and non-judgmental. At the time for praying those who use Prayer books will be free to use them; those who pray spontaneously will pray in the manner with which they are familiar and a time for praying in silence will be provided.

The first event, which will occur once we reach and unpack at the retreat center, will be a communal meal of Soup and Crackers and then the formal introduction of all who are present. This gives an opportunity for everyone to get formally connected. It would also create a mood of warmth and openness

While sharing the first communal meal music is played quietly in the background. Each participant will be encouraged to bring a CD or Tape with a favorite music selection. These would provide the background music during meals. The provider of each piece of music played would be identified and the individual would share what makes the particular music meaningful to the one who brought it. This is

also aimed at helping each person to hear and respect differences in taste of music and sounds. The idea will also be emphasized that differences can also enrich others in various ways.

The formal training will begin when all are seated in the conference center or the living room. The first order of business is to go over the rules of conduct during the training.[55] This will be followed by the formal introduction of each person. Each person will be paired with the person next to him or her. They will share information about themselves, and each person will introduce the other. No one will be allowed to introduce him or her self. This is the first listening exercise so that each person must remember the information shared without writing it down. At the appropriate time the information will be shared with the entire group. This is similar to the volunteer listening to the patient and not distracted when thus engaged.

The exercise and Yoga session will be next followed by a time designated for prayer. After the prayer, time will be spent in free-associating. This will not be a didactic or time for intellectual pursuit but rather a time in which all will have the opportunity to reflect on - a time when they were ill, in the hospital or going through a difficult period. Each person will share an experience and tell what was helpful and not so helpful when visited by visitors, volunteers, relatives and

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[55] See page 43

friends. Each person will be invited to recall what may have been more comforting to him or her during that time of difficulty. Ten minutes will be given for each person to write down those memories and reactions. Then time will be allowed for some to share that history and reflection. Then we will have a break. This will be a forty-five minute free time to walk and explore the nature preserve. The participants will have the opportunity to go off privately or as they wish. It gives time for some private self-reflection. Others may take this opportunity to carry on the process of deeper connection. The process of sharing can become emotionally intense and so periodic breaks may help to reduce intensity and anxiety.

During this break the mid-day meal will be placed in the oven and other lunch materials will get prepared. After the break all will return to the meeting area to continue the sharing of experiences. The purpose of this exercise is to show that while each participant is coming from a different religious tradition yet the feelings experienced by all are not expressed in denominational terms and can be felt and understood by all. Instead of going around in a circle, I will encourage the participants to share their experience when they wish. In this way the level of anxiety will be reduced and no one will feel pressured to be the next speaker.

The next activity will be the first psycho dramatic presentation. This is followed by reflective evaluation by participants, comments and observations by observers

and then group discussions. This will focus on the feelings generated by the dramatic enactment and any other relevant emotions. The morning session will end with another ten-minute break before lunch. All are encouraged to interact informally as the lunch is finalized. I will use these breaks to observe, evaluate and document how the retreat experience affects interaction among the participants.

The preparation of the meal will be another opportunity for the volunteers to get to know each other better and appreciate and respect differences in terms of diet and food. Each person will be encouraged to bring some food item to be served at the mealtime. The main course will be provided by the department of Pastoral Care. The fully furnished kitchen will make it easy to prepare and serve the meals. All will be allowed to assist in the preparation, serving and cleaning up after the meals. It will be an opportunity to build bridges and destroy barriers, which often divide individuals and communities. The act of preparing, sharing and eating together will help in the bonding of the volunteers. Communication will be enhanced and a climate of trust and cohesiveness will be fostered.

Role Playing - Psychodrama

Psychodrama will be used in training at the retreat and at the bi-monthly seminars to help the volunteers learn to be more effective in meeting the patient's needs.

Each person playing the role of patient will be given one of the following vignettes. At the retreat the first two will be enacted. Each team will act spontaneously without any prompting. A third case will be scripted and dramatized by the volunteer participant/dramatists. This text is intended to give them a model to be considered as a guide.

The first two presentations will allow them to be or act as they would when visiting with patients like those in the cases assigned. The third is intended to give a sense of direction with the full text provided for the actors. Below are the cases that will be used for dramatization and study during the Retreat and other Training.

1. Patient is angry with everyone and curses God. Loss of spouse – divorce is pending in the court. Worrying over prospect of going life alone. Feelings of guilt about his past inappropriate behavior and misconduct. Shock, disbelief and feeling confused.

2. Patient is religious but does not want any God talk at this time. Talks about killing herself. Talks without making eye contact. Speaks of hopelessness and guilt. Does not sleep well at nights. Self- report of sexual abuse. Distrust others. Have vague memories of inappropriate sexual contacts in early childhood.

3. Patient is a child and is anxious; wants to pray. Read scripture and sing. Feels loneliness when family is not around. Feels fearful about undergoing surgical operation. Anxiety and panic attack occurs often.

4. Patient is Jewish and states that he has some close Christian friends. Feels guilty about some family issues. He is gay and does not believe or follow the traditions of his family. He likes to argue with the chaplains.

5. Patient is hard of hearing; does not believe in God, fearful of dying. Uses alcohol and other mood altering drugs. Denies chemical dependency is a problem. Broken shoulder due to accident – driving while intoxicated. Patient in police custody.

6. Patient welcomes every religious person with the hope that at least one of them may have the right connections and can bring about some healing. Ask for any and every religious symbols any chaplain or visitor can offer.

7. A patient who is legally blind tells that he believes his health condition is because God is punishing him/her for past sins. He does not feel he should take the medication because it would be going against God's will. His children do not visit nor care much about him.

8. Patient informs you that AIDS seems to be disease but he/she is praying for a miracle and cure. Wants to know if God can forgive and heal him.

Patient longs for companionship of friends. Expresses pain and resentment over missing an intimate relationship.

9. Patient is surrounded by many religious symbols – Bible, Koran, Crucifix, Buddha, and Star of David. Fears that his mental illness is a curse from God or due to a curse someone has put on him. Patient is often sad and confused.

10. Patient asks, "Who are you?" You respond "A volunteer from the Pastoral Care Department"; the patient says, "I have my own religion". Later patient states distrust of church people and recalls being sexually abused by so-called Christian leaders.

Each person will be given the opportunity to be one of the ten patients described above and each will play the role of the Pastoral Care Volunteer. The person playing the role of the volunteer will imagine that the patient is in the hospital. During the dramatization, the patient will be lying on the bed or sitting on the chair beside the bed to give dramatic effect. The position assumed will be the choice of the one playing the role of the patient. In a similar manner the visiting volunteer will have an unscripted dialogue when visiting the patient.

Each observing participant at the retreat will be given a pad with ten pages.[56] At the end of each dramatization, time will be given for each person to answer the questions about the particular case on the note pads. After ten minutes time will be allowed for all to share their thoughts and observations. This could be quite unnerving for some persons. In order to reduce fear and intimidation, it will be clearly stated that the aim of these exercises is to help us to improve our skill at Pastoral Care giving. It is not a matter of judging anyone; instead it is a way of helping all of us to become better in our work. It is also important to remember that there is no right and wrong in this type of service, more often we will discover how we can do our caring better.

Each participant will pick one of the ten patients to be enacted and the order of enactment will be voluntary. This enables the more confident participants to do their enactment first. The initial response of most of the volunteers who are participating in the retreat would be that of withdrawal and resistance. There is that fear of exposure, incompetence and ineptness. These defenses will prove a hindrance to the growth and learning process. Using the tools of affirmation, compliments and encouragement I guide the process of evaluation and thought sharing. This will help others feel more confident and less anxious when it is their time to participate in dramatization as patient or pastoral care giver. Blatner notes that some of the essential qualities, which will make spontaneous acting

[56] Sample Page of the Note Pad – see Appendix F

meaningful, are "an openness of mind, a freshness of approach, a willingness to take initiative, and an integration of the external realities and the internal intuitions, emotions, and rational functions."[57]

As the most confident individuals begin the dramatization and are supported by my affirmation, others will be empowered to participate with more confidence. As the sense of acceptance, purpose, trust and openness is fostered, it is hoped that all will feel encouraged and empowered to be themselves and act their part spontaneously in a creative manner.

The post dramatization discussions will serve as a feedback for the participants and learning experience for the entire group. It will give an opportunity for reflections on one's feelings in the moment. It will also serve to highlight the strengths and weaknesses of each participant. The use of the video recorder and the playing back of each session prior to the discussions unique styles of each person will not escape observation and constructive critical evaluation. It is intended that ego boundaries will be strengthened and the growth capacities of all will be expanded. As each person listens to others and feels the genuine compassionate reflections from another perspective, it is hoped that greater trust and openness will evolve. This will in turn help to strengthen the group bonding.

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[57] Blatnet and Blatner, p. 64.

Two of the ten patient cases will be enacted or dramatized during the retreat. Those, which are not completed, then will be completed during subsequent bi-monthly Tuesday afternoon training seminars at the hospital. These sessions – the retreat and Tuesday seminars are opportunities for the continued development of community among the volunteers. It will also be a time to engage everyone in sharing and participating. The anticipated results are an enriched experience in which interpersonal relationships can develop and exploration of our values and the ability to enunciate them.

Most of the participants will not know each other. Most will get to know others, as all will wear nametags. Before each session a few minutes will be taken to get the participants further acquainted. Each will be asked to find a new partner with whom they have not spoken directly. This forced activity will accelerate communication and interconnectedness. The focus of the "getting to know you" will be on ***who you are*** and ***not what you do***.

Group members will be invited to introduce their partner and to say something they have learned about the person. This self-disclosure helps to build trust and can be a great icebreaker. It will also develop the listening skill. Each pair will not be allowed to write the information shared and will be responsible to remember and share that which they have been told. This is a skill the volunteers will find

helpful as they visit with patients and listen to their stories and any other relevant communication.

The psychodrama will be enacted in the presence of the entire group. An area with a bed and a chair will be set aside as the staging area for the drama. The person acting the part of the patient will be given a hospital gown, which will be worn during the dramatic enactment. The position or posture taken by the patient will be done at his or her discretion. The person playing the role of the visiting pastoral care volunteer will also act on his or her own volition. I will request that the positions taken be such that the observers are able to see both actors' faces. All other activities during the presentation will be observed, noted and discussed during the discussion and evaluation time, which follows each case study.

During the discussion and evaluation period each person will be invited to speak about the feelings they believe would be experienced by both actors on the basis of the way they acted and the things they said. All would be requested to focus on both words and actions and reactions. The actors will also be asked to share the feelings that they experienced during the skit. This will give the opportunity for all levels of feelings to be explored. Everyone will be invited to express him or herself by speaking in the first person. e.g. "I feel" or "I thought..."

As the participants speak about feelings it will also give an opportunity for memories of past or present feelings and even past or present conflicts to arise and express themselves. After drawing together these responses I would ask each participant to write down how they viewed themselves and the role they were now called upon to play in the hospital? They would be asked to describe their roles in relationship to the patients, the pastoral staff and to each other.

The after lunch session will have a twenty-minute break at 2 PM and the psychodrama will end at 4:45 PM. A light snack will be served and we prepare to leave by 5:30 PM. We will clean up all areas used and return the rooms to the conditions in which we found them and then depart the retreat center. Some may use the journey back to the city as an opportunity to get further acquainted while some may use it as a time of rest. As the director of the program, department and this project I will be observing what new connections are being formed. The retreat ends when we return to the hospital and we say goodbye and depart to our respective homes. My parting words to all will be "Let us continue this growing and learning experience in our bi-monthly Tuesdays training session."

Retreat Schedule

6:30 AM	All meet at the Hospital
7:00 AM	Depart Hospital – Introductions while traveling.
8:30 AM	Arrive at Retreat Center, Unpack and Settle In
8:45 AM	First Meal Soup & Cracker : Selected Music & Story
9:00 AM	First Session – Introductions; Yoga Exercise and Prayer
9:40 AM	Reflections: When I was sick: Helpful & not so helpful memories.
10: 00 AM	Walk – Explore the Trails
10: 45 AM	Psychodrama Case I & Group Discussion
12: 00 PM	Lunch – Music: My Favorite & Story
1: 00 PM	Psychodrama –Cases II & Group Discussion
2: 00 PM	BREAK
2:45 PM	Psychodrama – Scripted Case enactment & Group.
3: 45 PM	BREAK
4: 00 PM	Snack, clean up and pack to leave.
4:30 PM	Evaluation – Questioner, then open reflections.
5: 00 PM	Leave Retreat Center

6: 30 PM Return to the Hospital

The Training Seminars

The seminars will be held on the first Tuesday every other month from 5:30 to 7:30 PM. These will be training sessions and reinforcement of principle explored at the retreat. There will be psycho-dramatic presentation and evaluations and discussions. The material in the appendix [58]will be used.

A significant piece of this training will involve the participant's input. As they self reflect and talk about their experiences their ego strengths develop and they will begin to understand the concepts of transference and counter transference. Other concepts like the observing ego will be introduced and the building of confidence in serving patients who are from other religious traditions will be one of the goals. I would like to add a fifth session, which would be dealing only with managing Psychosocial, Cultural and Spiritual Diversity.[59] This would be a cognitive session with a videotape presentation. My reservation at this time is due to the fact that there are many things I would like then to learn but this is not possible for people who are volunteering to commit so much of their time.

The bi-monthly meetings with a regular psycho-dramatic presentation and discussion will help to develop the clinical skills of the volunteers. This modality goes beyond what was started by J.L. Moreno in 1920 and is not limited to narcissistic need gratification[60] but allows for increased spontaneity. As they

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[58] See APPENDIX D to G

[59] Snyder, Sherry 1997 p. 1

[60] Hemenway 1996 p. 103

discover that irrespective of religious tradition of the patient or the volunteer – the pains felt and the loneliness experienced by anyone, these can be effectively responded to by any trained caring and compassionate human being. The religious tradition, while important, is not what the patient seeks for first – what they yearn for most is the caring, compassionate and empathetic human presence.

In these sessions the didactics will focus on what the volunteers must **do** to be of help; what they must **know** to be of help; what they must **say** to be of help and what they must **be** to be of help. They will be encouraged to read relevant literature and use the developing library in the department. Much attention will be given to directed listening and the use of silence.

Each session will conclude with group experience. This is intended to engage the volunteers experientially and reflectively, subjectively and objectively, affectively and cognitively, personally and professionally.[61] The small group discussions will help them to become more aware of themselves and also sensitive to the dynamics of the group. It is this self-awareness which is necessary for caregivers to be attuned, as they reach out to others and experience transference and counter transference.

Elements of an encounter group will be the dominant modality. The group is time-limited and the volunteers are not specially individuals but persons who choose to serve in the hospital setting. The goal will be both personal and interpersonal growth, openness and honesty in listening, sharing and learning. I as the director of the demonstration project will facilitate the group. It is hoped that as community and intimacy develop there will also be greater self discovery. The overall benefit will be less focus on the religious divides and greater appreciation

[61] Hemenway 1996 p. X

of the fact that all trained volunteers can make a significant contribution to the pastoral care of the patients irrespective of faiths, beliefs and traditions.

Methods of Assessment

Before the retreat and seminars and also at the end of the training series, each participant will be requested to describe their understanding of their responsibility and role as a pastoral care volunteer[62] . Their response before the beginning of the training will be compared with their responses after the end of the training. This will allow me to see how they have grown and changed over time and how the training has affected their perspectives and mission.

There will also be a questionnaire[63] which all will be required to fill out shortly after the close of the retreat. This is to assess the retreat-training program. The following scale will be used to assess the retreat training program: 4 = Excellent, 3 = Good, 2 = Fair, 1 = Poor. Following this quantitative response will be a qualitative evaluation. This section will have three questions, which will elicit information concerning each participant's experience relating to the retreat and training seminars.

The verbal responses and the general response of the volunteers will also be used as broad indicators of satisfaction or dissatisfaction with the program, process and training. Listening and observing on the part of the director will not be overlooked.

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[62] See Appendix A

[63] See Appendix B

A final assessment will be given after four training seminars following the retreat. This session will bring to a close the training of these volunteers to serve all patients irrespective of the volunteers or the patients' religious beliefs or practices.

Chapter 4

THE RESULTS – QUANTATIVE AND QUALITATIVE

The Retreat Experience

The retreat took place at the Baileys Farm in Ossining New York on October 24, 2002. There were sixteen participants (10 women and 6 men).

Four Seminars were conducted after the retreat in the Social Work Conference room and the Solarium at the Woodhull Medical & Mental Health Center. These were held every other month and we met for two hours (5:30 PM to 7:30 PM) on Tuesday afternoons. The attendance increased at the seminars and by then all the volunteers knew each other. The seminars would begin with the serving of supper. This would be for half an hour and it gave all participants the opportunity to renew and strengthen acquaintances. The meal was followed by a half hour didactic presentation on some aspect of meeting the patient's need and patient relations. A typed copy summarizing each training session is distributed at the close of each class. These are included in APPENDIX F to I. The final hour we spent enacting the Case assigned (volunteer visiting with patient as described in Case Study[64]). These sessions were a continuation of what was begun at the

[64] See Chapter 3 p. 49-51

retreat. The didactic presented at the Tuesday Seminars served to educate the participants and equipped them to move beyond religious cliché or other sterile pious ways of speaking with the patients. It also helped them as they did their role-playing during the psycho dramatic presentations. Some remarked that they felt they had become more competent and confident as they visited with the patients and as they put into practice some of the techniques they learned through the psycho dramatic exercises.

The qualitative data that I collected came from five assessment tools. The first is the Pre-retreat questionnaire in Appendix A. There was only one question. By this I sought to discover what each participant did when they visited with patient prior to the retreat and training seminars. At the close of the training the same questionnaire was given to the participants and a comparison was made to see if there was any significant change and or growth. During the morning session of the retreat a questionnaire was given[65] they were asked to indicate that which was desirable and undesirable to them when they experienced illness. This was intended to help each participant enter the experience of the patients they visit. This collection of personal responses formed some of the qualitative data used in

[65] See APPENDIX E

this demonstration project. At the fourth Tuesday training session the final evaluation was given. It was the same as was given before the training began.[66]

The Gathering

Most of the volunteers live in the neighborhood of the hospital. While many are within walking distance others either take public transportation – the bus or the train and a few drive or are driven to our meeting site in the lobby of the hospital. All were invited to be in the lobby before 7:00 AM since that was the time for our planned departure to the retreat center. By 6:30 AM the first two persons arrived. They were both excited and expressed this verbally. They stood at the main entrance looking for others. Four more arrived in the next ten minutes and inquiry was made as to who would be attending. The next three who arrived indicated that one volunteer would not be able to attend because her husband was feeling ill.

It was interesting to see the response. Even though some did not know the individual who was not able to attend, all expressed their sorrow. The mood I felt was one of anticipation – this was personal as well as the sense I felt among those

[66] See APPENDIX C

present. Two of the volunteers ask to be excused so they could telephone a mutual friend to ensure she would be on time. They reported that there was no answer to their call and they expressed the hope that she was on her way. With ten minutes to the time of departure I sensed a bit of agitation from some. This was expressed by such expressions as "I hope she/they get here soon". Every person who arrived during the last ten minutes was greeted with cheers as though each had crossed a finish line after running a race. The jubilation was punctuated with apprehension as someone would mention the name of an individual who had indicated their plan to be in attendance.

The arrival of the bus at 6:55 AM created its own excitement. All were disappointed that a school bus rather than the expected Coach was to be the means of transportation. Each person gathered their possessions and all boarded the bus. The food supplies and the material to be used at the retreat were all carried on to the bus. It was decided that we would wait until 7:15 AM before we departed. This would be done to accommodate anyone who might be that late in arriving. Only one person arrived five minutes after the originally planned time of departure. She apologized and expressed gratitude for our waiting.

Inasmuch as I try to keep to times decided upon, that morning I was the least anxious about time of departure. I wanted to accommodate possible latecomers by extending the time for departure. I may have shifted my anxiety to the

numbers in attendance rather than the promptness in attending. When the time of departure arrived, I joined the group in scanning the area as the bus pulled out of the hospital premises. With mixed emotions we left the hospital. I had hoped to have at least twenty persons present.

Sadness was expressed that others could not make it. It was revealed that four persons had to be at their place of work in the city. This led to comments about jobs and talking about taking or getting "time off". A couple of others had not indicated whether or not they would be attending the retreat and regrets were expressed for the woman who husband was ill and so was unable to attend.

The Retreat Center

At 8:45 AM we arrived at the retreat center. Everyone helped with unpacking the bus. When all the supplies were brought into the building and placed in their respective area, the group gathered in the common room and were given information about the layout of the building and where to find rest rooms and the meeting areas. The building was an old stable - belonging to a manor house complex, which was converted into a residency with two floors. The retreat activities took place on the first floor. The large den or common room had sofas, lounge chairs, rugs, a fireplace, tables and easels. It was here we conducted most of our activities. This environment enabled us to create a very informal and warm atmosphere, which was comfortable for all.

Warm soup and crackers tempered the brisk fall weather. This was prepared in the well-equipped kitchen by some of the volunteers. When it was time for this first meal all gathered in the dining area and each person served him or her self. Those who had wandered outside - to view the lay of the land, returned to partake of the nutritious and body warming soup. While we ate music was played on the CD and Tape player. Each participant was requested to select and bring along a recorded piece of music, which held some significance for the person who brought it. After each piece was played the provider was invited to tell why that music was chosen and share anything else which was meaningful or significant about the music. I collected the cassette tapes and the CD from each person while we were en route to the retreat center. Each was labeled – the name of the person to whom it belonged and the title and number of the selection to be played. They were not kept in any special order and would be played at random. It was significant to me that three individuals stated, "I do not know if that is like what you want". They appeared uncertain and apologetic. I reminded them that all that was requested was for them to share some piece of music they liked or enjoyed. There were three different responses. One said "there are other music that I like and have ". To my inquiry why did you choose this one? The reply was, "I think the others would like this better." I found it significant because her concern was about what she perceived others would like. I inquired as to how she came to decide on what they would like and her response was "I

guess they are all Christians". This response gave me a feeling of satisfaction. I thought that if for this reason alone – to point out the dangers of assumptions, this retreat would be worth the effort. Not all were Christians. One individual was Muslim.

The second person indicated that hers was not church music. She was assured that whatever she chose was good and acceptable. She heard the request and responded. She did not let her "self" get crushed by the concerns of others likes or dislikes. I was impressed by the fact that she was able to hear clearly and respond appropriately. Here again would be material useful in the training process. The "tight rope act" was to be able to use all these incidents as learning tools without anyone feeling condemned in the process.

The third person indicated that he had a number of CDs with him and I could choose the one I considered most appropriate. This provided me with another teaching tool. He had many favorites and was prepared to be accommodating without a loss of self-identity. The idea of "most appropriate" was not missed. I asked him "most appropriate for whom?" It was pointed out that the choice in this case was to be made by each participant. I felt that there was an underlying fear of being judged. As we had this honest dialogue there appeared to be a sense of relaxation and a greater degree of freedom. He then chose one of his collections to be played at the appropriate time.

I explained that music, which was brought by each person, would be played at special times and this would give us an opportunity to hear different types of music. It was pointed out that taste and styles differ and it is a healthy person who is able to co-exist with differences. We are a microcosm of the patients we will be serving. They have many and varied tastes, and as we seek to serve them it becomes necessary to be able to stay with that which is different and unfamiliar.

The first piece of music that was played was familiar to all – Amazing Grace How Sweet the Sound. There was a quiet buzz and a few would hum a phrase or two. The second had a Caribbean beat with religious words. There was a higher level of energy felt in the room and one could see more bodily movements. The third selection was in Spanish and the Hispanic participants with one accord joined in the chorus. The fourth selection was in Arabic with distinctly Middle Eastern tones. The response written on many faces was that of a question. "What is that"? Clearly most of the volunteers were not familiar with that type of music. All listened with keen interest as we got a mini lecture about the music. The Middle Eastern sounds created the most interest among the musical sounds heard in the morning.

After the meal of soup and crackers we all gathered in the large common room for the first formal meeting of the day. Each person chose a seat in the big circle and the group members, instead of introducing themselves to the group were

invited to share as much as they wished about themselves with the person to their right. The person in turn would do the same. Before we began the introductions, the objectives of the retreat were presented and we established the ground rules.
See Chapter 3, Page 43

The seating arrangement was unstructured and the order of introducing ones partner was also unstructured. The intent was to minimize controlling the group as much as possible. Each person spoke when they chose to do so and no one was locked into a sequence so all were free to listen to the others and then speak when they chose to do so. All were invited to "listen carefully as each partner spoke, listen just as we should to the patients as they share their own stories." The group was also invited to focus on sharing information about themselves – who they are and not focus on what things they did. After each person was introduced all were given the opportunity to add any other information they wished to share.

Observation

It was interesting to observe the keen interest paid by each person as the other individual introduced him or her. The reactions were many and varied. Sometimes there were approving smiles, at other times there were disapproving shaking of the heads from left to right – as if to say, you have it incorrect. Some complemented their partner for doing a good job. Some reactions could not be

instantly interpreted: examples were when an eyebrow was suddenly raised or knitted. The group was often so intently focused on the speaker many may have missed some of the things I observed. Other interesting responses were "Oh that is lovely"; "Well, Well"; "Just like me". It could be seen that bonding was taking place to a greater degree. Participants began identifying with one another more and more and approving glances were cast. The strangers were becoming friends with common threads of identity. The religious divides seemed to have all disappeared or were all shunted – although not intentionally. It was the observation of the body language of some which prompted me to invite all or anyone to correct or add any relevant information after all the introductions were made. This had the advantage of correcting any unintended errors and making everyone comfortable.

The quantitative results on the evaluation forms submitted by the participants, rated the first activity – the introductions and getting to know each other better as excellent by 13 persons and good by 3 others.

The next activity took everyone back to the apparent religious divides. This was intentional. For the participants to be truly effective pastoral volunteers they must be able to live with tension. While the sharing of their history and who they were was without the divisiveness of religious traditions; for completeness, the religious component must not be neglected. The knowledge of and respect for

other rites and ritual, which are different, sometimes strange or even incomprehensible, is important, if the volunteers are to effectively serve in this multi cultural milieu. The previous exercise had the effect of connecting the group together and this building of trust made it easier to not be as critical or resentful to that, which was new and different. Each opportunity to form connections with others made the group more cohesive and tolerant of differences. I felt very comfortable and felt the honesty of the participants. All were engrossed in the activities.

It was now the time for prayer or meditation. Everyone at the retreat had prayer as part of his or her religious ritual but the manner or ways of praying were different. There were some who were accustomed to reading set prayers, others prayed spontaneously, others prayed in chorus – many persons praying at the same time. There were those who chanted their prayers and nasal intonation was part of the ritual for others. They were also different postures assumed during prayer. Some were accustomed to kneeling, others stood and genuflected – swaying, bowing movements back and forth. Interestingly, the volunteers who, as a part of their religious practice, prayed with persons only of their religious faith - did not attend the retreat and I wondered how they would have reacted or fitted in.

The transition from sharing of information about each other and introducing one another; was done with music. This was followed by a brief acknowledgement of different styles of praying. The playing of two different pieces on a CD player – one was a Tibetan Buddhist chanting of the OM and the other was the chanting of prayers by Christian monks in a monastery. These were used to set the mood and the centering of the self. All were invited to stand and were led through a Yoga routine and focused on breathing followed by Guided Imagery. A very quiet Meditation type music was played in the background on the CD player and I guided the imagery with the words, which follow.

> *"Each of you choose a comfortable position. You may sit, stand, kneel, lie on the carpet, just find a position that you feel comfortable. Take a few deep breaths and imagine you are basking in a calm and serene environment. Let go of all your anxious thoughts, release the tension and tightness in your body, and relax. Let you body experience a sense of rejuvenation, renewal and repose. Enjoy the invigoration and repose. Feel the peaceful calm letting go can bring.*

Imagine yourself in the company of a holy presence; note the smiles of approval you receive. Become conscious of your cleanness and the welcoming environment. Feel the gentle wind in your face, observe how it blows the lace curtains hither and yon. Imagine the holy presence inviting you to follow through pastures with flower in full bloom. The sky with thin clouds whisking by and at the end of the field you are led to a babbling brook under a wide spreading tree. Birds flit from branch to branch and at the foot of the tree on two stones you both sit. Then the holy one says to you. "I am with You. As often as you wish, come back to this place. I am with you."

This was followed by a few minutes of silence. I then asked if anyone desired to offer any additional prayers at this time, as we would wait for a few more minutes in silence. Within a few seconds two persons began spontaneous prayers. One gave way to the other and after both had prayed one person requested all to join in the "Our Father". This was done and only one person was not familiar with that prayer. This session ended with a prayer in Arabic, to which many said Amen.

This session raised the consciousness of the group to the reality of diversity even in such a small group. It also revealed the evolution of trust when the majority said Amen for a prayer in Arabic, a language they did not understand and from a tradition that has had much negative press in recent times.

I asked the group to give me their reaction to this segment of the program. Many stated that the imagery was very relaxing and they felt as if God was present. Others indicated that often they just rushed into prayer and once they had spoken or made their request it was "time for the next activity". Another person said, "The breathing exercise and quietness was different". She was accustomed to many voices being heard during prayer. Another member stated that "not speaking, like saying thanks or making a request during this time of prayer felt like not praying at first."

The responses were open and frank and the majority found the initial activity of breathing and yoga movements as new, novel but helpful. There were two individuals who were silent and I could feel that they had some misgivings about the activities. They did not behave hostile but were very reserved and non-expressive.

The quantitative results on the evaluation forms submitted by the participants, rated the second activity – the yoga, meditation and prayer as excellent by 9 persons; good by 5 others and fair by 2.

The next activity was a continuation of writing. This was intended to be a period of "Reflections – When I was sick: Helpful and not so helpful memories." This was in preparation of the psycho dramatic enactments which would follow the

free time allowed to explore the area. Each person filled out a questionnaire[67] and after ten minutes the opportunity was given to share some of their experience, feelings and emotions about one such experience. Only three persons were able to speak before the time allotted had expired.

The next activity was an unstructured break for forty five minutes. All were invited to explore the grounds. They exited through three different doors on different sides of the lodge. Interestingly they all met together on the side that led to the lake. There were many other trails but they all headed towards the lake. I joined them but kept in the rear. I did not wish to influence their decisions and was also able to observe the group from this vantage point.

During this period of time they broke up into smaller sub-groups. It was noticeable that these groups would change in size and membership. From my observation there were four individuals who were the undeclared leaders. It seemed as if groups formed around them. Another point of interest to me was that one of the four leaders was also one of the two individuals who were very silent throughout the exercise of yoga and praying. This individual was not very vocal even when walking the trail to the lake. Even then she appeared to moderate the group gathered around her. It was obvious that a community had

[67] See APENDIX E

formed and the movement was very fluid as individuals interacted with each other. The religious divide did not manifest itself as all freely associated.

The first psycho dramatic presentation took place after the free time for walking. This first presentation involved three of the participants. One played the role of the patient and two were the pastoral volunteers. The persons playing the role of volunteers were Protestants by denomination. The room was re-arranged so that the group members could see the role players who were at the other end of the room. The patient was lying on a couch and the visiting volunteers were located on the side, which enabled us to see their faces. The patient lay between the group and them.

Role Playing – Psycho drama

Having entered the room and greeted the patient, both volunteers sat facing the patient. They identified themselves as volunteers from the pastoral care department and indicated that the nurse informed them that the patient was sad and might welcome a visit from the volunteers. The person playing the role of the patient responded:

Verbatim Case I

Patient: "I am angry at God and with everyone. My wife has filed a divorce which is pending in the courts. I am worrying about going life alone. I feel guilty about some of my past inappropriate behavior and misconducts. I am still in shock and I can't believe what has happened and I feel very confused."

Volunteer (male): You do not have to be angry at God. He will take care of you.

Volunteer (female): May be you could ask your wife for forgiveness.

Patient: I am so depressed and confused.

Volunteer (female): If you prayed to God he would forgive you.

Patient: I have not been in a church for such a long time and have even forgotten about prayer. My head is hot.

Volunteer (male): Are you having a headache or feeling pain?

Patient: I can't even describe how I am feeling. It is not like one place is hurting me. I just feel strange.

Volunteer (female): How long have you been feeling the way you do?

Volunteer (male): May be you need to try and rest some more.

Patient: I am sick and tired of resting. That is all I do. I need some relief from all this.

Volunteer (female): I can give you a Bible to read when you feel distressed.

Patient: A Bible cannot help me now.

Volunteer (male): What do you think will bring you comfort at this time?

Patient: I was thinking about that. Many thoughts rushed into my mind. I was

Volunteer (female): May be you should

Volunteer (male): (*To the other volunteer*) Why not let him finish, he is saying something. (*To the patient*) You were saying "Something rushed into your mind…"

Patient: I forgot what I was about to say. It wasn't important.

Volunteer (female): As I was saying…..The Bible and going to church would be good for you.

Volunteer (male): It may not be what he needs now. I too have had some moments, when, I too did not want to read anything – when I was feeling down and out.

Patient: (*To the male volunteer*) You understand how I am feeling.

Volunteer (male): I am not sure. You need to tell me more.

The enactment lasted about twelve minutes. After the spontaneous dialogue the participants were debriefed about their roles. The person who acted as the patient was asked how it felt to be playing that role. He responded, "At first it felt a little awkward but soon it was as if I were a real patient. I do not know how it happened but it was as if it was real." He went on to mention that he had two friends who went through a similar experience and remembers how they described their feelings of anger and resentment. In this dramatic presentation he guessed that he found himself caught up in the event as though it were his own experience. He went on to express that this was a real experience many persons go through everyday.

The observers all applauded and commented that they did a very good job. Some remarked that they also were caught up with his emotions and could identify with the moods, which such information elicited. One person said "I wonder how I would have reacted if I were in the patient's shoes?" Another said "that would drive me insane if I had to contend with that type of situation." A woman said "he brought it on himself so he should not be worried about what is going to

happen to him now." Some of the group members were engaged and ready to analyze the patient's feelings, situation and reactions. After noting some of the comments I pointed out that what we need to do was, to reflect on the volunteers' interactions with the patient.

I asked each volunteer to describe how it felt listening to the patient. The first speaker said that at first she felt nervous and was concerned about not saying the right things but as she looked at the group every now and then, she would always see someone nodding their head approvingly and soon that initial fear subsided. The other volunteer then expressed a similar idea but his first focus was sympathy for the man in his situation. As soon as he said that, I thought that there were more dynamics at work here more than I had initially thought about. The feelings of a man for another man caught in this situation might be different from that of a woman who might be looking through the eyes of the absent wife. I began wondering if this might get so defused that the objective of the training to keep the focus on the patient would be eclipsed by each person's emotional feelings. It then struck me that this scenario is ideal because it gives me the opportunity to keep the focus where it should be kept – on the patient and the presenting issue. It would also be an opportunity to point out the tragedy of assuming, judging and playing the role of the patient's counselor or advisor.

As they dialogued I had a strange feeling, it was a mixture of sadness and happiness. I was sad because as I listened to them, I realized that many well meaning volunteers often do more harm than good by the things they say. I was happy that this training could help to make a difference for many.

After the three participants described their feelings about the experience we replayed the recording and continued the process of evaluation. Before this was done I pointed out that it is not always a matter of being right or wrong but "is there a better way we could have provided pastoral care." Having said that I invited everyone to listen carefully to and focus on the patient's comments, which we had recorded. Listen not only to the words but to the feelings which underlie the words. They were reminded that in the actual visits we do not have the luxury of recording and replaying so it is essential to focus on the patient at all times. While we are focusing on the patient we must also be aware of our own feelings but keep it in check.

We then played the recording and invited the two volunteers to identify the feelings which the patient might be experiencing on the basis of his words and as they might recall from his body language and expressions. The other participants were then given the opportunity to share their observations. The many feelings evoked, seemed obvious once the attention was on the patient and his feelings. Many acknowledged that their natural mode was that of evaluating and judging

the rightness or wrongness of a matter or action. They were commended for recognizing that tendency and also reminded of its limited value in pastoral service to the patient.

As the rest of the interchange with the patient and volunteers was played the volunteer actors were able to point out the flaws in their interaction and I did not observe defensiveness from any of them. Over and over I would emphasize "put yourself in the patients place" and this seemed to have been helpful. As the volunteers made their observations they were supportive "true" or "yes" responses from the other group members. It was like a very supportive family gathering and discussion and there were no threats or intimidation.

The group then gave their reaction to the first dramatic presentation. The frank and open discussion included group processing in which members spoke about parallel personal experiences. One person spoke of not being able to deal with her feelings because of her fear of some church members who seemed to ignore some realities. It in turn caused her to suppress some things to her own injury. She expressed her own hunger for someone to just listen to her. That would have made a difference.

It was then pointed out that at no time was the patient's pain, grief or other feelings acknowledged. The patient was not invited to explore his options. The group began talking about divorce and related issues. After a few minutes

someone noted that divorce was not the issue. I concurred and reminded them that "it is not about us and what we think or believe, we are here to let the patient find his voice and explore."

It was now forty minutes since we began this session and the members were invited to write out what their reactions and feelings were about this psycho dramatic presentation. After five minutes of writing, a break was taken.

The responses to this first presentation were varied. One person was most concerned about the patient being angry at God. Another was wondering if the patient's plight was not a theological inevitability – God's retribution on the man. A number of the written responses after this presentation, indicated that they could now understand why judging was dangerous. They did not and still do not have all the facts about the man and his family issues and even then where is the compassion we all should show. Another individual noted that it is so easy to assume that our values are the values by which to measure others and he would be working to avoid such assumptions. Another person reflected that patients sometimes manipulate the staff to achieve their ends. For another person the whole problem was summed up in "the wages of sin is death."

The responses made in a self-reflective manner were those, which seemed to enter into the feelings of the patient. One person wrote, "I related to the patient as I felt the same way when my husband left me with two young boys and he

moved in with some young woman who could have been his daughter. We had never had a fight or anything. You can imagine my shock, disbelief and confused feelings also. I would attend church regularly but that did not save me from my troubles. It was a miracle I did not go off my rockers. If anybody came to me and told me any nonsense about - God and punishment or retribution for my sins, I would have driven them away. I could see myself in the patient." As I read this I thought that this would be useful when I spoke with the group about transference and counter transference.

Another person locked on to the feeling of loneliness the patient was experiencing. His loss was due to death of his spouse; the lack of social contact and the diminished relationship and the feelings of depression were things he could identify with. He felt that exploring options and reducing isolation would be ways in which the volunteers could better serve the patient in the first scenario. He also proposed challenging the patient to overcome the tendency to self-pity and would recommend increased involvement with other persons in more communal activities.

The final person was drawn to the worry and guilt the patient spoke about. This I would also bring to the groups' attention – everyone will do and say things differently and that is fine. This participant wrote about feeling so vulnerable and articulated the burden of remorse she had felt in previous situations. She spoke

about avoiding any easy reassurances, being generous toward others and letting go of irrational guilt and unrealistic expectation of the self. Finally she identified self-punitive and self-condemning attitudes as not helpful for the patient or the volunteer. These comments by the participants provided me with the opportunity to piggy back other ideas on those presented. One such concept was that of guilt being linked to early childhood experiences; of not being good enough for total parental acceptance and affirmation.

The increasing consciousness of how one's self can influence a process was seen in the remarks of one individual who indicated that in the process of listening and observing the drama she would get lost in thoughts. As she listened to the patient's story she was not sure sometimes which experience was activating her feelings. Was it that of the patient or her own story, which was parallel and so, close to his? The temptation to say, "I know how you feel"[68] is ever present but must be suppressed. Every story is unique and the temptation to try and fix it for others can often yield baneful results.

It was observed that the psycho dramatic presentation had some serious limitations. There was the anxiety which was brought on: of not making mistakes, saying the wrong thing, sounding foolish and being ridiculed or laughed at by others. There was also the reality of looking at things through the lens of the

[68] See APPENDIX F

teachings of one's religious tradition. There was also the fact that it seemed as if many different issues were presented in just the opening sentences of the patient. One person said, "Where do I begin? Is it the first thing that is said that is important or is it the last idea?" The complex and multifaceted outpouring of the patient seemed to arouse many emotional feelings. I reminded the group that acknowledging the overwhelming and complex nature of his experience is all that they could do; at that time. And for him such recognition might be enough.

The results of the quantitative written evaluation of this the first psycho dramatic enactment ranged from eleven persons rating it excellent; five giving it a good and one person rating it fair. I suspect that the individual who still voiced opposition to the psycho dramatic enactments as a useful and relevant tool, rated it fair. Blatner indicated that there would be those who would be defensive to psycho drama as a clinical technique and process.[69] The first discussion was similarly rated - eleven persons rating it excellent; five giving it a good and one person rating it fair.

Lunch Break

After completing the evaluation of the psychodrama and the discussion we adjourned for lunch. There was much excitement and commendation as we all moved to the kitchen and dining area. The aroma of soup on the stove, bread and

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[69] Blatner 1988, p. 2.

pies in the oven wafted through the building. Everyone had an opportunity to participate. Some set the tables, others got the juices and tea ready. Those at the stoves kept the food from being burnt. The varying colors of the foods were only rivaled by the fall colors of the beautiful trees surrounding the building. The glass, which separated us from the outside, provided us with a clear view of nature's serene, pastel and varying hues. The music in the background changed in beat and tempo as well as in tone. A different person provided each piece and their taste was reflected in the sound. A fireplace enhanced the rustic setting. When the fireplace began to crackle it was like a magnet drawing iron fillings in concentric circles. Only the cry of hungry stomachs overcame the magnetic field of the fireplace. Each person served him or her self and a restrained buzz could be heard as the meal was consumed. An inquisitive deer with her fawn in tow, stopped by at a safe distance, and she could be seen by all. It seemed as if they came by to inspect the city folks who earlier had traversed the grounds. It was a courtesy call, which was acknowledged with smiles. Not assured that a licensed hunter was in our midst she was not beguiled by the smiles and as quickly as she had put in her appearance, just as quickly she said her good byes. We were grateful and after the hearty lunch many went outside hoping she had left a trail to her den – but no such luck.

The lure of the fireplace was too much for some to resist. With a well quenched thirst and a satisfied appetite many sunk into the sofas and arm chairs which

graced the area. It was not long before two had fallen asleep and one provided a raucous refrain with his snores. It seemed as if everything conspired to bring the group together. There was no odd one or drifter. All were part of what appeared to be a seamless fabric – pastoral care volunteers.

All agreed that the food was excellent but I realized that while it was very good it was too much. Next time the volume would be less. Everyone was ready for a siesta after the heavy lunch. There was soup, lasagnas, meats, bread, roll, pies, cake, cookies, fruits, juices, tea and water. After the meal some had moved to the kitchen where they quickly cleaned up all the pots, dishes and utensils. That activity was not enough to ward off the arms of Morpheus, which seemed to have embraced most persons.

Psychodrama – Case II

The second psycho dramatic enactment was presented after lunch. As with the first, three other persons volunteered to participate. One would play the role of the patient and the other two would be the visiting volunteers. My original plan was to have one volunteer visit with each patient but just before the first case enactment the idea came to me that with two volunteers acting together there would be less anxiety, timidity and fear. There would also be a supportive feeling among them and greater participation would occur since the time was limited. The first enactment went well and so I will use this format for training. In real life

experience it may also be an ideal to work for, except that the volunteers come at the time that is convenient to them. Whenever possible I would encourage them to work in pairs.

The person who was to play the role of the patient was given her part which she read and after a few minutes she took up her position on the couch which was to be her bed for the enactment. The volunteer came in after permission was given. The woman took a seat and the gentleman remained standing.

Verbatim Case II

Patient: *(Patient is not looking at the visiting volunteers. She lies on her back looking up into the ceiling)* "I grew up in a very religious atmosphere but something happened. In the church!! I sometimes feel like killing myself for what I caused to happen. *(She talks without making eye contact.)* I feel hopelessness and guilt. I do not sleep well at nights. I told the social worker what I think I remember I went through. *(Self- report of sexual abuse.)* I really do not know who to trust. These strange vague memories of inappropriate sexual contacts in early childhood haunt me day and night.

Volunteer (male): We are here and can pray for you. We are from the pastoral care department.

Volunteer (female): How best could we be of help to you?

Patient: I really don't think anybody can help. I just want to kill myself.

Volunteer (male): That would be committing suicide and God could not forgive you if you did that.

Volunteer (female): You must feel very frustrated and perplexed?

Patient: I am a bad person even though I was gong to church.

Volunteer (female): Is that really how you feel?

Patient: That is how I think God looks at me. At nights I have all these horrible dreams.

Volunteer (female): Who else have you spoken with about this situation?

Volunteer (male): You need to pray and get God's help and forgiveness.

Volunteer (female): Many times a trained Therapist or a Psychiatrist could offer you some valuable help.

Patient: I do not trust those people.

Volunteer (female): Is there anyone you feel safe trusting?

The woman who played the role of the patient played her role with great emotion and deep feeling. The interaction between the patient and the volunteers went on for about ten to twelve minutes. The dialogue seemed to flow as if scripted and the "make believe" seemed real. I could sense a greater level of composure among the actors and a willingness to be vulnerable.

In the first case study the participants were invited to share their thoughts about the enactment once they were through but after this demonstration I did not open the discussion. The participants began to talk about how they felt.

What was notable in this presentation was the difference between the male and female volunteer's responses to the patient. The male volunteer sounded overbearing and judgmental while the other volunteer – the female, seemed to

move to the feeling of the patient. It was as though she sought to counteract the other volunteer without rebuking him. She kept the focus on his feelings and needs while the other volunteer sought to use his standards and theology as the "yard stick" against which the patient was measured or directed.

This observation – the female was more attentive to the feelings, may be taken to be a universal truism but many men are also sensitive to the feelings. It could have also been the reverse. It is also interesting to note that without proper training it is easy to be locked into a pattern of responding and communicating and be ignorant of or ignore other ways of responding.

One member of the observing group acknowledged that the responses of the male volunteer were a mirror image of her normal responses to the patients. She also expressed satisfaction that she is able to be here to learn better ways of becoming a more effective pastoral care volunteer. I felt very good and this assured me that the time was not wasted having this retreat and training. A lively discussion ensued about how one's theology affects one's words and actions. The male volunteer was doing his part and giving his response with sincerity. It was this type of honest response to the patient that is useful in training volunteers to become more effective. As they hear themselves and hear the response of others to their comments, they can become more conscious of the need to be properly trained. A well-trained volunteer will be able to meet and work with someone

who does not hold or have the same values or value system and still serve them in a caring and compassionate manner.

It was pointed out by one of the observers that in as much as she believes in God's power, in matters like suicide it is best to also seek professional help. I confirmed this observation and used this opportunity to emphasize the interdisciplinary nature of care giving. All were informed that it was important to share certain significant information not only with the Chaplain supervisor but also with the direct nursing staff.

A short didactic was conducted at this time distinguishing between a pastoral and social visit. The difference between them is the point of focus. The pastoral visit focuses on the person and not on general external subjects or events. The pastoral care giver accepts the tension as it arises and is not there to make it better by maintaining a congenial atmosphere. The comfort provided by the pastoral person is one which helps the individual in facing rather than avoiding or denying. Generalizing and universalizing realities should not eclipse the patient's role of reflecting, thinking and feeling. The facing of reality – what is, is not replaced with, what ought or should be. Instead of entertaining, the movement is towards deep intimate sharing. Instead of focusing on religion and the differences in denominational polity the focus is on God and the relationship we have with the Divine.

Using the first response of the volunteer in this case presentation - "We are here and can pray for you." I encouraged them to do their praying before the visit. Not everyone welcomed prayers. Empathy rather than sympathy was what people appreciated. As much as possible leave your curiosity, issues and problems outside. Listen with the ears of your heart and be observant of the patient's body language. This is possible only as one maintains appropriate eye contact.

They were encouraged to let the patient talk more and then they should reflect back what they say to help the patient go deeper into their feelings. It is these feelings expressed by the patients, which can be explored. By so doing the patient is enabled and encouraged to make their own decisions and the volunteer is not making decisions for the patient. At times it may be appropriate to briefly share something about yourself with the patient. Be careful not to try to fit things using yourself as the standard.

Finally they were reminded to keep in touch with their own feelings, so they would not enter into those of the patients. Last but not least Psycho social, Spiritual and Multi-cultural differences must always be recognized and respected.

At the close of that brief didactic one of the participants added "avoid medical diagnosis and advice." This led me to ask the group if there were any other things we need to take into consideration? The responses were, "do not talk too much and ask too many questions", do not try to convert people"; "do not judge the

patient", "do not be arrogant or rude even when some of them can be nasty to you", "do not stay if the patient wants you to leave". The more they shared their ideas the more participants joined in the discussions and reflections. Again the time for this session had come and some could not make their contribution.

Psychodrama – Case III

The third and final case dramatization for the day was done differently. There are ten cases, which would be enacted by the volunteers before they completed the training program. On the retreat the first two were enacted. The third case was scripted. This involved two volunteers who would simply read the script through and then dramatize the scene while reading the text. This was done in order to give the entire group an opportunity to see a model, which could help them.

In the first two presentations they did their own improvisation and we all discussed the enactment. This time they are given a model, which they will also be able to analyze and criticize. During the bi-monthly meetings the other cases will be used in the other psycho-dramatic training sessions. Two persons volunteered and I read the information about the patient's background. The psycho-dramatic presentation then followed.

Verbatim Case III

Background of this patient:

He met you in the visiting area and when you told him that you were Volunteer Chaplains he requested that you visit with him in his room the next day. You checked with the volunteer who also visits that floor and got some information about him. He is a 40-year-old male who has held membership in different denominations. He is the father of two boys (12 and 14). He is divorced and acknowledges he has AIDS. He has been in and out of the hospital recently a number of times. He has a picture of his lover and another of his two sons on the wall in his room.

Volunteer: (*Raps on the closed door. No response. Knocks again. As you are about to leave, the door opens.*) Good morning Mr. A. is this a good time to visit with you?

Patient: I did not feel like talking now. I am not feeling like my real self.

Volunteer: Then may be I could come back tomorrow since I will be on duty. That would be no problem with me.

Patient: (*Pauses for awhile*) Ok! Let us make it now. Ok, come in. you can sit on these seats by the foot of the bed. Can I get you a soda?

Volunteer: I recently had a heavy breakfast. Thanks for the offer.

Patient: Is it that you are afraid to drink from me?

Volunteer: Oh no. As I said I just had a heavy breakfast.

Patient: If you change your mind let me know. I will get you something to drink.

Volunteer: Thanks. I would let you know. (*Pause*) You mentioned that you were not feeling your real self.

Patient: You want to know the truth. I am sick and tired of everything.

Volunteer: Can you tell me why you seem so angry and upset? Maybe if you talk about it that might help.

Patient: I have my doubts about that but what the heck! People think I have AIDS but I don't. It is just that I am run down and I have not been able to fight this infection. My immune system is a little weak. I have been here five times now.

Volunteer: You really sound upset.

Patient: Of course it is upsetting to me.

Volunteer: Why?

Patient: Why? You know why. (*Pause*) I have AIDS. (*A blank stare is on his face*)

Volunteer: This must be frustrating. I would like to help you through this.

Patient: This has been hard for me. I have AIDS. I am gay. What else?

Volunteer: What else?

Patient: I have always tried to please everybody but I suppressed my feelings. I got married and had the boys but the marriage did not work. It is like I always knew I was gay but could not admit it to myself.

Volunteer: That sounds like you had a great struggle.

Patient: O yes! When I "came out" all hell broke loose. My wife, my family, everybody was "up in arms". Now they have calmed down but then it was hell. I was in some bad relationships but my present partner is wonderful. It is crazy! How did I end up like this? Am I being punished for being honest?

Volunteer: Punished by whom?

Patient: Everybody, my family, my friends. Some of my family members come often but my mother she drives me insane. She is always prodding me. She says I need forgiveness from God and I need to make it right with Him. I think that is a lot of "bulls". I do not think God cares one bit. There is too much going wrong on earth to thinks that a God is up there and even cares.

Volunteer: You seem to be not only angry with your family and friends but also with God.

Patient: You believe God gives a hoot? I used to go to church and was in all sorts of bible study groups. Now I do not want any part of that. Look at all the heck of a suffering – not only myself but there are a whole lot of others like me. Look at all the suffering, not only older people but children and babies; young adults and others suffer. This God stuff is sheer crap.

Volunteer: This is a tough time for you. It seems as if you feel forgotten by God.

Patient: You are sure right. I feel alone and abandoned. I used to believe in God and attend church but not anymore.

Volunteer: Mr A. in the book of Psalm in the 88 chapter the psalmist utters sentiments similar to your. May I read it?

Patient: Ok. I would like to hear it.

Volunteer: *(I read the Psalm and he had his hand at his jaw the entire time.)* The writer of this chapter sounds as if he was in deep trouble.

Patient: *(Shaking his head and crying)* I am tired. Could you leave the Psalm with me for a day or two?

Volunteer: Yes. I can do that. I will be back tomorrow.

They all cheered when it was completed. The individual who played the role of the patient was asked to describe how it felt as the actor of the sick individual and as the one receiving spiritual care. He acknowledged that if he were the patient he would feel embarrassed, resentful, angry and frustrated. He would also feel ashamed about contracting AIDS. There would also be anxiety for his children and be concerned about what "church people" he used to worship with would be saying. The last thing he would want is for anyone to come preaching to him.

At first he felt defensive and then surprised that the volunteer did not attack him nor condemn him. He was also happy that he listened to him and constantly focused on how he- the patient, was feeling. Acting out the part was easy as it drew upon emotions with which he could identify.

The individual who played the role of the volunteer indicated that playing the part was easy and reading it was not difficult but the responses would not have been those she would have given. She was also surprised at the way the responses were framed in a very disarming manner. It allowed the patient to feel heard, cared for and listened to. She said, "I would really like to be this skillful".

She indicated that her first natural response was to judge the patient and speak about God's judgment on iniquity. "It will take discipline not to try to weigh

others in the scales of my religious beliefs." The more she thought about it the more she saw that more was achieved by the responses she read than by those she would have made spontaneously.

The other volunteers were invited to share their thoughts. Almost everyone echoed the sentiment that they all responded to the case internally, from their church's theology and teaching. There were many issues that were raised and just to try to discuss any one of them would lead to heated debate and no unity or consensus. Three persons for three different reasons felt more compassion for the patient and could hear his pain more quickly. One indicated a close family member had contracted AIDS and the feelings and attachment to the individual was stronger than the condemnation for the relative. Another spoke of his child "coming out of the closet" and the family dislocation it caused, but in the midst of this his greater fatherly love has not waned. The third person spoke of the pain it engenders when one is out of step with the norms of a community and the feeling of loneliness one experiences. As the director I pointed out that these were great observations and these related to some topics we would discuss in our bi-monthly meetings. The title of this issue was called Transference and Counter transference.

There were some dissenting voices. One stated that it seems almost as if one is turning a blind eye to wrongdoing if one says nothing about moral behavior.

Another stated that this was where the Christian volunteer came in. He was to help save these souls lest they died in sin. The third person explained that having gone through a divorce and seeing how this case is so close to hers, she had little pity for the patient.

The first two dissenters were asked if they felt the response in the script - of the volunteer to the patient, were helpful? They both agreed. Then they were asked if they thought that confrontation using different value systems would have been more effective and again they both agreed that confrontation would not be helpful. All came to the conclusion that it will take training to help them to be that tactful and skillful.

The third dissenter was commended for recognizing and acknowledging her own biases and encouraged – as were all other participants, to try to be aware of such interferences. One member of the audience mentioned that she had stopped listening to the patient at one stage because she had become emotionally enraged by the patient's divorce and his gay relationship. This was because of situations in her life and the hurt it revived in her memory.

It was noteworthy that even though our group was small, the patient had caregivers who were supportive of him and others who were not as supportive. They had different reasons for giving or withholding their support. One person's response was, "one must love the sinner; in this case the patient; but not the sin –

his divorce, gay relationship and his activities which led him to contract AIDS." Here I pointed out that we do not know all the mitigating circumstances and therefore cannot and should not judge.

During this debriefing a few persons acknowledged that this model presentation really helped them to see how different their approach to visiting with patients has been. One said, "Now I can really see what you mean when you say it is all about the patient and not about us, the caregivers." Another person indicated that if this had been a real person she had met, she might have not seen the patient as the patient but as her brother-in-law and her anger and resentment towards him might have made it impossible for her to be the volunteer pastoral care giver she was called to be. The participation of the observers was spontaneous. Each told personal stories with great feelings. They spoke freely and openly. I watched with bated breath as they all interacted. They were a caring, trusting and open community. They had moved from discussing Case III in simple clinical terms. They were seeing the case as a mirror image of their own lives. The case was a vehicle for becoming aware of their personal and inner feelings and emotions. When the time allotted had expired, I brought this session to a close.

The break and snack time was followed by the closing activity. All were invited to fill out their evaluation forms. From the quantitative data, 14 persons rated the third psycho drama excellent, 1 rated it good and 1 rated it fair. The person who

gave it a fair also wrote a little note. It stated that "for all practical purposes it will take some time to move from the position of feeling that saving a person's soul is the most important work a volunteer can help in doing. During a person's illness it is one of the most susceptible times to get people to make decisions to serve God." Another person commented that she was happy she did not have to participate in the dramatic enactment during the retreat because of her shyness. She is able to give the Eucharist and help people to attend the Mass because it does not involve much more than her doing those things. At a later presentation I pointed out that "being with and listening to the patient is the most important role we can play." It requires us being still and attentive.

As we were closing one person remarked how it was interesting to see different movements taking place in the last enactment. The patient makes contact, and then withdraws. Then he opens a bit and seems to be evaluating the caregiver. Finally there seems to be a feeling of safety and trust develops. During the entire process the volunteer pastoral caregiver keeps attentive focus on the patient. Another remarked "don't worry, one of these days we will master the art."

It was as though they wanted to discuss the case some more. Now most persons were standing but still talking about the scene. One person spoke about her own feelings of insecurity and being judged by others and how difficult it is to be open. She commended the volunteer for being so patient with the patient.

Another person stated that it would be good to get to play the role of both the patient and the caregiver at sometime. It is as we try to see and hear from both perspectives we can become better at our work. One said we would be as good as the Chaplains and another chimed in, "Maybe even better". I could not resist saying. "That would be wonderful. Our patients would be thus better served."

Another person stated that these enactments really give us an insight into who we are. As we see the real self at work - which has some dark spots, we are better able to develop and become what could be considered a more wholesome self. Another pointed to the fact that "if we could forget religion and denomination and all that stuff when we went into the patient's room and simply visit each person as a human being with feelings which could be responded to, then we may be able to connect more readily to the patients." The response to that by another person was "no, you can't do that. That would be denying the truth. That would be phony." At this point I interjected. "In this our training, no one is asked or required to deny your particular tradition. Your theology informs your action but it is not for you or any of us to project ourselves and our beliefs, rites or rituals upon the patient." At a latter time I mentioned, that we should be aware that there will be patients and circumstances which will challenge us and for which it would be better that other persons provide the care needed.

The Training Seminars

The momentum set off by the retreat at Baileys Farm was so high and the enthusiasm so great that attendance at the bi-monthly seminars was almost 100 percent of the registered volunteers. A light supper was always provided so that those who were employed did not have to worry about preparing an evening meal. The hospital provided a delightful and attractive meal for all the sessions. After the second session I shared with them the idea of having a fifth session but stated it is optional. The response was "we will be there". The attendance at that session was again almost 100 percent of the volunteers.

Except for the last session, all four seminars followed the same format of psycho dramatic presentations, reflections, observations and group discussions. A didactic presentation was also made. The process was similar to those at the retreat. The difference was in the level of comfort and improvement of their listening and communicating skills.

There was also a significant development in the over all working relationship of the volunteers. Emotional and spiritual maturity was manifested in their interpersonal relationships. I made a systematic and conscious effort to commend them individually and as a group when I saw progress. It was interesting to note that the issue of authority did not arise at anytime. There was also a constant attempt to integrate the theory and practice and the interaction of the volunteers

with the patients indicating their learning experience was translated into better patient interaction.

Chapter 5

DISCUSSION AND IMPLICATION OF THE DEMONSTRATION PROJECT

The response of the participants to the Retreat and Volunteer Training Program will be evaluated in this chapter. Both the quantitative and qualitative data will be evaluated. The implications will then be discussed.

The consistency of responses between the quantitative and the qualitative results will be analyzed, evaluated and addressed. The results and data will reflect whether the individuals felt they had or had not gained from the retreat and training experience. It would also reflect if the participants perceived the development of a community. I will analyze the responses in connection with the presenting problem. By so doing I will ascertain whether or not the analysis is congruent with the presenting problem. It will also determine if the analysis is congruent with the stated objectives of this project.

The application of the religious and clinical principles will be discussed in conjunction with the analysis of the data. Then to conclude, I will explain the contributions of this demonstration project to the wider context of pastoral

ministry and the implication for use in any community with a multi-cultural and spiritually diverse population.

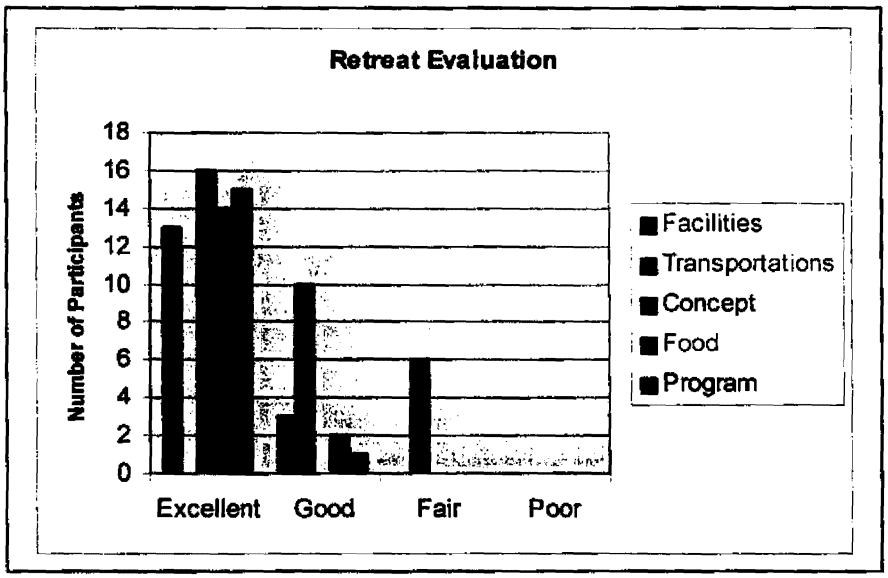
This chapter will be divided into three sections. The first is the Retreat Experience and refers to all that related to the time and activity at the Baileys Farm Retreat Center. The second section is the psycho dramatic enactments and group process. In the third section I will bring together the first and second sections to explain the present and future implications of this project.

The Retreat Experience.

The quantitative results from the evaluation forms indicated that most of the participants rated the activities very favorable. They evaluated the facilities at the retreat center, 3 persons rated it good and 13 persons rated it excellent. The transportation, 6 persons rated it fair and 10 rated it good. The concept of the retreat all 16 persons rated it excellent. The program at the retreat, 2 persons rated it good and 14 rated it excellent. The food service, 1 person rated it good and 15 persons rated it excellent. See Graph #1:

The transportation did not get any excellent score in these evaluations and this was due to the vehicle the transportation company sent. There was a misunderstanding in the communication between the hospital transportation department and the bus company. Instead of a Coach the company sent a school

bus and we all were disappointed. The time the bus arrived and the time for departure would not allow us the opportunity to wait for a replacement and so we all boarded the bus and got to our destination. The driver losing his way twice did not help the situation.



Graph # I

Driving for two hours on the school bus is even more uncomfortable for adults. A number of these persons were in their middle years and the rigid seats were not comfortable. The lack of toilet facilities on the bus was also a concern for me but we realized that the alternative – to wait for a coach to come for us, would deprive us of precious time. This would also reduce our time spent at the retreat center.

The responses to the other questions were fairly consistent. One of my objectives for the retreat was to create an environment that was open, inviting and non-threatening. By conducting it away from the hospital the participants got an opportunity to get a ride upstate during the fall - when the leaves display their resplendent hues, and it provided an opportunity for them to relax in a well run, equipped and maintained Lodge and retreat center.

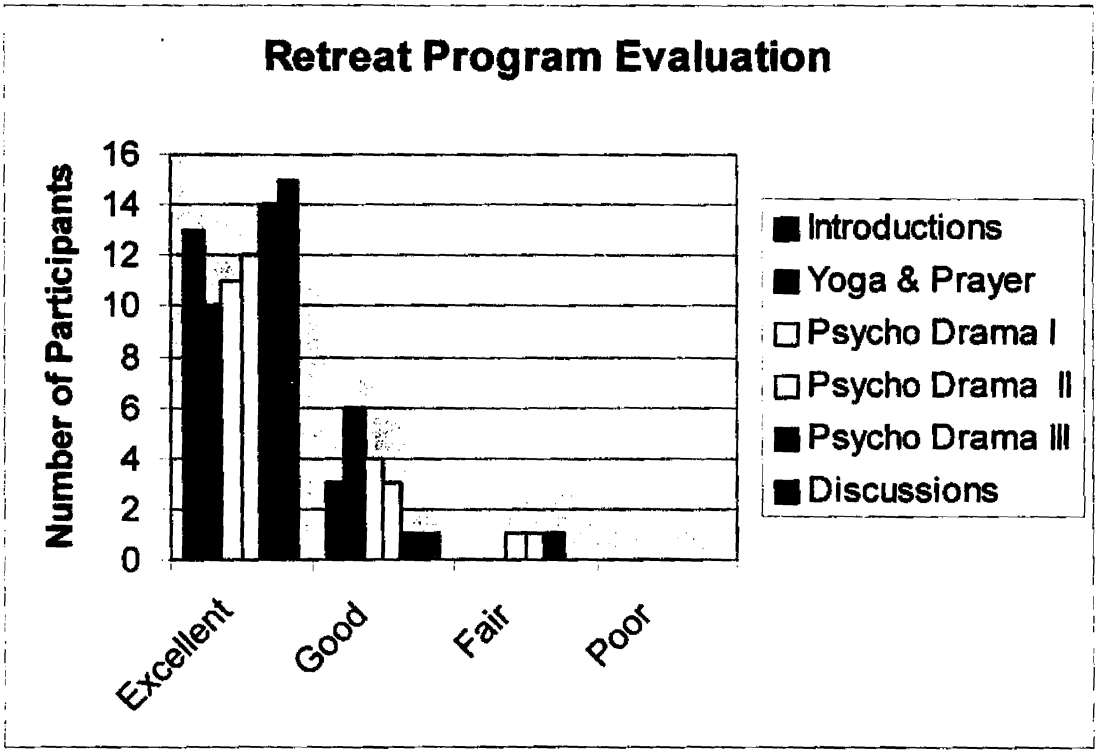
Beside the transportation problem the quantitative results showed that the majority of participants had a positive view of the retreat and the program. These results need to be understood in conjunction with the qualitative results. The quantitative results alone are not sufficient to gain a complete comprehension of the dynamics of the retreat. Qualitative information from the written evaluations and verbal responses will supplement and interpret the quantitative results.

While the mode of transportation was not the most comfortable yet the time spent in travel helped to accomplish one of the goals of the retreat – getting to know each other better. There were groups which formed and changed in composition - new groups would form and so people had an opportunity to know each other better. I encouraged this process while were at the hospital. Just before our departure and when the bus made some stops I asked the participants not to get stuck with one or two persons but to try and get to know everyone present. Some communicated across aisles and some did so with those seated

before or behind them. The discomfort was also a topic which helped in the group forming process. The group may not have been conscious of the positive effect which came out of a negative situation. If we had the coach, many would have relaxed and slept or watched television. Those comforts would have kept individuals in isolation and less connectedness would have been achieved. The common bonds between the participants may well have been cemented while they were transported to the center.

The food and food service got the third highest rating in this section. As the group prepared, shared, ate and cleaned up together, there was a great spirit of camaraderie and support. The partaking of different types of foods and hearing about different ways of cooking and preparing meals were agents in the formation of community, which was an objective of the retreat. The partaking of meals together did not foster and encourage religious divisions or distinctions. Before the meal I offered a blessing and gave thanks. The program did not seek to deny the reality of religious rites and rituals and thus the prayer. It is the imposing on others - a particular tradition or our own, we seek to guard against. A blessing from the Psalm was used. By this act we all connected with God and each other as we held hands in prayer. After the prayer we all ate and were satisfied.

Questions were raised as to how and why things were done and said, but in this non-threatening environment people felt free to ask questions and also to be heard. Many were the times one would hear someone saying, "It is the first time I am talking to a follower of Islam" or, "It is the first time I am understanding ..... I thought....." Or "I did not know that..." I pointed out that diversity was not only in religion but with so many cultures it is necessary for us to be patient, open and willing to listen to those who are different from us.



Graph # 2

The time of shared meals together became a great time of bonding, learning and respect. Some indicated their plans to incorporate some food preparing techniques along with their own. Another expressed her joy and extolled the benefits of this pastoral care departmental activity. She stated, "Some of the things I learned during the morning I will surely put into practice in my everyday life." Another was overheard saying, "It is really nice how he is teaching us to talk to the patients. They never used to do this before." The response to that was, "I really did not like the change of directors and when he first spoke about us serving all the patients and not just those from our faith, I thought he was crazy, but now I can see that this is a good thing he is doing."

After the meal one person said to me, "I really like the exposure you are giving us and it can be carried over into other aspects of life other than patient care." A Eucharistic minister who is Roman Catholic joined in and stated that for years she had been just giving the Eucharist but was excited to do more for the patients. She then corrected herself and said, "Instead of just doing, I will be more present to them and that feels very satisfying."

The self-correction indicated to me that another objective of this retreat was being met. There was now the realization that "doing for the patient" and "being with the patient" are two different things. The latter activity is the more desirable of the two. The mealtime gave them an opportunity to reflect on and respond to

some of the material covered during the morning session. This was an unstructured encounter group experience.

Often the volunteers worked in isolation and are disconnected from each other but this training and sharing of meals together will help each individual to connect with others and with their inner self. The interactions help to expose them to differences – of beliefs, ways of doing things, cultural diversities, etc Yalom states, "they explicitly strive for some change – in behavior, in attitudes, in values, in life style, in degree of self actualization; or in one's relation to others..."[70]

The yoga and praying exercise were intended to be that special time of calm and tranquility. All the participants have prayer as part of their religious ritual but the evaluation results for the yoga and praying time had 10 persons rating it excellent and 6 rated it good. It got the same rating as the transportation. Latter discussions revealed that the mode of yoga was not a vehicle with which they were familiar – to be transported in, to experience the Divine. It was like the school bus which brought us to the retreat. Their individual methods of prayer were the coaches with which they were familiar and would have felt more comfortable.

All was not lost by the exercise. It was an eye opener for some and one person declared that "yoga was only a gimmick and a tool of the devil". There was a

strange silence as the individual spoke but another replied that "we have to be careful how we judge other ways of doing things." A third person *(looking at me)* stated, "I guess this is why we are having this training so that we can become familiar with the many other ways patients approach the Divine." I remained silent for a while, and then I asked, "any other thoughts, ideas or suggestions?"

A discussion followed in which most persons shared how prayer was practiced in their tradition. I added that we must remember that many non-Christians are very devout people and prayer is part of their ritual. The manner, mode or styles may be very different and that is why we seek permission and follow the patient's lead. It is respect for others and their way of life which will allow us to be embraced by them and open doors to their emotional needs.

These discussions helped to accomplish another objective of the retreat. The participants began to reflect upon their own traditions and became willing and open to listen, learn and reflect upon other traditions without rushing to judgment. One person commented that he was not about to change his beliefs but he could see that there are many different models and we can learn from others. He liked the breathing exercises as a means of centering oneself. Another acknowledged that she had a certain formulae that she always used in prayer and that would be offensive to some persons. To this one responded, "You must be

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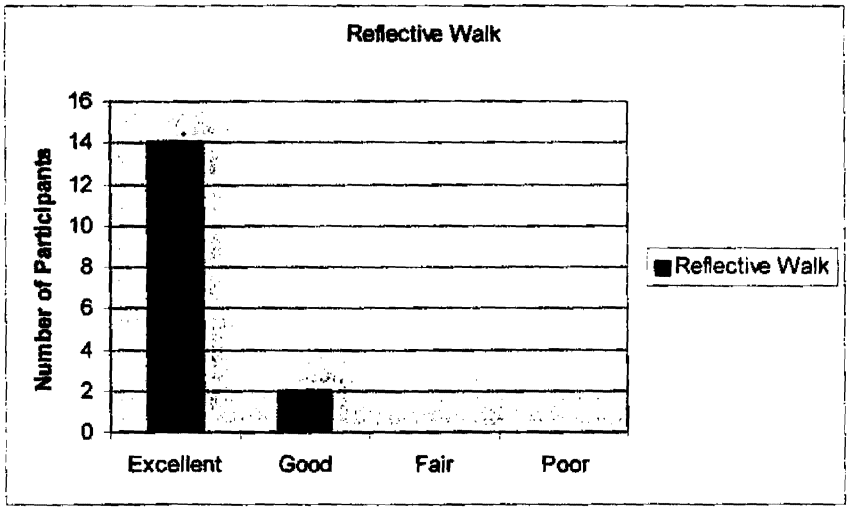
[70] Yalom: 1970, p. 489

wise as a serpent and harmless as a dove." I added, "Not cunning but tactful and respectful, if you are going to be a caring pastoral care giver."

The yoga and prayer session gave them an opportunity for serious reflection and discussion. There was also a distinct desire by the majority to change any pattern of action which would create barriers rather than building bridges to the patients. This was the point Yalom made about groups which experienced growth in their encounters. These he called encounter groups. They were not for therapy but enhanced growth among the members.

The opportunity to walk during the free time and explore the grounds after the morning session was welcomed by all. This was an opportunity to get some exercise and further discuss some of the morning events. This was rated excellent by 14 persons and good by 2. See Graph # 3 :



Graph # 3

The exploring of the environment eclipsed the earlier discussions. I had hoped that the previous session would be the main focus of discussion at this time but that was not to be. All were enamored with the natural environment and like children out of school they walked among the trees with the resplendent fall colors, they followed the trails to the lake and examined the scenic setting. It was evident that this was a connected community. There were four unstructured groups with different number of persons in each. They were actively engaged in conversation as they walked to the Lake. Only one person walked by herself, even though she was invited by others to join them.

The comments about this time varied. One person wrote, "It was as if I were in heaven." Another spoke of the tranquility of the retreat center as the environment many patients would do well to be in. Another person wrote, "This is what I needed. The training and the place are both good for me. I love it all."

One person expressed, "It is not fair to take us here for only one day. Since this place is so beautiful and well equipped with rooms and beds and all that we would need, why not have the training over a weekend. I am certain the others would agree." On the return journey to the hospital, similar sentiments were expressed. Another person remarked that – "With two more days like this we would become pros."

While most persons were caught up with the outdoors during the free time walk, one person wrote, "As I was walking it came to me that I will have to accept people as they are and not try to change them. The idea that it is all about the patient is really different. I always felt it was about accepting the Savior." This individual spoke with me frequently and it was as if he was going through some struggle. I assured him that he was not denying his faith in God nor was the training intended to undermine spiritual concerns. The focus was on discovering the patients' needs and being supportive as they faced their realities.

Psychodrama and Group Process.

The psycho dramatic enactments were the main teaching tools for the training process and the retreat. These enactments were followed by the group discussions in which participants shared their life experiences with others in the group. Both the psychodrama and the group discussions are clinical techniques and these are closely akin to the principle of systems theory.

The group formation, which began at the retreat, continued throughout the training on Tuesdays at the bi-monthly meeting of volunteers. They acted as a group, as is expected in systems theory. At the close of the retreat and training, each person goes back to their respective systems – families, mosques, churches, synagogues, work place, etc. They have not changed or denied their identity or community from which they came or to which they belong. The training with its

new techniques and approaches does not require one to deny their faith, belief or identity. It heightens the individual sense of self, while in relationship with others. This we speak of as self-differentiation. It is the cornerstone of the systems theory. Yaolm states, "Differentiation means the capacity of the family member to define his or her own life's goals and values apart from surrounding togetherness pressures, to say "I" when others are demanding "you" and "we."[71]

Thus another objective of the retreat was to teach the participants how to develop and maintain the sense of one's self as well and recognizing and respecting the self of the other person. By so doing, respect for the other and at the same time maintaining one's integrity would be accomplished simultaneously. This healthy approach would prevent feelings of being in opposition to or being abandoned or isolated.

As the participants enacted or observed the enactments in the various dramatic presentations they had opportunities to make contact with their own feelings. Each case presented was drawn from real life situations and most of us present could feel the connections with the many feelings and emotions they evoked. This could be felt on both levels – the individual as well as the group. On the individual level participants could see their ego involvement in many situations and also become conscious of the way it could help or hinder in communicating

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[71] Yalom 1985 p. .27

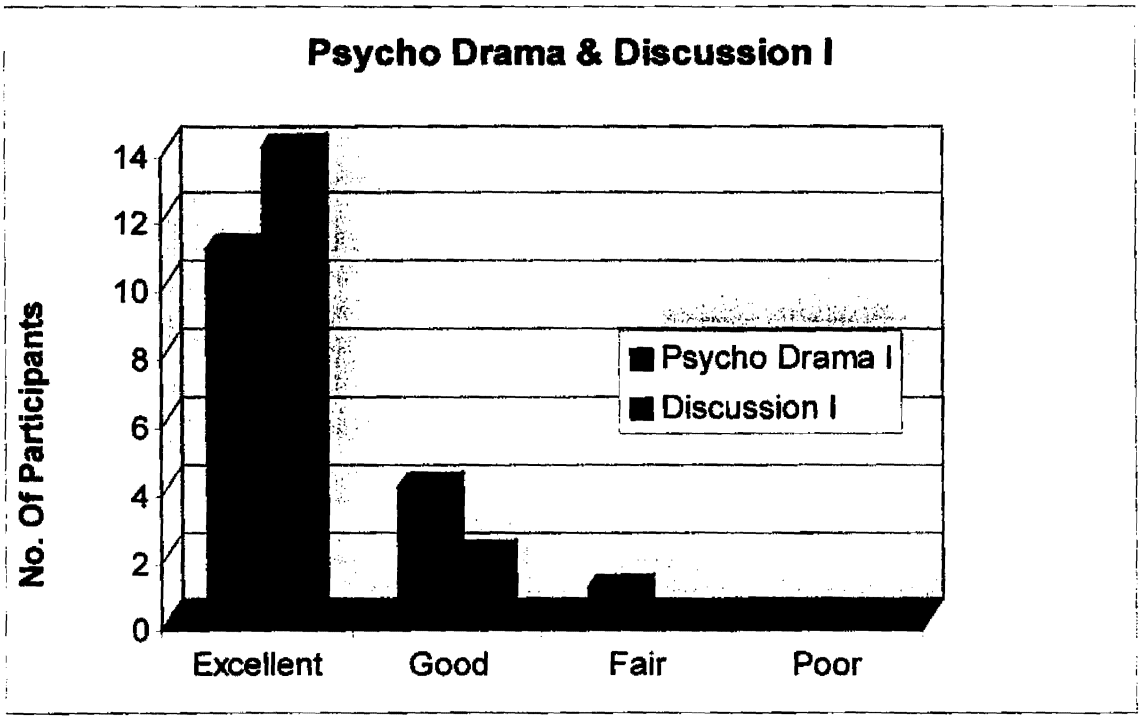
with the patient. On the group level it was evident that all had strengths and weaknesses and all were given the opportunity to grow. This prevented the defenses of blaming or withdrawing to be strengthened as each recognized that together all were becoming better pastoral care givers. With each case enactment and discussion the group was developing and forming into a more open, accepting and growing community.

The quantitative results of the psycho dramatic presentations were not the same in the first and second cases, which they enacted. The third case, which was scripted, got a higher evaluation but the evaluation of each discussion was the same. This indicated that while the participants may not have felt satisfied with the enactments, the discussions, which followed each, were considered helpful. The overall objective was thus met; as the intent was to look at the ways we interacted with the patients and discuss how we could improve. The fact that the discussions were rated so high indicated that the group was open to positive criticism and recommendations. The initial defensiveness and resistance, which could be felt initially in some of the responses, soon gave way to open and welcoming acceptance of opposing ideas.

Preceding the first psycho dramatic enactment there was the time of introduction and exercise. The purpose of these was to further develop group cohesion, trust and the spirit of community. Everyone got introduced by the person sitting to his

or her right. After the introductions the floor was opened for anyone to share additional information. Only three persons felt they had to speak due to omitted information shared with their partner or because of a correction.

The quantitative results for the first psycho dramatic enactment showed 11 persons rating it excellent, 4 persons rated it good and 1 person rated it fair. The discussion, which followed this first enactment and case study, was rated excellent by 14 persons and good by 2 persons. See Graph #4 :



Graph # 4

The quantitative results when compared showed that the discussions were having the desired effect. The participants enacted their normal role, as when visiting with the patients – were able to see and hear from others that there was room for improvement and change.

The group listened to the actors and joined in later sharing what they would have done or said. Some acknowledged where they had made mistakes in the past. One individual began in a defensive mode by saying, "we Pentecostals...." And I thought, "Here come triangulation", but another Pentecostal quickly rejoined and said, "It is easy to shut out others and ideas by saying we do things this way or that way. The Catholics could also say the same, let us try and be open to some new concepts." I felt that this invitation was helpful in preventing triangulation and a building of barriers and boundaries. The consequence of this participant speaking up enabled others to speak up and become more open and receptive.

These cases helped the participants to explore not only their feelings as it related to the patients but to a greater extent the challenge was to move beyond the dynamics of the personal as well as the dynamics within their own religious traditions. Whereas a significant number of participants were initially motivated to reach out and save souls in the eschatological sense now they are trained to try and be present with the patient rather than moving the patient to the place the pastoral care giver may deem to be safe.

During the retreat it was not my aim to classify and define all the dynamics I saw at work but I made note of the same and the circumstances with which they were related. In the coming months these would be addressed in the Tuesday seminars, at the appropriate times. Some terms were briefly defined and described. I told them about the triangle in which they could become or feel trapped; to one corner was their response and feelings, the next those of the patients and finally the perceived goal/ teaching or rites of each person's church or religious tradition. If the focus is on the patient, then there is no tension. What the care giver or the tradition says or believes is not projected upon the patient.

One person surprised me by indicating that for a while she had some misgivings about a position her church takes relating to people who seek and obtain a divorce. She was supported by another individual who spoke about the many levels of pain she had experienced by her own divorce. There was the crushed self; there were the blaming family members and the ostracizing congregation. As she spoke a hand reached out and held her as a show of support. Here people had connected across religious lines. The hearts were knit together. This was another positive outcome of this first psycho dramatic enactment. I sensed that trust was developing more as individuals risked sharing more openly about themselves and the religious communities from which they came.

Gradually the group began to self-differentiate. They would speak about the case presented and move into their own parallel experiences. They could accept their inappropriate but good intentions when visiting with patients and speak about it. Many by the nodding of the head or saying, "Yes" would identify with another who shared similar experiences. At the same time I observed that connecting with another did not lead to complete agreement with outcome or conclusions. There were boundaries that were maintained by some and were advocated to be moved by others. This was verbalized as the patient's marital condition was discussed.

Because this was a training process I allowed them to free associate and even leave the patient and shift the focus to themselves. By so doing I was able to call their attention to what had occurred. The dynamics of transference and counter transference was at work. It was this openness and spontaneity, which allowed the group to experience growth. The willingness to overcome their natural resistance was admirable. There was also the interesting phenomenon of some persons willing to speak publicly in the group about having a position, which was not supported by their tradition. They were not fused and claimed their own identity.

On two other occasions before the retreat, the psycho dramatic method of enacting cases were used but it was lacking the type of spontaneity which was at work here at the retreat. This could have been due to many factors – the newness

of the method to the group; there may also have been the risk factor – fear of failure or appearing to be doing or saying the wrong thing; or lack of trust, to mention a few. Another important factor for some may have been the presence of the religious authority – the Priest and Sister. After the group realized that these individuals had gone through similar trainings and had their epiphany moments also, they seemed to be more prepared to be themselves. The response at the retreat was so much more spontaneous than the first two sessions. One other factor may have been the location. Being away from the regular environment can lead to a more relaxed and open climate. Blatner states that for such dramatic work to be effective there needs to be "an openness of mind, a freshness of approach, a willingness to take initiative."[72] The initial four persons who initially expressed the idea that - "This new method of acting – as if we are with a patients was artificial and not realistic", changed their perceptions at the retreat. The other three had become active participants and effective contributors to the process. They were identifying with and connecting to the others and engaging in the process.

The second presentation was entered into with greater enthusiasm and assurance. According to Blatner, "The essential qualities of a spontaneous act are an openness of mind and freshness of approach, a willingness to take initiative, and an integration of the external realities and the internal intuitions, emotions, and

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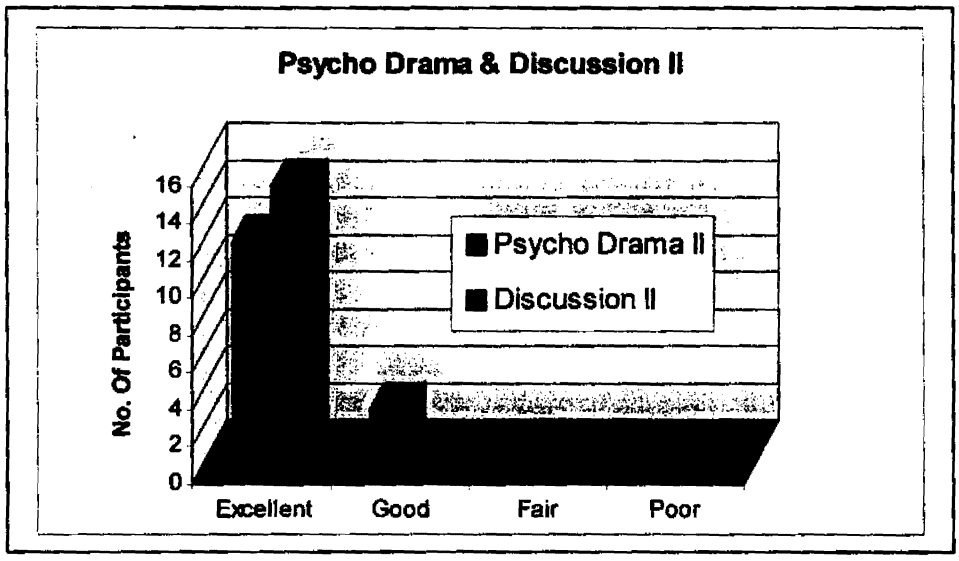
[72] Blatner, 1988, p. 48

rational functions."[73] The group was ready for this session. A very good lunch and a brisk walk in the Fall atmosphere after an enthusiastic morning session, had everyone invigorated and ready for the second case enactment.

As the second psycho dramatic quantitative results showed 12 persons rated it excellent, 3 rated it good and 1 rated it good. As for the second discussion, 15 persons rated it excellent and 1 rated it good. See graph # 5 :



Graph # 5

The format was the same and the case was different. This time the participants were more comfortable after the trepidation of the morning enactment had worn away. The case enactment evoked many strong feelings and this was felt most in the discussions, which followed the enactment. My involvement in the discussion

[73] Blatner: 1988, p. 64

was almost non-existent. Quickly participants were able to challenge each other and provide corrective suggestions. They were speaking to each other, listening to each other, and together were recognizing areas of strengths and weaknesses. Those who initially admitted that they were shy and timid were also involved in the discussion. One person acknowledged that, "For some reason today I did not feel intimidated or feel like shutting up when someone suggested I do or say something differently". The climate was open and mistakes were expected but all understood that anything said in the drama would not be fatal.

The ego was not threatened and all could throw caution to the wind as they explored their untapped energies and skills. In this family system the process of self-differentiation continued to manifest itself.

The participation in these psycho dramatic enactments helped to create a very congenial and cooperative atmosphere in which everyone appeared very connected. The objective of the retreat was to create an atmosphere, which would promote connectedness among the participants. It would also deepen the individual's sensitivity to others who are from other faith traditions. The results of meeting this objective would change the focus from denominational representatives, to patient caregivers irrespective of religious tradition. It was clearly evident that the participants had developed greater trust and openness and were prepared to take greater risks.

This non-anxious setting allowed the participants to be themselves and the well intended but inappropriate dialogue gave everyone an opportunity to listen to and hear him or herself critically without anger[74] or others such defenses emerging. From my observation, one person benefited the least. He felt that "soul saving" was the pastoral care work. The other non-medical work is social work. It was because of this person that I used a scripted case for the next enactment. This gentleman seemed to work from his head only and failed to let his feelings come to the forefront. I wondered if he was repressing some feelings. It was clear to me that he needed to put him in the patient's position and try to see through those eyes. Attempts were made to help him to be more reflective and less judgmental and defensive. Earlier in the day the group was asked to write out a reflection of a time they were sick or in the hospital and to recall helpful or not helpful comments made to them at that time. These recollections were intended to help them hear and see the negatives and to guard against those pitfalls.

The retreat provided a framework in which participatory activities like eating, dramatization, exercising and reflective group discussions helped to build a communal spirit. There were individual connections and that in turn extended to the formation of a community. They were functioning as a group and religious diversity was not allowed to prevent cohesion. The barriers and boundaries were lowered as trust, respect and openness was allowed to flourish.

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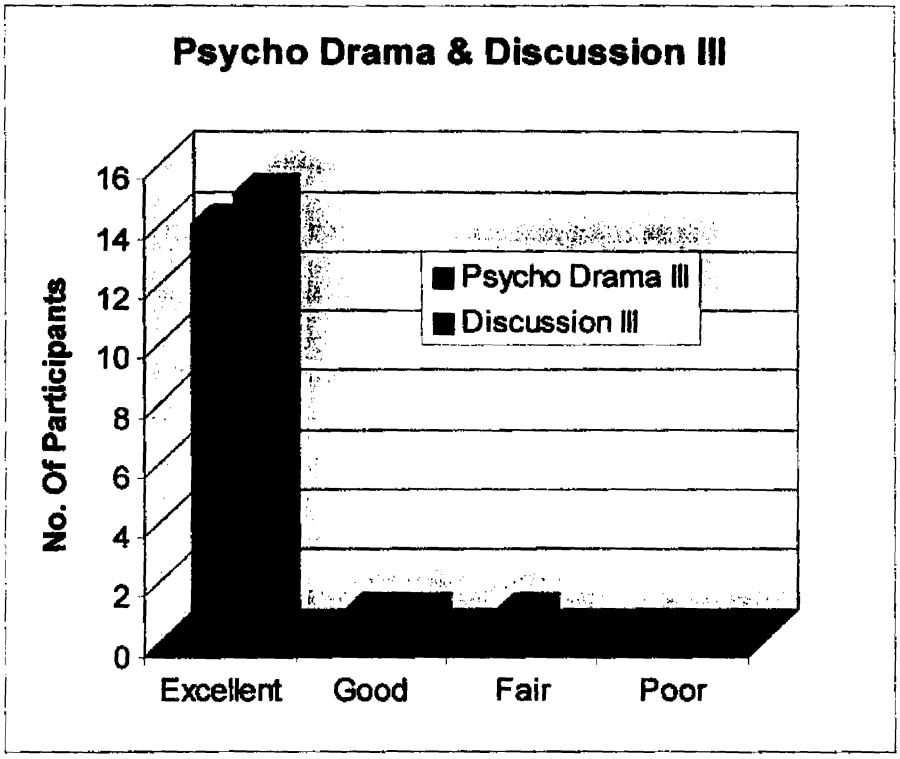
[74] White 1977, page 516

The third and final case study for the day using psychodrama was scripted. This was done to show the participants that the use of scripture and prayer is not taboo or to be avoided but rather to be used judiciously and not thrust upon the patient. The quantitative results for the third psychodrama reflected acceptance of the process. The evaluations were 14 persons rated it excellent, and I rated it good and another rated it fair. The discussion which followed the enactment was rated excellent by 15 persons and good by the other person. See Graph # 6 :



Graph # 6

One person considered the drama and discussion good and another person rated the drama poor. I had an instinctive response to these evaluations but then realized that there was room for improvement in most human interactions. I felt that the individual who saw no value in the drama was rigid but after some time I realized that I may be too optimistic. This process of learning might work for one individual and not for another. I may have been forcing or projecting my own expectation and not allowing the group and individuals to move at their pace.

I worried also about the participants becoming exhausted but that did not prove to be an issue. One person remarked that we should have begun the day with this sample text and so they would have been able to say the right things. I pointed out that the aim of the training might have been defeated if we did that. Having each person speak as they would normally do when visiting with a patient enables us to hear ourselves and see what we need to correct.

During the discussion another person expressed the feeling that the responses of the volunteer - in the drama, were a bit artificial and evasive. He also felt that he was evasive and not being very helpful. To this comment another responded, "Remember, the Director said we are not here to fix or solve all the patients' problems." At this point I was tempted to enter the dialogue but sensed the need to let them analyze the presentation themselves. My tendency to be directive

rather than facilitating almost hindered the group process. I restrained myself and remained silent and allowed them to discuss the drama.

One participant expressed satisfaction that a case with an AIDS patient was included. She did not know how to deal with such persons as she saw it as a judgment of God upon sin. Others intervened and pointed out that AIDS was contracted through many means and many innocent persons were thus afflicted. This was a very spirited discussion and many personal stories were told. The opportunity to see from the patient's side was expressed by two persons.

Another found it difficult to listen to a patient speak about God in what she considered a disrespectful manner. Again another participant indicated that people were at different places in relationship to God and we cannot make them behave as we believe they should behave. The response to that comment was, "It is hard to listen to such disrespect but I guess it will take time." One participant acknowledged that she would always rebuke anyone who would say things like "This God stuff is sheer crap." She went on to say, "I guess I can't do that anymore." I sat there smiling on the inside. They were getting it. I just said, "You are doing well."

The response of most of the participants to the use of Psalm 88 was surprising. One said, "That was cool." Another said, "The Psalm is really good. Almost everybody is open to the Psalm." I asked them if they thought that life must

always be comfortable and predictable for it to be well lived and meaningful. This led them to talk about their beliefs and disbeliefs. I then invited them to revisit the feelings about which they wrote in the morning – recalling some time when they were sick and their response to visitors who were not on the same page with you. They were reminded that sometimes we and patients need to be left alone.

With fifteen minutes left before we ended the program for the day, I asked them to share their feelings about the day. Most persons said it was excellent and the activities were very helpful to them. One person stated that she felt skeptical at first but thought that the training would enable the volunteers to do more than they were presently doing. Others expressed that they felt more connected to the other volunteers and they all were on the same page now. Most acknowledged that the psycho drama was very helpful and should be continued in our bi-monthly meetings. The participants were becoming open to themselves and were open to growth. This was a sign of success that the objectives of the retreat were met.

The discussions after each dramatic presentation benefited the participants in two ways. They were able to hear from others and get their perspectives about their interaction with the patients. They were also able to talk about some of their experiences, which paralleled those of the patients. One person inquired if there would be opportunity for them to meet and talk about their visits with patients

when they came to the hospital each week? My response was, "This is a goal to which we will work." Presently when the volunteers come to the hospital, they work along with the unit chaplains to whom they are assigned. He or she will determine where the volunteer goes and what is assigned them. The need for debriefing is something we will seek to provide for all the volunteers.

Two individuals commented about the support, which the participants gave to each other. The technique of psychodrama proved very effective as a teaching and learning tool. Throughout the days activities all the participants functioned without any direct reference to their religious traditions. They functioned as care givers, giving and receiving support from each other without projecting or denying the religious tradition to which they belong or are members.

The Training Seminars

Supervising the project taught me many things about myself as well as the group. The planning and executing of those plans was the least stressful. It was the unplanned interferences, delays and irresponsible behavior of some individuals, which hindered some of the planned activities. The annoyance was always eclipsed as I saw the volunteers functioning autonomously and with poise. The volunteers in this first demonstration were not required to draw up a learning contract. That is something I am thinking about for the future. I will also look at

the screening of volunteers more carefully and inform those who apply – that they will be required to participate in a special departmental training and evaluation before they could be accepted as fully accredited volunteers on the pastoral care team. Participants may discontinue attendance at anytime if they feel this is not the ministry they wish to be engaged or involved.

There will also be a definite effort to develop the resources in the department of Pastoral Care and offer greater learning opportunities. This will not be restricted to the volunteers but will also include the Grand Rounds for the medical interns. The diversity in religious traditions is one of many differences, there are cultural as well as economic ones and the training offered here is applicable to all diversities. By this training all can learn to listen with respect and touch each other in a compassionate and appropriate manner.

Concluding Remarks

The satisfaction of the participants was verbalized as soon as we concluded the last discussion of the day. They expressed it in many different ways. "This was a great day"; "This was wonderful, it should be done every year."; "It is good to have a change of leadership from time to time, we never had this before."; "I learned a lot today."; "I believe every volunteer should have this training."; "I had

my doubts about this program but I came for the trip upstate and I am glad I came. It is a good thing you are doing."

From these comments and more I felt and they felt that the objectives of the retreat were met. The bi-monthly Tuesday Seminars were well attended and a case was enacted each month followed by group discussion and interaction. A brief didactic closed each of the sessions.

The volunteers were more enthusiastic about their role as patient caregivers and were open to suggestions for personal growth. One individual decided she wanted to get more training and is presently enrolled in the first unit of basic Clinical Pastoral Education offered through an affiliate of Healthcare Chaplaincy Inc. in New York City.

Many of the participants have expressed their satisfaction with the greater level of consciousness they now have about psychosocial, multi-cultural and spiritual diversity. The most satisfying thing is they continue to keep their religious identity but it is not allowed to interfere with their work for the patients. There was also a heightened consciousness of how important it is to listen to the patient and at the same time be conscious of one,s own feelings.

This demonstration project showed that the main objective was – to develop a network of trained pastoral care volunteers from different religious communities

who would be able to serve patients irrespective of religious differences. This would become possible as the skill of listening is developed. It also would be important for each person to be aware of his or her feelings and how others may trigger emotions. The process would enable the caregiver to maintain integrity and at the same time support others on their own journeys.

The intent of the retreat was to be a point of departure for the training of the volunteers. This was continued until all the cases have been enacted and discussed along with some relevant didactic. The group process also enhanced growth for the individuals as well as the group.

It is hoped that trained volunteers will replicate the attentive listening practiced and modeled by the staff chaplains. The volunteers at the present time outnumber the chaplains five to one, thus five times as many visits can be made by these volunteers when compared to the paid staff chaplains. They can create an atmosphere of support and healing and as their listening skills develop they will aid in the healing process which every patient desires. Their presence will make a difference for those patients who would otherwise feel disconnected and isolated. They will also form a connecting link with the patient and the community. They can be a ready resource for many who may not be well connected to centers and other agencies within the community.

I realize that this training with all its good intentions would not be acceptable to all. Some individuals could only work with people of their own religious tradition. They are not able to listen to others and could only seek to convert others to their own way of thinking, acting and being. These volunteers would not be prevented from serving as volunteer pastoral care givers but they would be allowed access only to members of their faith traditions. I will require that all volunteers attend the training programs and I will have consultation with other Pastoral Care Directors, share my findings and observations and get advice.

I also learned - by observing the way each person chose where they sat for meal and all other sessions that many dynamics were at work at many levels. I observed that three persons sat next to newly found friends from the first meal and for subsequent events. During the main sessions in the common room/den, the majority sat in closer proximity to old friends. Another three persons indicated their preference for the rocking chair and armed sofas dictated the choice for sitting. This illustrated the complexity of the human psyche and how varied are the factors involved in decision making. A lesson I learned from this was that while my goal is focused on integrating a diverse community, success or failure cannot be determined without recognizing the many dynamics at work within the group. The individuals, who sat with their old acquaintances or those who chose the type of seat to sit on, may not be any less connected to new

friends than those who sat with the new friends. I will not always know how well my goals are achieved but I will be open to doing my best.

Future Implications

It is my aim to have this demonstration project become a model for training volunteers for pastoral care service in the health care setting. Any pastoral care department can replicate this process. In the twenty-year history of the hospital and the department, this was the first departmental retreat. The response of the hospital administration, staff and volunteers to the idea was very positive and a greater enthusiasm developed after the event. All have agreed that an annual retreat with the same purpose should become part of the calendar. The connection with each other and the feeling of being supported and being supportive will enhance the skills for working with the patients who are as diverse as the volunteers are.

This demonstration project proved that this model of a retreat and training can be very effective in helping institutions who have individuals from different religious communities, serving as patient caregivers. This model can be expanded and tailored to meet other types of communities like prisons.

With the limited budget and the few Chaplains employed in any healthcare institution, it is necessary to train as many of the volunteers in these institutions

so that they can be more effective pastoral caregivers. The ratio of chaplains to patients will always be lower than that of volunteers to patients. With this larger pool of workers, institutions would reap great benefits by investing in such training. Not only is the institution helped by this model of training, but the society at large. When individuals are more open and tolerant of differences, less tension, resentment and animosity is fostered. When respect for others and careful listening is practiced greater understanding will occur. This training may be valuable to all of society.

There was the time constraint I experienced with the one-day retreat. Often the time expired and all persons who wished to participate did not have the opportunity. This was noticeable when they were sharing their experiences about their own illness and pain. This was its own source of pain. For the future a Weekend Retreat may prove to be more practical. The training seminars at the hospital will be expanded and the training director of the hospital has invited me to prepare similar material to be used in the Medical Grand Rounds for the Residents.

APPENDIX A

Pre-retreat and training Questionnaire

The Work done by Woodhull Pastoral Care Volunteers

Name.....

As I visit with patients I .....

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APPENDIX B

Pastoral Care Volunteer Training & Retreat Evaluation

Using the scale (4=Excellent; 3=Good; 2=Fair; 1=Poor) please rate the various aspects of the Volunteer Training Program and Retreat by filling in the blank before each statement.

1. _____ Transportation for the Retreat Center.

2. _____ Facilities at the Retreat Center.

3. _____ The concept of the Retreat .

4. _____ The program at the Retreat.

5. _____ Getting to know you introductions at the Retreat Center.

6. _____ Yoga and Prayer Exercise

7. _____ The Psycho-dramatic presentations Case I

8. _____ The Psycho-dramatic presentations Case II.

9. _____ The Psycho-dramatic presentations Case III

10. _____ The Discussions following the dramatic presentations.

11. _____ The Bi-monthly Tuesday Seminars.

12. _____ The Food Service for the various sessions.

13. _____ The Professional Knowledge of the Director.

9. _____ The Concluding Discussions.

Pastoral Volunteer Retreat & Training Program

1. What was the most helpful part of the Training program?

2. What was the least helpful part of the Training program?

3. How did this training program affect the way in which you see your work as a Pastoral volunteer?

4. How has the training changed your way of seeing yourself as a volunteer?

APPENDIX C

Post-retreat and all training Questionnaire

The Work done by Woodhull Pastoral Care Volunteers

Name.....

As I visit with patients I .....

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APPENDIX D

Psycho-Dramatic Presentation : Case Number.....

Name of Observer.....

From your observation what do you think you know or observe about the patient?

1.

2.

3.

4.

What would be some of your responses?

A.

B.

C.

What would you differently?

APPENDIX E

WHEN YOU ARE OR FEEL SICK

What Do You want – Desire or Wish for?

1.

2.

3.

4.

What is it you do not want, or is not welcome or turns you off?

1.

2.

3.

4.

APPENDIX F

TRAINING SEMINAR: WHAT TO SAY AND NOT TO SAY WHEN SOMEONE DIES

What to Say	What Not to Say
1) I'm sorry.	1) I understand how you feel.
2) I'm sad for you.	2) Death was a blessing.
3) How are you doing with all of this?	3) It was G—d's will.
4) I don't know why it happened.	4) It all happened for the best.
5) What can I do for you?	5) You're still young.
6) I'm here and I want to listen.	6) You have your whole life in front of you.
7) Please tell me what you are feeling.	7) You'll feel worse before you feel better.
8) This must be hard for you.	8) You can have other children.
9) What's the hardest part for you?	9) You can always remarry.
10) I'll call you tomorrow.	10) Call me when I can help.
11) You must be hurting.	11) Something good will come out of this.
12) It isn't fair, is it?	12) At least you have another child.
13) You must really feel angry.	13 He (she) led a full life.
14) Take all the time you need.	14) It's time to put it behind you.
15) Thank you for sharing your feelings.	15) Be strong.

APPENDIX G

TRAINING SEMINAR: CHECKLIST OF POSITIVE LISTENING SKILLS

Did I listen for the underlying feeling as well as the content?

Did I listen for what was said and was not said?

Did I communicate and I heard and received the other's experience? Restate Empathetic

Did I reflect back what I heard in a way that allowed the other to agree or correct?

Did I ask questions to clarify and not to satisfy my curiosity?

Was I able to elicit concrete information when necessary?

Was I able to connect with a use the other's words, images, metaphors, symbols? Was I attentive to body language?

Did I keep my own agenda out of the exchange?

Was I able to be continuously present and responsive?

Was I comfortable with silence? Was I able to maintain appropriate eye contact?

Was I able to make connections with what I had heard the person say at another sessions?

Did I keep the focus on the other's experience even when I occasionally shared my own? Disclosure

Was I attentive to the movements of God in the various arenas of the other's experience? Did I notice the movements of God in the other's life, in myself, and in our exchange?

APPENDIX H

TRAINING SEMINAR : Phrases for Paraphrasing

The following are some phrases that you can use when you and the other party have established a reasonable level of rapport and you believe that your perceptions of the flow of the conversation is accurate.

You feel ...	From your point of view ...	It seems to you ...
In your experience ...	From where you stand ...	As you see it ...
You think ...	You believe ...	I'm picking up that you ...
I really hear you saying ...	Where you're coming from ...	You figure ...

The following are some phrases that you can use when you and the other party have not established rapport and that you feel that there may be some confusion or lack of clarity in your understanding of the flow of the conversation.

I'm not sure if I'm with you, do you mean...

Is there any chance you are feeling ...

Let me see if I understand ...

Correct me if I'm wrong, but ...

This seems to be a long shot, but ...

This is what I hear you saying ...

What I'm picking up ...

I am wonder if ...

Does this seem reasonable that you ...

Is that what you mean?

I sense that maybe you ...

As I hear it, you (feel, think, etc.)

Is it conceivable that ...

I guess that you're ...

From where I stand ...

Could it be that you are experiencing ...

I get the impression that ...

Is it possible that ...

Maybe I'm not right, but ...

Is that the way you feel?

What I guess I'm hearing ...

Does this sound reasonable, that ...

Obstacles to Effective Listening

Prejudging the Communion:

Rehearsing a Response:

Filtering Out Messages:

Daydreaming:

Focusing Attention on Language or Delivery

The Three Clusters of Listening Skills

The three clusters of listening skills are Attending, Following, and Reflecting.

Attending skills include the following

A posture of involvement:
Appropriate body motion:
Eye contact:
A non—distracting environment:

Following skills include:

Door openers:
Minimal encouragers:
Infrequent questions:
Attentive silence:

Reflective skills include the following:

Paraphrasing:
Reflecting feelings:
Reflecting meanings:
Summative reflections:

APPENDIX I

TRAINING SEMINAR : FEELING WORDS

HAPPY	SAD	ANGRY	DOUBTFUL	MISCELLANEOUS
Buoyant	Ashamed	Annoyed	Defeated	Bored
Brisk	Blah	Awkward	Dubious	Cruel
Calm	Choked up	Belligerent	Evasive	Distant
Carefree	Compassionate	Bewildered	Distrustful	Envious
Cheerful	Concerned	Bitter	Helpless	Humble
Comfortable	Disappointed	Boiling	Hesitant	Jealous
Complacent	Discouraged	Confused	Hopeless	Mixed-up
Contented	Dismal	Cross	Indecisive	Preoccupied
Ecstatic	Dreadful	Enraged	Perplexed	Torn
Elated	Dreary	Frustrated	Pessimistic	
Enthusiastic	Dull	Fuming	Powerless	AFRAID
Excited	Embarrassed	Furious	Questioning	
Exhilarated	Flat	Grumpy	Skeptical	Alarmed
Festive	Gloomy	Indignant	Suspicious	Anxious
Generous	Heavy-hearted	Inflamed	Unbelieving	Appalled
Glad	Ill at ease	Infuriated	Uncertain	Apprehensive
Grateful	In the dumps	Irate	Wavering	Awed
Hilarious	Low	Irritated		Cautious
Inspired	Melancholy	Offended	PHYSICAL	Cowardly
Jolly	Moody	Provoked		Dependent
Joyous	Mournful	Resentful	Alive	Dismayed
Jubilant	Out of sorts	Stubborn	Breathless	Doubtful
Lighthearted	Quiet	Sulky	Empty	Fearful
Merry	Somber	Sullen	Feisty	Fidgety
Optimistic	Sorrowful	Wrathful	Hollow	Frightened
Peaceful	Sulky		Immobilized	Gutless
Playful	Sullen	FEARLESS	Nauseated	Hesitant
Pleased	Sympathetic		Paralyzed	Horrified
Relaxed	Shameful	Bold	Repulsed	Hysterical
Restful	Unhappy	Brave	Sluggish	Impatient
Satisfied	Useless	Confident	Stretched	Insecure
Serene	Worthless	Courageous	Strong	Nervous
Surprised		Daring	Sweaty	Panicky
Sparking	HURT	Determined	Taut	Petrified
Spirited		Encouraged	Tense	Pressured
Thrilled	Aching	Hardy	Tired	Shaky
Vivacious	Afflicted	Heroic	Uptight	Shocked
	Cold	Impulsive	Weak	Scared
EAGER	Crushed	Independent	Weary	Suspicious
		Loyal		Terrified

Anxious
Ardent
Avid
Desirous
Enthusiastic
Excited
Intent
Keen earnest
Proud
zealous

Despair
Distressed
Heartbroken
Injured
Isolated
Lonely
Offended
Pained
Pathetic
Suffering
Tortured
worried

Proud
Reassured
Secure

INTERESTED

Absorbed
Concerned
Curious
Engrossed
Excited
Fascinated
Intrigued

AFFECTIONATE

Aggressive
Appealing
Close
Loving
Passionate
Seductive
Sexy
Tender
Warm

Threatened
Timid
Tragic
Wishy—washy
Worried

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