

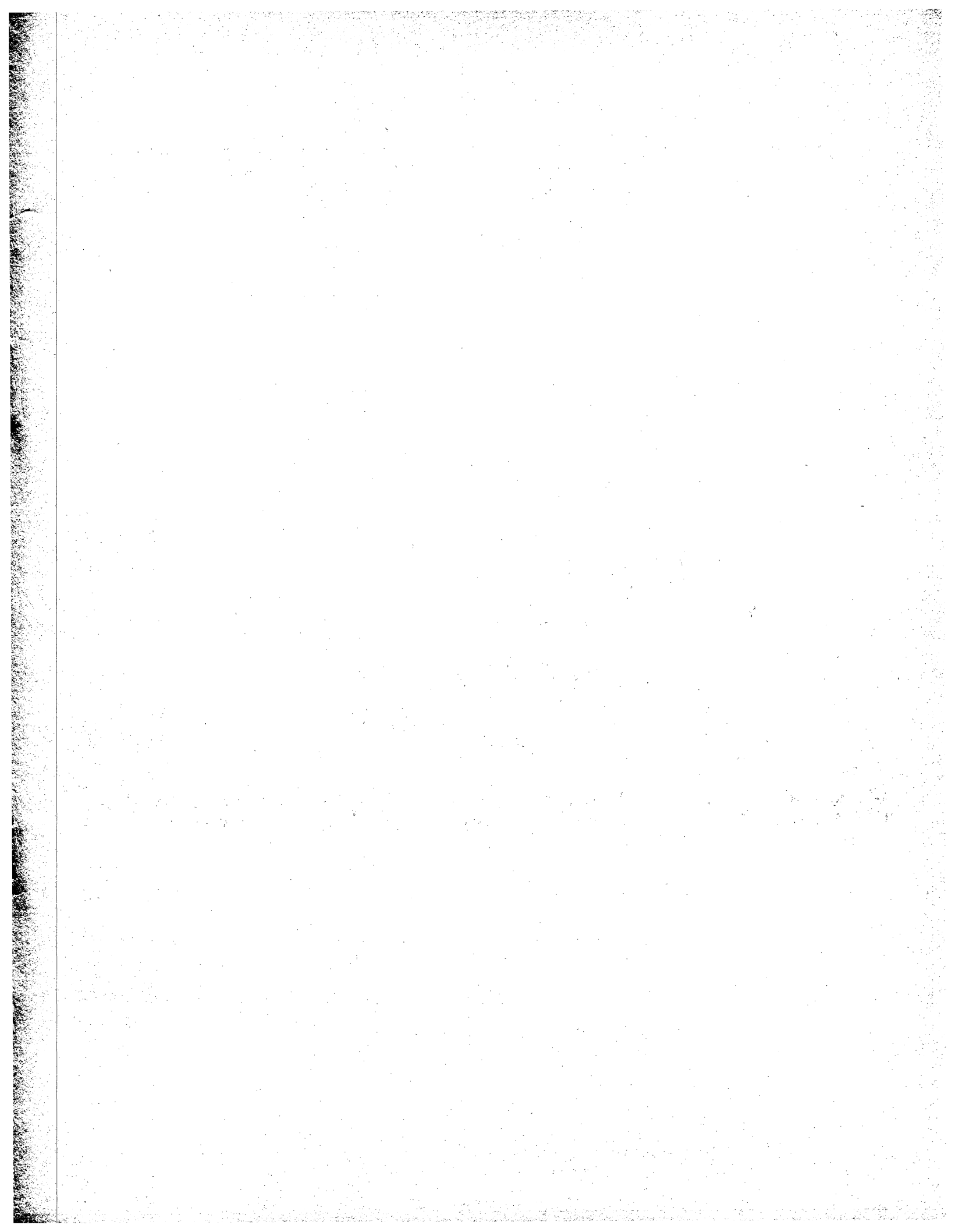
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# **VOLUNTEER FRIENDLY VISITOR**

## *Training Course*

NEW JERSEY STATE DEPARTMENT OF HEALTH

REVISED JANUARY 1968



VOLUNTEER FRIENDLY VISITOR

TRAINING COURSE



New Jersey State Department of Health  
Division of Chronic Illness Control

State Committee on Volunteer Friendly Visitors

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## State of New Jersey

### DEPARTMENT OF HEALTH

JOHN FITCH PLAZA, P.O. BOX 1540, TRENTON, 08625

New Jersey takes pride in its broad tradition of volunteer services. These efforts have played an important part in extending health and welfare services into the community. As a further step toward meeting the needs of the homebound, chronically ill, aged and socially isolated, in 1962 this Department initiated a program of assistance to community health and welfare agencies, churches and other selected groups, through enlistment and training of Volunteer Friendly Visitors.

The unique feature of this program is that it does not require the establishment of any new agencies. It is administered by a State Committee of volunteer professional and lay persons appointed by the State Commissioner of Health and organized originally under the inspired leadership of Mrs. Asher Yaguda.

The third edition of the Volunteer Friendly Visitor Training Course Manual is based on five years experience and the training of more than a thousand Volunteer Friendly Visitors. It provides for fourteen hours of instruction with additional optional sessions available for certain specialized areas.

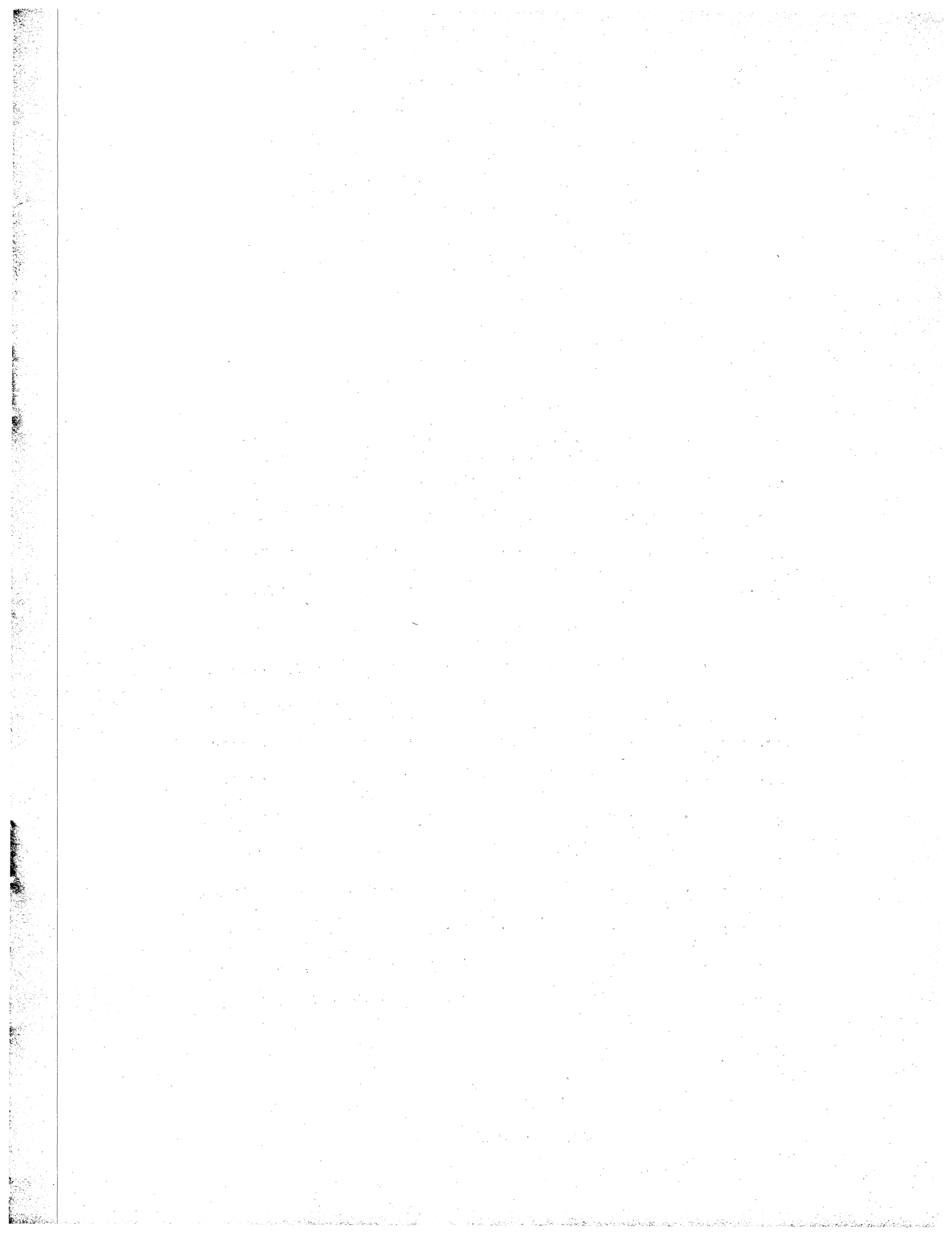
The Division of Chronic Illness Control which coordinates the Volunteer Friendly Visitor Program is sincerely grateful to all those who have generously helped in the development of this course and other facets of the Program.

A handwritten signature in cursive script, reading "Roscoe P. Kandle".

Roscoe P. Kandle, M. D.  
State Commissioner of Health

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GUIDE FOR INSTRUCTORS

In preparing the curriculum it has been the Committee's intent to build upon sound principles of pedagogy and of social welfare practice. It assumes average intelligence, humane disposition, willingness to learn and to give time and energy for others. Adaptation for adult lay men and women places greater emphasis on life experience than upon prior academic achievement.

In this framework, formal lectures are less desirable than an informal setting for group participation. Semi-circular seating at tables, if possible, promotes group cohesion as well as individual comfort. Fifty-five minutes periods would permit five-minute relaxation breaks.

The members of the class should be encouraged to contribute as well as to receive ideas and information. A measure of latitude is assumed for instructors in adapting material suitable to the locale - rural or urban setting, population components, etc. Such factors will suggest homely allusions and meaningful case illustrations.

Training for volunteer service aims first, to mobilize personal assets and strengthen wholesome attitudes; second, to develop understanding of others; and, third, to impart knowledge of the environment.

As in every learning situation, a measure of widened perspective and deeper self-understanding may be expected. This process includes the confronting of minor anxieties related to any new experience. The resolving of normal anxieties should be met through continuing supervisory consultation. It is hoped that this course will provide a foundation for enriching the Volunteer Friendly Visitor's knowledge and skills, and thereby enhance the service given to others.

SUB-COMMITTEE ON COURSE CONTENT

VOLUNTEER FRIENDLY VISITOR

TRAINING COURSE OUTLINE

<u>Session</u>	<u>Topic</u>	<u>Taught by</u>	<u>Hours</u>
I	Introduction to Program Film: "This is My Friend" Discussion by State Committee Member	County Coordinator	1 1/2
II	Understanding People	Social Worker	1
III	Aspects of Health	Public Health Nurse	1
IV	Problems of the Homebound Film: "Proud Years"	Public Health Nurse	1 1/2
V	Mental Health	Psychiatrist or Psychiatric Social Worker	1
VI	Growing Up	Psychologist	1
VII	Growing Older	Social Worker	1
VIII	How the Community Helps	Community Services Coordinator	1
IX	The Friendly Visit Role Playing	Social Worker	1 1/2 1/2
X	Observing and Reporting	Social Agency Supervisor	1
XI	Recreation - Arts and Crafts Role Playing	Occupational Therapist Recreation Worker Group worker	1 1/2
XII	Joy of Service	Clergyman or community leader	1/2

## SESSION I

### Introduction

1 1/2 hr.

In a society in which people are concerned about the needs of people, the horizons of volunteer service are only as limited as the creative imagination of the community's health and welfare agencies and its interested citizens.

In a mobile society, patterns of housing, family living and ways of caring for the chronically ill and disabled have changed. These new patterns have fostered isolation and distance, creating impersonal relationships and diluted family ties. Traditional family and neighborhood supports in times of illness and adversity have almost entirely disappeared. This cultural change has had its greatest impact upon the homebound, chronically ill and socially isolated individual. The need for filling this social void is great.

New Jersey is proud of its long history of leadership in the development of voluntary services, dating back to its Colonial heritage.

The Volunteer Friendly Visitor Program of the New Jersey State Department of Health, Division of Chronic Illness Control, is a community service designed to assist health and welfare agencies through enlistment and training of Volunteer Friendly Visitors in "Friendship with Understanding."

#### A. Need

The number of homebound, chronically ill or socially isolated persons living in New Jersey is not known, although figures may be available in some communities through registration of the homebound handicapped. Figures are available from nursing, boarding and homes for the aged which are licensed by the State.

Many homebound persons are lonely and time passes very slowly for them. The majority would benefit through added contacts with their communities. Such social contacts would serve to relieve their families to some extent.

There is a margin of rehabilitation potential both social and physical in all persons which may be stimulated by promoting an interest in old or new hobbies, in local and world affairs, and by a simple demonstration of interest by a knowledgeable volunteer. The community has need of the wisdom and experience of these isolated citizens.

The Volunteer Friendly Visitor Training Course can strengthen and extend services to persons in the community by supplementing with volunteer effort the professional services available in the State.

## B. Voluntary Services

New Jersey has a broad tradition of voluntary services. In 1962 there were 875 agencies of all kinds of which 400 were State-wide, 140 were limited to Essex County, 215 limited to services in Newark, 115 had programs on a regional basis, and 5 were national in scope. The efforts of volunteers were a motivating force in stimulating the establishment of many of these agencies. Agencies cannot meet all of their needs without utilizing volunteer services in the community.

## C. Program Plan

The Program does not require establishment of any new agencies at the State or county level. It is administered by a committee of professional and lay persons under the aegis of the Division of Chronic Illness Control, New Jersey State Department of Health, through its designated Program Coordinator.

The State Commissioner of Health, through his appointment of the Chairman and members of the State Committee on Volunteer Friendly Visitors, has assigned the responsibility for development of the Program throughout the State. The Department of Health supplies services such as consultation, publicity, secretarial services and all other materials essential to the Training Courses.

The State Committee is composed of representatives of those groups within the State with experience in training home visitors, representatives of professional fields pertinent to training, and lay leaders.

The State Committee has developed the course content which trains Volunteer Friendly Visitors for multiple agencies simultaneously; a Publicity Kit; Guidelines for Participating Agencies; standards of qualifications and approval of instructors; and a Procedure Manual for County Coordinators.

## D. Administration

Courses are conducted on a county or regional basis. There is no registration fee or other charge to the Volunteer Friendly Visitor or to the "host" agency. All courses are under the direction of the New Jersey State Department of Health and the State Committee on Volunteer Friendly Visitors. Certificates and identification cards are issued by the State Department of Health upon satisfactory completion of the entire course.

The "host" or sponsoring agency is responsible for recruitment and screening of volunteers, instructors, and for providing orientation to the agency's objectives and program. The agency is also responsible for the assignment and supervision of Volunteer Friendly Visitors.

#### E. The Volunteer Friendly Visitor

The Volunteer Friendly Visitor may be any stable, mature man or woman who likes people and who has been referred by a "host" agency for training. Training is provided for teenagers who are actively participating in a hospital volunteer program. Friendly visiting is an opportunity for community-minded persons to devote some of their time in service to others.

Visitors are screened for suitability by their "host" agency. Each agency provides indoctrination in agency program and policies prior to the Visitor's enrollment in the Training Course. The Visitor must accept supervision on the job; abide by regulations prescribed by the agency; accept in-service training and furnish his own transportation. An identification card must be carried when serving the public.

#### F. The Volunteer Friendly Visitor's Role

Many times the greatest contribution a Visitor can make is by being a "good listener." Attitudes are important because they can open doors to a good relationship with the individual and his family.

Some of the services to be provided by the Visitor are reading, writing letters, interesting the visitee in old or new hobbies and discussing community and world events.

Where special services would be helpful, for example, arts and crafts instruction, the Visitor's services will be supplemented by specialists.

#### G. Performance and Supervision

The "host" agency supervisor will discuss individually with the Volunteer Friendly Visitor the person or family assigned to the Volunteer Friendly Visitor. The supervisor may escort the Volunteer Friendly Visitor on the occasion of the first visit to introduce the Visitor to the visitee.

The frequency of visits will be determined by the Supervisor after consulting with the visitee, his family and the Volunteer Friendly Visitor.

The Supervisor will evaluate written reports submitted regularly by the Volunteer. The reports will be required by the agency and will include pertinent observations of needs of the chronically ill, homebound or socially isolated person.

#### H. Summary

Wilferd A. Peterson in "Friendship" has said:

"To be a friend a man should strive to lift people up, not cast them down, to encourage, not discourage; to set an example that will be an inspiration to others."

The basic premise of the teaching in this Training Course is "Friendship with Understanding." Through the contribution of time and understanding, the homebound, chronically ill and socially isolated in the community will again find hope which will be reflected in their renewed zest for living.

## SESSION II

### Understanding People -- Ourselves, Others

1 hour

All human endeavor involves a certain amount of social interaction and association with other individuals. Personal satisfaction in the home, on the job, and in the community is dependent on the individual's ability to get along with his fellow man. This involves a recognition and acceptance of individual and cultural differences, strengths, weaknesses, goals and aspirations.

In order to work effectively with people and help them in a time of stress, it is important to have some understanding of them and their reactions to problem situations. Understanding self is an aid to understanding others.

#### A. The Individual and His Home

##### 1. Each person is different because of:

his unique heredity

his health and physical stamina which may vary

parental and sibling relationships

school experiences

employment and career experiences

social relationships outside the home

mental and emotional strengths

his social environment

##### 2. Each individual behaves differently because:

he is the product of his own particular environment and social experiences

the same individual varies from time to time

people tend to react more positively to people of similar backgrounds and cultures

prejudices and stereotyped ideas are developed from early childhood

3. Differences should not be judged as "good" or "bad"

they may reflect cultural patterns

deviations from accepted so-called "norms" are not necessarily wrong - merely different

Differences are reflected in the general atmosphere of the home:

the nature of the inter-personal relationships between parents

between parents and children

attitudes toward and relationships with other members of the household and community

values assigned to household maintenance, established routine, money, diet, personal possessions

social acceptance

religious observances

B. The Effects of Chronic and Disabling Illness on the Family and the Individual

1. The Individual

Social effects may be:

loss of prestige within the home

reversal of role -- from independence to dependence

restriction and deprivation of social contacts

Physical effects may be:

pain and discomfort

outward physical changes and physical deterioration

inability or restriction in caring for personal needs

changes in eating and sleeping habits

Economic effects may be:

change in the standard of living

added financial pressures

Psychological effects may be:

inability to accept reality

fear and anxiety

despair and depression  
frustration and feelings of inadequacy  
feelings of guilt  
feelings of rejection  
apathy and indifference  
feelings of uselessness and helplessness  
desire to withdraw  
resentment and hostility

## 2. The Family

Social effects may be:

curtailment of social activities and social contacts  
inability to maintain former social standards -- ex.,  
orderly home, smooth-running routine  
increased burden of care  
feeling that no one cares

Economic effects may be:

loss of income  
increased expenses  
reversal of bread-winner role  
need to move into less expensive housing  
indebtedness  
loss of financial independence  
need to apply for aid

Psychological effects may be:

anxiety and worry  
inability to accept the reality of the situation  
over-protectiveness and pity  
resentment and bitterness  
feelings of guilt

feelings of frustration and despair

desire to escape from an unpleasant situation  
"What did I do to deserve this?"

C. The Understanding Visitor Accepts People as They are

1. Desirable qualities are:

genuine and warm interest in people

desire to be of service

patience and humility

a sense of humor

ability to seek and accept professional guidance

loyalty and confidentiality

D. Summary

Every human being is different. He is a product of his social environment and life experience.

The sick person feels a sense of loss and change. He is subject to many conflicting emotions and pressures.

Illness or social isolation may change a family's life. It can diminish resources, change a standard of living and impair relationships. It may create resentment and a sense of being burdened.

The Volunteer Friendly Visitor accepts people as they are. "Friendship With Understanding" is offered by the Volunteer Friendly Visitor to bring encouragement and new interests into the home.

SESSION III

Aspects of Health

1 hour

"Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. The requirements for health may go beyond the old definitions. It is recognized that a necessary part of the equipment of every human being is social health. The ability to live in harmony with other kinds of people, with other traditions, with other religions and with other social systems throughout the world."

Dr. Brock Chisholm  
Director-General  
World Health Organization

Physical Health

- A. The term "health" does not relate to a wholly measurable quality or condition.
1. It can best be described in terms of the degree to which the composite or aggregate powers of the human organism are able to function.
  2. The term becomes fully meaningful only when we are confronted with its opposite - disease or defect.
- B. This concept of health embraces the entire being.
1. Man is not a composite of separate entities, such as body, mind, and spirit, arranged in a presumed ascending order of importance.
  2. He is a multi-dimensional unit, with each component--chemical, physical, spiritual, intellectual, or emotional--existing as an element within a complex of inter-relationships.
  3. Each component becomes useful only in identifying certain aspects of living (for example, "the spiritual life," "intellectual powers," "physical health").
- C. In the normal, or at least usual, course of events man will seek to establish and preserve wholeness.
1. He will strive to maintain his integrated state against the adversities of life.
  2. He will resist disease or retardation in growth  
to preserve his life  
to gain the opportunity to realize his potentialities.

3. He will attain both self-identification and recognition through the most complete development of all his powers.
- D. Resistance to disease becomes progressively less with increasing age.
1. Older individuals frequently die from diseases which would not have destroyed them when they were young.
  2. Aging, medically speaking, is the change which occurs in the cells and organs of the body as life continues.
  3. It is a depletion of physical and mental reserves.
- E. During the last half of the 19th century medicine made great strides in the control of infectious diseases such as cholera, typhoid, tuberculosis, diphtheria and dysentery.
1. Control of the communicable diseases eradicated many acute diseases of childhood.
  2. In 1900 the average life span was forty years
  3. In 1959 the average number of years of life remaining increased to 67.3 for males and 73.9 for females.
- F. Advances in medical knowledge have contributed to the prolonged life span.
1. In 1900 there were 3 million persons over 65 years of age
  2. In 1956 there were 14 1/2 million persons over 65 years of age
  3. In 1960, in all age groups under 55, the New Jersey death rates were lower than the corresponding national rates. However, in each of the older age groups beginning with 55-64 the New Jersey rates exceeded the national rates.
  4. New Jersey has a greater proportion of its population in the older age groups compared with the United States as a whole.
- G. Principal Causes of Death for All Ages in New Jersey in 1966 were:
1. Diseases of the circulatory system
  2. Malignant neoplasms
  3. Vascular lesions affecting the central nervous system
  4. Influenza, pneumonia and bronchitis
  5. Diabetes mellitus
  6. Cirrhosis of the liver

## RESTORATIVE SERVICES

A. During World War II comprehensive rehabilitation programs were developed for the disabled.

1. Programs have expanded to include all ages and types of disability

(Use Case Illustrations)

2. Causes of disability

accidents

developmental diseases

acute infections

chronic diseases

congenital defects

aging

B. Objectives of Rehabilitation

(Use Case Illustrations)

1. Prevention or elimination of disability

2. Reduction or alleviation of disability

3. Re-training of the disabled to his maximum potential

C. Rehabilitation needs and goals differ with the individual

(Use Case Illustrations)

1. In children a crippling condition may exist in a healthy body

2. In older persons crippling may be superimposed on the pathology of the aging process.

## SUMMARY

Health is a state of complete physical, mental, and social well-being.

Man is a unique individual who strives to maintain himself against the adversities of life and seeks to improve his well-being.

The causes of physical disability are accidents, acute infections, congenital defects, developmental diseases, chronic diseases and aging.

Present-day medical problems show that more aged people with chronic conditions survive today than in the past. Emphasis on rehabilitation is geared to the elimination of disability or the reduction of disability.

SESSION IV

Problems of the Homebound

1 1/2 hrs.

From the first onset of illness, subtle changes take place in the relationships between the patient, his family and the outside world. Familiar routines are disrupted and contacts outside the family circle are frequently severed.

After an initial period during which the homebound patient may be the center of attention, receiving a good deal of preferential treatment, life settles down to a monotonous routine. The horizons of the homebound individual shrink appreciably as new disabilities and limitations are imposed by illness. Friends may lose interest as time goes by. As the sense of isolation increases, the homebound patient may tend to become more withdrawn.

A. The homebound individual may react in many different ways:

Loneliness, rejection, lack of motivation and insecurity  
resulting from mental and physical inactivity

Physical or emotional stress which results in exhaustion

Negative attitudes which result in resentment or resignation

Loss of self-esteem

Frustration at inability to participate in family life  
and responsibilities

Shock and anxiety at the loss of contemporaries

B. The family may experience many changes

Re-arrangement of the usual pattern of living

A sense of burden imposed by care of the individual with  
long-term chronic illness

Constant drain of time and energy by demands for attention  
and diversion

Inability to cope with emotional problems related to illness

C. There are many different kinds of dependency needs

Physical dependency which requires help with washing, dressing  
or feeding

Emotional dependency caused by narrowing social relationships  
or deprivation

A combination of both physical and emotional dependency which  
may be exaggerated by illness or disability

D. Dependency needs may differ at different times

In childhood there is a need for love, protection, physical care, food, clothing and shelter

The homebound child may present special additional problems:

inability to attend school or a delay in entering

inability to participate in out-of-door activities

lack of friends

lack of interests

as a result of the increased strain on the family, an attitude of hopeless resignation about the future may develop with the family and the child.

With the older homebound individual, some of the same dependent needs of childhood reappear:

with the loss of economic independence

with physical disability or limitations to age

loss of status and authority within the family group

E. Homebound persons may have many special needs

1. Special housing modifications and safeguards

Example:

ramps  
handrails  
elevators

2. Public health nursing services

3. Nutritional services

Example:

meals-on-wheels  
special diet counseling

4. Shopping services

Example:

for the house-bound aged person living alone

5. Home Care Services - A coordinated Home Care Program is one that is centrally administered, and that through coordinated planning, evaluation and follow-up procedures, provides for physician-directed medical, nursing, social and related services to selected patients at home.

The Program is primarily intended for patients whose health needs:

do not require hospitalization and cannot be met on an ambulatory or out-patient basis

require a complex of medical, nursing, social or related services over an extended period of time

can feasibly be met by the Program in a suitable physical and psychological home environment

(Note: Use case illustrations)

Home care services may include the following, depending upon the needs of the individual under care:

physician  
nurse  
physical therapist  
occupational therapist  
speech therapist  
social worker  
dentist  
nutritionist  
homemaker  
volunteer friendly visitor  
chiropracist

6. Loan closet supplies

Example:

self-help devices  
wheelchairs  
walkers  
hospital beds  
bed-side commodes

7. Vocational guidance services

Example:

home teaching for handicapped children  
vocational counseling and re-training for the disabled  
limited employment in the home

## 8. Diversional therapy

### Example:

talking books  
arts and crafts  
record players  
traveling libraries  
windowsill gardening

## 9. Pastoral counseling

## 10. Friendly visiting

## 11. Transportation for special purposes

### Example:

medical centers  
church  
Golden Age clubs

## F. Summary

The homebound individual may feel isolated, rejected, and neglected. He may develop feelings of frustration and annoyance because he cannot function as adequately as in the past. He resents his enforced dependency upon others. The homebound person loses his sense of independence and may grow weary of his confining, restricted environment.

The family may find it difficult to cope with the specialized routine required for the homebound person, and may resent having their lives and their home disrupted by the demands made upon them.

The homebound child may find himself completely isolated from his peers; unable to attend school or participate in learning experiences; and deprived of opportunities for previously enjoyed recreation. Subtle personality changes may result from this isolation.

It is frequently necessary to "build in" many supportive services or resources for the homebound in order to sustain the individual in his own home such as home care, homemaker or friendly visiting. Many professions and skills are required to meet these needs.

## SESSION V

### Mental Health

1 hour

In order to have a good understanding of mental health, one must have some recognition of the forces that maintain and can improve it, as well as those that are detrimental to it. Healthful living requires a sense of balance. It is necessary to have some knowledge of the instinctive human drives with which the individual is equipped, as well as the environmental influences to which the individual has been subjected.

Good mental health involves: the ability to meet daily life situations constructively; the ability to establish positive and meaningful relationships with other people; and, the ability to plan intelligently for the future in the light of previous knowledge and experience. Every individual has emotional problems, but whether these problems make him ill or not depends on the strength of the individual's personality, the support he receives, and the degree or quality of the stress created by the problems presented.

#### A. The Mentally Healthy Person:

Can deal constructively with reality even at its worst

Gets satisfaction from struggle, particularly as he turns adversity into achievement

Finds greater satisfaction in giving than in receiving

Can live comfortably with his tensions and anxieties

Has a sense of security - both internal and external

Relates himself constructively to others with mutual satisfaction and helpfulness

Learns to profit from experience

Has a capacity for love

#### B. The Effects of Chronic and Disabling Illnesses on Mental Health

In cases of severe illness, there is, almost without exception, severe emotional involvement. The degree to which an individual can adjust to the chronic illness or handicap will be dependent to a large extent on his pre-illness personality.

Chronic illness with its associated physical impairment, requires some understanding of the patient's attitude toward his own "body image" with resulting frustration and depression.

At the onset of the chronic illness or handicap there is frequently a severe "mourning period" due to loss of function, social status, or employment.

There is often belief in the "miracle of complete recovery" - wishful or magical thinking that through some miracle the patient will get well and be able to pick up where he left off. There is a rejection of the reality situation.

When the patient realizes that there will not be a complete recovery, depression and frustration deepen.

Each individual will react differently to a given situation, depending upon his personality.

Some chronically ill persons react by showing: anxiety, belligerency, suspicion, apathy, confusion, embarrassment, discouragement, withdrawal, seclusiveness, forgetfulness, fear, child-like behavior.

Others may develop feelings of guilt and self-punishment.

Others may be non-communicative. They are afraid to express their fears aloud, or they may be afraid to express negative thoughts for fear of antagonizing those about them on whom they are dependent.

Others may develop delusions, hallucinations, and ideas of persecution.

#### C. The Mental Patient at Home

Due to new methods of treatment, patients in increasing numbers are able to return to their homes for a convalescent period prior to discharge; again, due to intensive hospital treatment and an effective aftercare program, patients are discharged sooner and before they become dependent on the hospital and too far removed from their former environment.

For those patients returning to their homes, the Volunteer Friendly Visitor may have contact with the patient while visiting another family member or for the express purpose of serving as a Volunteer Friendly Visitor to the recovered mental patient. The Volunteer Friendly Visitor has a distinct responsibility to the recovered mental patient as she relates to him during his period of adjustment to his new, yet familiar, environment. She can do much through her own understanding and attitudes to help dispel misconceptions of the family and friends about mental conditions by remembering:

The patient is making an adjustment to a new environment -- while it is his home and his former "world," he has been away and needs time to readjust to his family and living patterns in the home, the neighborhood, and the community

The recovered patient is a mature adult who expects to resume his place as a member of the family and who expects to be accepted as such

He has a right to disagree, to get upset when things go wrong - we all do

He should be given, and encouraged to accept, responsibilities in the home

He should be given support, affection, and respect and be treated as a person who has recovered from an illness, not as a person who is still sick

If a Volunteer Friendly Visitor in her contacts with the recovered patient notices signs of depression, over-excitement, or distinct changes in personality or speech, she should report this to her supervisor for appropriate action.

#### D. The Role of the Volunteer Friendly Visitor

1. An awareness and acceptance of the emotional disturbances of the chronically ill or handicapped patient can be the first step in helping him toward a better adjustment.

2. Encourage the patient to express himself

A patient with a chronic illness or handicap left to himself cannot help but review his whole life in the light of his present situation with varying emotional reactions.

The emotionally upset person has a tendency to withdraw from reality: blank-out unpleasant situations; or react in a defensive, depressive or aggressive manner.

3. Help the patient to utilize all positive existing factors in coping with his problem. A patient's strengths may include:

courage

intelligence

knowledge

past experience

family and friends

religious faith and personal philosophy

perseverance and determination

compensatory optimism and self-reliance

4. All unusual emotional disturbances or unusual behavior should be brought to the attention of the supervisor of the Volunteer Friendly Visitor for appropriate action.

The supervisor then transmits this information to the patient's physician for his evaluation of the degree of mental or emotional disturbances.

The observations of the Volunteer Friendly Visitor can also help in the determination of whether specialized services are required for the welfare of the patient or his family.

Just as the Volunteer Friendly Visitor does not attempt to diagnose or prescribe treatment for physical illnesses, she does not attempt to diagnose or treat emotional or mental disorders.

#### E. Summary

It must be recognized that emotional and mental disturbances go hand in hand with physical disturbances, especially those of a chronic and incapacitating nature. There has been a growing national concern regarding the effects both on the individual, his family, and the community of disabling emotional disturbances. There is an increasing awareness of the importance of promoting and maintaining good mental health.

Chronic physical illnesses with their accompanying social, emotional and mental disturbances do, unquestionably, present a serious problem. However, the picture is far from hopeless. Medical science is continually making great strides forward. Through research, preventive measures, and the use of new therapies, many of the incurable illnesses of yesterday are curable today.

Professional people in the associated fields of psychiatry, psychology, sociology, and social work have marshalled their resources to help people and families in trouble, and to assist them in making a good adjustment.

SESSION VI

Growing Up

1 hour

The wonderful world of childhood sometimes becomes the magic realm of growing up. A child whose security is threatened by illness--his own, or a member of the family--will necessitate special understanding by the Volunteer Friendly Visitor. Careful screening to select persons who understand and love children will make much of the following information simple review.

This is the period in which foundations for a sense of trust are built. It is also the period in which the infant's needs to explore his environment exceeds his ability to do so without understanding and help. Failure to receive appropriate stimuli, understanding of physical and emotional needs and assistance in meeting them poses a barrier to later steps in the maturation process.

A. The Child's World:

Revolves around his family and home  
Is on a much smaller scale than that of the adult  
Needs emotional security to thrive  
Feels threatened by disapproval  
Needs recognition of his accomplishments  
Is different from every other child

B. The Child and His Family:

Believes his family, whether good or bad, is the best  
Knows being disciplined is part of being loved  
Likes to be first with his parents--some jealousy among  
    siblings is normal  
Competition among children in a family is normal  
Ruptured family ties leave scars  
Copies the likes and dislikes of his family  
Learns moral values and patterns from his family

C. The Child and His Friends:

Needs friends as part of growing up  
Learns to share as a result of parental teaching  
Sometimes indicates insecurity or need to be loved by  
    withdrawal or aggressive behavior  
Uses play as a normal outlet for energy  
Peoples his play world with imagination  
Learns self-control as part of getting along with others

D. Making Friends With Children

The successful Volunteer Friendly Visitor:

Is natural - children always know if you really like them

The period of passage from being valued for what one did, to who one is can be stormy indeed. Most older people survive the passage because they have built throughout their lives an inner core of courage and self-respect to serve them during this period of change. Few escape without some feelings of loneliness and a need for companionship and belonging. Feelings of uselessness and the need for being useful through a meaningful pursuit, lack of self-confidence in being able to develop new relationships, new interests and new skills; timidity and withdrawal; need for new sources to provide recognition and respect, status and affection are common.

#### B. Time and Tasks

The middle-aged dream of retirement often fades when the overabundance of time becomes a reality. What can be done with all the hours we inherit? For the baby, the adolescent, the young adult, the middle aged, society has definite jobs. The small baby must eat and sleep and grow; others go to school, work, raise children or keep house. For the aging person, there is no such expectation, and unless he is one of the "autonomous" elderly, who keeps going on his own creative steam as he has all his life, life becomes goalless. Much remains to be done in this area, so that, as has been said, life may be added to the years, rich, personally meaningful life.

Society measures status and usefulness by productivity, responsibility and earning power. Status and a sense of self-worth deflate markedly when there is no longer a job to indicate the degree of productivity and the measure of responsibility, and when there is no longer a pay check regularly coming into the home as a measure of one's value to the world.

#### C. Aging is Universal

It is common to every person and not peculiar to a small portion of the population.

There are approximately seventeen million persons 65 years of age and over

They range in age from 65 to 112 years

There are more women than men

The majority of women are widows

Basic needs are food, shelter, clothing, health care, companionship and love, and a reason for living. The basic needs of all people are the same.

## SESSION VII

### Growing Older

1 hour

Aging is essentially a progressive reduction of reserves and an aged person is one whose reserves have been reduced over the years in any area--physical, psychologic, or social--to the point where he is approaching the margin between independence and dependence. He is, therefore, more likely to be thrust over the margin by stress and trauma than is the younger person with greater reserves and is thus in greater need of supportive measures during these periods of stress.

As each year passes, the new group of people who achieve the status of "retired" or "older" citizens has different characteristics. The educational level rises, because of the development of universal education that occurred in the early 20th century. The percentage of foreign-born Americans has decreased because of the lessening of the in-migrations of the early 1900's.

Money, medical research, creative ideas, and supportive community services have been created to keep more people alive longer. The success these efforts have achieved can be measured concretely by the steady increase in numbers of persons living longer, as well as the increased proportion of older people in the population.

Existence without meaningful purpose has long been recognized in man's history as an empty gesture. The first step in planning a good program to serve older people is to keep in mind that all older people are not destitute, do not have chronic diseases necessarily, and are not in the hospital.

Each community will be called upon to re-examine its present programs with an eye to making them more satisfying and useful to its residents. Exploration will reveal areas which need expansion as well as development. One of the most important jobs to be done with purposeful living involves changing the attitudes of older people about themselves, being older, and community attitudes toward aging.

We recognize now that we can help to give a purpose to living by helping to provide satisfying human relationships and activity which have real meaning for each older person.

#### A. Cultural Attitudes About Aging

Negative attitudes abound concerning growing older. Older people often react with confusion and quiet desperation to the high premium given to youthful qualities and attractiveness, since bodily changes inevitably accompany the passage of years.

To be young is desirable and desired. As yet, no fountain of youth has been found to reverse the aging process. Feelings of unattractiveness and loss of self-worth by the older person often result. Physical and sexual prowess are related in people's minds to youth. The actual or imagined sense of loss in one or both of these areas may bring self-doubts.

5. People close to the adolescent's own age and interests are frequently more important to him than adults.
6. Although the adolescent may appear to rebel against time and behavior limits, actually these restrictions help him and guide him in his behavior with other young people.
7. This most difficult period in which the adolescent is called upon to struggle largely by himself is a crucial one in his development since the solutions of conflicts achieved in this period become the equipment for his adult relationships and the carrying of his place in society.
8. If the adolescent process has been successful, the individual emerges an adult.
9. Sexual manifestations may cause self-consciousness. There is a marked difference between the maturity of boys and girls at this age.

G. Summary

1. The Child's World

His family - relationship to each parent, each sibling, grandparents, especially in the three-generation household

His peers - relationship to others

Himself - search for individual identity - as others see him - his needs, his aspirations, his frustrations, his joys

2. Special approaches to children while "Friendly Visiting"
3. Special approaches to homebound children, and how their situation differs from above  
fears attached to being homebound  
skills helpful in handling relationship of well to sick
4. Adolescence is a transitional phase in growing up, fraught with physical, social and emotional conflict
5. His own peer group is more important to the adolescent than the adult group

Is interested in what interests the child  
Scales activities to the child's level of accomplishment  
Accepts the child's world as it is without judgment  
Does not make promises he can't keep  
Praises successful effort and minimizes failure  
Does not compare one child with another  
Tolerates rejection and waits for the child to come to him  
Responds with warmth to humor and affection

E. The Homebound Child's Limited World:

Is cut off from normal childhood activity outside his family  
Presents many special problems because of illness  
Requires time-consuming care  
Has great need for love and attention to stimulate growth,  
health and self-confidence  
Has a shorter span of attention  
Needs outside interests and companionship  
Sometimes has many personality changes because of illness  
and prolonged institutionalization  
Frequently may become demanding and irritable

Deviations in physical appearance and equipment - real and unreal -  
may pose a barrier to fulfillment of the child's need for affection  
and love.

Placement in special classes or schools for the handicapped may  
pose serious blocks to the development of a healthy self image  
and afford poor preparation to later living in a non-handicapped  
community.

F. The Adolescent

Because of rapid physical growth in this period, the adolescent is  
in an unstable environment in relation to his own body and the  
changing reactions of his outer environment in response to the  
changes in him. The strange and new inner urges cannot be handled  
by solutions drawn from previous experiences.

1. Parental attitudes, cultural factors, economic conditions,  
position in the family constellation, position in the social  
group (with respect to popularity) and opportunities for social  
experience are important.
2. The greatest requirement for growth during this period is the  
possibility for experimentation in the impending adult role,  
within a loving and limiting environment.
3. Any physical impairment or handicap and limited environment  
(such as hospital, special home, etc.) pose problems in ac-  
complishing the growth of the adolescent.
4. Adolescents frequently vacillate emotionally between childish  
and adult behavior, and frequently appear unreasonable.

#### D. Aging is Normal

Growing up is spoken of with respect, while growing old is spoken of with fear. This fear develops from a picture of aging which involves physical illness, loss of faculties, and living in the past. It is necessary to recognize that most people draw their picture of the aging process or being aged from those who live around them.

#### E. Human Relationships and Aging

In a well-balanced life it is assumed that people will want to spend time with others as well as alone. Being alone can be enjoyable, but it can be devastating when it is imposed. Many people have had to work all their lives with no time to develop a vocational interest. Others have viewed recreational pastimes as child's play or sinful.

#### F. Aging is Variable

The way in which each person ages is unique. It is now known that the state of a person's well-being in the later years develops from his personal life pattern of work, activity, rest, human association, diet, exercise and mental attitude. People's reaction to life's experience varies.

Aging is variable and no two persons will react physically, socially or emotionally in the same way.

There will always be come vigorous, mature, serene, active persons of 94 as well as some physically frail, emotionally depressed, socially inactive persons of 65 years.

The circumstances of life for older people vary as they do with other age groups. It is clear that not every person 65 years of age and older will find purpose in living in the same way.

Not every person will need or want the same degree or the same kind of community opportunities for successful living.

#### G. Aging and Illness are not necessarily coincidental

Many persons have accepted the stereotype that ailments and ills are the natural accompaniment of old age. A new concept is being recognized now which points up the difference between the physical consequences of age per se and illness. This imposes greater individual responsibility to prepare for a healthy old age through improved living habits in the early and middle years.

#### H. Older People Represent Three Generations

The age group known as aging covers from 65 to 112 years. In no other stage of life is a forty year span lumped into one category. This group represents at least two, and frequently three generations. Therefore it is necessary to recognize that the characteristics of the younger-older group may be different from the middle-older or the older-older groups. More work needs to be done to

identify the variable factors between these three stages of aging. They live with their spouses, with relatives or friends, as boarders or alone.

Some 5 per cent live in institutions such as homes for the aged, nursing homes and hospitals.

The other 95 per cent live in their own homes, in the homes of relatives or friends, in apartment houses or in rooms.

Frequently one finds an older person who has outlived the other family members, and is now alone.

Much is to be said about families and their older members. The three generation household had just about disappeared. Where family relationships have been healthy and satisfying before, this continues, and the older relative feels loved and cared for. Where tension, discord or lack of understanding prevailed, there is lack of understanding and even neglect.

The need is great for friends, as at any age; however, statistically, one out of every twelve persons lives to be older than sixty-five, and few people have been able to develop eleven or more friends who will remain with them in later years. Opportunity is necessary for meeting and making new friends and acquaintances.

Mobility and transiency characterize our way of life, and often older people must decide to remain in their "home towns" or move on with the younger members, to unfamiliar places and adjust anew.

#### I. Older People Can and Do Learn

The modern literature in gerontology makes clear that the capacity of older people to learn is not necessarily diminished. The learning pattern may change and differ from the learning patterns of children. The speed of learning may be slowed, but the learning may have a deeper value. The capacity to learn new things and to relearn the old is still great.

Most of these seventeen million people have at least an eighth grade education. Some have never learned to write or read. Some are highly educated.

In our society an agile mind and a facile memory are often mistaken for intellectual endowment and creativity. Older people are apt to interpret memory loss, no matter how slight, or a slowing up of the learning process as the loss of mental or creative capacity.

#### J. Older People Can and Do Change

A common fallacy is that older people will not change. Frequent demands for readjustment are made upon older people in giving up a job, changing their physical environment and way of life of many

years' standing. A transfer into a smaller house, a different community, a home for the aged, or the home of a daughter or son demands great capacity for adjustment.

Death frequently comes to one or the other of the major companionship of life, marriage. The ties of life routines developed, with love, affection (or even lacking these) are broken and need to be replaced.

#### K. Older People Want to Remain Self-Directing

Expressions such as "older people are just like children," "they never want to decide anything for themselves" are misconceptions. On the contrary, maintaining self-direction as long as possible is usually the chief desire and a major factor in self-respect. It is now understood that any sound plan for change in the life of the older person must be kept insofar as possible under his own control. Even when complete control of decisions about his life is not possible, his maximum participation in decision-making should be sought. Many are physically able, keen of mind, active and interested in the world around them.

A few of these persons are working full-time, some part-time, but the greatest number have retired from paid employment.

Income will increase with larger social security payments and the spread of private pensions.

There are those who are ill or enfeebled, who cannot get around, who may be confused mentally, or who feel defeated.

#### L. Older People are Vital Human Beings

The approach to older persons is often colored by misconceptions. One common tendency is to assume that physical limitations and handicaps imply total inadequacy. It needs to be recognized that the requirement for physical help to cross the street does not imply that the person does not know where he is going. Each older person is a living, vital, interesting being with whom association can be rewarding and beneficial, irrespective of the state of physical being or life circumstances. Clarity of mind is aided by the constant use of the mental faculties in learning new things and in maintaining social relationships with others. Where there is a vital life in the present, there is small need to live in the past.

#### M. Summary

Older people have life experience and wisdom as well as energy and vigor. Communities need these qualities, and other people need the chance to perform usefully contributing to community life. One way is by volunteer friendly visiting.

Basic Concepts to be Covered:

1. Expanding longevity and the social problems it creates
2. Variety in patterns of aging
3. Younger old people versus older old people - their varied needs.
4. Cultural negative feelings about growing older, both because of the premium on youth, and the association of age with death and illness.
5. Tasks of the elderly - the need to develop meaningful existence past retirement age.
6. Choice for elderly becomes smaller and needs to be expanded for continuing growth, the essence of life.
7. Need for change of attitude about getting older, as well as need to tackle the real and basic problems.
8. Some fallacies concerning old age -- it comes with rigid attitudes, it is equated with childishness, it is equated with illness and helplessness.
9. While the community (that is, society) is the central provider for secure and comfortable aging, self-direction and decision making should continue for independence is also the essence of life.
10. Living arrangements of older people
11. Widowhood and remarriage
12. Income of older people
13. Need for medical care
14. Need for vocational help or avocational help -- importance of recreation.
15. Special agencies in the community which help older people with their problems.

## SESSION VIII

### How the Community Helps

1 hour

Instructors should prepare a brief picture of the county or city from which the volunteers have been recruited. This presentation should include the following:

A history of the area covered

The population components

Any unique resources and characteristics

#### Sources of Information:

"This is New Jersey" by John T. Cunningham is a good basic reference. Local community organizations, Councils of Social Agencies and the local Chamber of Commerce can provide informational material such as maps, etc.

#### Introduction

Community health and welfare services of today are an outgrowth of earlier community activities developed during the Colonial period in the United States. They were developed to meet unmet needs. They reflect the community's concern for all its citizens.

#### A. Family and Society

##### 1. Guarding and Strengthening Family Life implies that:

the family is the basic unit of society

families living in groups can achieve greater security and well-being

adversity striking one or more families soon overtakes others - disease, blight, delinquency

##### 2. Communities devise many services through planning and pooling of time, talent and tools:

for safety - i.e., police and fire departments, housing and building codes, civil defense

for health - i.e., public health controls, clinics, hospitals

for personal development - i.e., educational institutions at all levels

for cultural expansion - i.e., museums, societies to promote the arts

for enjoyment - i.e., parks, recreational areas

for convenience - i.e., availability of water, sewage,  
fuel, electricity, transportation

## B. The Communities and Their Stricken Members

1. Families as well as individuals are sometimes beset by disabling circumstances:

These may be economic, social, physical, mental,  
moral - singly or in combination

These factors may overwhelm the family's ability to  
function adequately and wholesomely

2. Communities provide enabling facilities and services which are designed to compensate for specific lacks and/or losses:

These facilities may be tax supported and operating  
within legally defined policies - i.e., public welfare  
departments, courts

They may be privately supported and operating under  
defined policies and programs - i.e., voluntary agencies  
to meet health, welfare or religious needs

3. Availability and Entitlement

Facilities and services are not automatically available  
to all members of the community but should be available  
to all who need them

Entitlement may be determined by

Investment - contributory plans such as Social Security,  
Blue Cross and Blue Shield Plans, Medicare, unemployment  
insurance, health and accident insurance

Purchase - payment of clinic fees, prosthetic appliances

Membership - as in fraternal organizations, church  
affiliations, unions

Military service - as in Veterans Administration facilities

Need - lack of financial resources

4. Modern community - national, state, county and municipal -  
has devised a wide variety of highly individualized services  
aimed at the "trouble spots" in family life

When unemployment occurs -

- unemployment compensation
- help in finding a new job
- vocational, counseling or re-training
- re-training or through vocational rehabilitation
- financial assistance when resources are exhausted

Loss or incapacity of parents

- child welfare services, such as Aid to Dependent Children
- family counseling services
- financial assistance
- school scholarship opportunities
- Social Security - survivor's benefits
- Veterans Administration dependent benefits

When illness occurs

- clinics and ward beds - sliding scale fees
- public health nurse services
- convalescent homes
- home teachers assigned
- visiting homemaker services
- mental hygiene clinics
- loan closet equipment, i.e., sick room equipment
- disability insurance
- community health services

Old Age Resources

- day centers and Golden Age Clubs
- Social Security
- pension plans
- housing of special design
- nutritional counseling services
- public health nursing services

Public Welfare Programs

- Aid to Dependent Children
- Aid to Blind
- Aid to Permanently and Totally Disabled
- old age assistance
- Medical Assistance to the Aged
- municipal welfare departments

5. Obtaining Community Services

The family may need help in applying

- by interpretation of agency policy
- by assistance in completing forms when needed

Persons outside the family may initiate the request  
for help

for someone physically or mentally incapable  
of doing so  
for neglected, unprotected or abused children

C. Summary

Services are provided by the community to serve citizens in need. The Volunteer Friendly Visitor's observations and reports help the agency to plan with the family. The making of referrals for community services is the responsibility solely of the agency.

SESSION IX

The Friendly Visit

1 1/2 hrs.

Volunteering is important to the individual who gives of his time, effort and devotion to help others. Everyone needs to feel needed. To be accepted as a volunteer means that one holds a position of honor and trust in the community.

The Volunteer Friendly Visitor makes a unique contribution.

A. The Spirit of Friendly Visiting

1. Friendly Visiting is a giving of one's time and self. Sharing is the keynote.

The visatee should derive the maximum feeling of ease and warmth from the visitor.

It is satisfying to both visitor and visatee.

Fills a need in the life of the visatee.

He does not work alone.

Staying power is important.

Small successes are the key to big ones.

Takes stock of himself.

Should not confuse his needs with those of the visatee.

Encourages the visatee to realize his full potential.

B. The Performance of the Friendly Visit

1. Observe environment and use for conversation
2. There are basic principles to be observed:

respect privacy

be non-critical, kind and courteous

be unhurried, give warm and personal attention

be an attentive observer and listener

encourage anything positive

keep a sense of proportion

Special consideration will need to be given to:

talk of institutionalization

talk of death

grief or loss

confidences

Note: Instructor should use case illustrations regarding above

- C. Guide to Relationship: interest, understanding and compassion (not pity) are your guides. Every person is different, and his physical condition and mood may vary from week to week. Therefore, friendly visiting must be "played by ear." No set rules will cover all situations.

Experience has shown that the following guidelines can be helpful:

Telephone patient or family in advance of visit.  
Notify them if the appointment must be changed.

If you have a cold or other infectious condition,  
cancel visits until recovered.

The first visit should be an "acquaintance" visit.

Enlist understanding and cooperation of household members.

Remember that interest span may be short and plan craft  
or recreational programs accordingly.

Listen for cues on former interests, or present ones.

Try to perform simple activities together. On the first  
few visits it is wise not to push this.

Take home conditions as you find them. Do not criticize  
or give advice on housekeeping. Remember you are a guest  
in the patient's home.

Stay only as long as you feel the visatee appears comfortable.

If you are visiting a bedridden patient, do not sit on or  
jar the bed.

Sustain patient's confidence in his doctor or in others  
concerned with his well being.

Do not discuss other patients' symptoms, treatments, etc.

If you sense a rejection, try not to take this personally. The visatee may fear that you too, as others before, will desert him.

Note: Instructor should use case illustrations showing ambivalence.

Do not accept checks for cashing, sign documents, or arrange for the sale of anything.

Wherever possible encourage the "doing for others" feeling, for service to others is one road to good mental health.

Do not promise more than you can fulfill

Introduce new and pleasant topics and activity

It is important to observe confidentiality with other Volunteer Friendly Visitors, as well as with the rest of the community.

Do not bring gifts which most often cannot be returned in kind by the visatee.

Some cookies (if diet permits), a cutting from a plant, a magazine article, newspapers, patterns for handiwork, recipes, or other tokens of friendship may be appropriate.

Make a definite date for the next visit together.

The agency will be helpful with problems that are bound to arise, and must always be consulted.

- D. A Volunteer Friendly Visitor should be: A well-informed person who understands the program and policy of the sponsoring agency and the tasks which he may or may not do.

He should be:

dependable and punctual  
leisurely  
interested and flexible  
an attentive listener  
a keen observer  
tactful and prudent  
courteous and kind  
encouraging - with restraint  
loyal  
patient and cheerful

The tasks he may do:

- chat
- read aloud
- write notes and letters
- try to develop interests, old and new
- initiate simple handicrafts
- play simple games - cards, checkers, etc.
- bring clippings from papers or magazines to encourage discussion
- bring plant cuttings to encourage in-door - out-door activity
- remember birthdays and holidays by cards
- with agency approval, shop if visitee is shut-in
- with agency approval, take visitee for ride
- recognize and report to supervisor needs which can be met by community resources
- share interests, i.e., discussion of T.V., radio programs, etc.

#### E. Summary

Common sense is the guideline for performing friendly visits. The Volunteer Friendly Visitor should reflect on his or her visits with himself, with the supervisor assigned by the agency, and should report back to the agency. The combination of reflection, self-discipline, giving, listening and observing, will aid in the development of skill in volunteer visiting.

## Role Playing

1/2 hour

### Note to Instructors:

Role-playing is a well-established method that achieves the greatest possible feeling of involvement by the participants to the situation under discussion. It is an actual dramatization of a case by members of the group, in front of others, after which the group discusses what they saw and how it might have been improved.

Role-playing is most useful in dramatizing human relations situations, principles of interviewing and counseling, and all problems of interpersonal relations. The case or situation to be "acted out" is explained briefly by the leader. Members of the group are selected (or volunteer) to play the parts of the persons in the situation, which they proceed to do before the rest of the group. The leader then conducts discussion, raising questions and bringing out principles he has considered in advance.

The degree of preparation for role-playing, as compared with doing it on the spur of the moment on a more or less impromptu basis, becomes a matter of question in using this tool. Some prefer that the dramatization be prepared in advance, others that it be done on the impromptu basis. It must be remembered that there are at least two major benefits of this method, the close feeling of involvement and understanding achieved by the total observing group and the even closer involvement felt by the actual participants in the dramatization. Probably more members can receive the latter benefit if it is employed more or less informally and oftener. If time permits and this is felt desirable, the situation can be acted out twice. Most role-playing incidents bring out the wrong way of doing things. After the discussion, during which correct principles are suggested, the right way can be acted out to show the group the way the incidents should have been handled.

Experience with role-playing has proved both meaningful and successful in this Training Course for Volunteer Friendly Visitors.

Observing and Reporting

Volunteer Friendly Visitors can make a significant contribution to agency services. A visatee's progressive improvement can often be traced to the energy, imagination, patience and devotion of the Volunteer Friendly Visitor. The ten million volunteers in the United States who serve their community agencies greatly enhance and extend the professional services available.

**A. Social Agencies are Community Instruments**

1. They are organized to meet health and welfare needs
2. They are accountable to the public for quality and quantity of services rendered

**B. Supervision is a Delegated Administrative Responsibility**

1. The role of the supervisor is:

To be a part of the agency administrative structure

To be responsible for correlation of agency program and volunteer performance

To be the channel of communication between the agency and the volunteer

To appraise performance as it relates to agency goals to be met

**C. The Trained Volunteer**

1. The purpose of training is to integrate theory with life experience

Self-awareness is essential to the understanding of others

2. Significant observations, objectively reported, are a basic responsibility of volunteering

3. Recognition and acceptance of code of ethical behavior

Respect for confidentiality

**D. Methods of Reporting Activities**

1. Through planned conferences with the agency supervisor
2. Through narrative reports
3. Through use of agency report forms
4. By telephone

- E. Instructors should exhibit sample reporting forms (see attached)  
Discuss and illustrate how the forms should be completed -  
illustrate
- F. Visiting Procedures
1. Frequency of visits will be determined by the sponsoring agency
  2. Transportation will be provided by the Volunteer Friendly Visitor, unless other arrangements are made by the agency
- G. Why Report Back
- Supervision and:
- responsibility to client
  - growth on the job
- Agency needs for data and current knowledge of the client
- Service to client is actually enhanced by thought and preparation
- H. How do we observe and know what to report
- Listening carefully not just to words
- Trying to get a proportionate picture and trying to separate the whole from the part one observes and vice versa.
- Noting changes in client - what we may do about them
- Knowledge of resources to help construct a fuller picture of the situation
- Confidences given, and confidentiality in the best tradition of volunteering
- Agency rules
- I. Self-awareness as a tool in observing and reporting
- J. Methods of reporting
1. Oral or written
  2. In individual conference or in a group
- K. The role of the supervisor in the agency, how he can help both client and visitor enrich the relationship.

SAMPLE REPORT OF VOLUNTEER FRIENDLY VISITOR

NAME OF AGENCY \_\_\_\_\_ ADDRESS \_\_\_\_\_ ATTN. OF \_\_\_\_\_

Name of Patient \_\_\_\_\_ Name of Volunteer \_\_\_\_\_

Dates of Visits \_\_\_\_\_  
(mo.) (yr.) (mo.) (yr.) (mo.) (yr.)

General observations - changes noted - needs or recommendations:

Re: Patient

Re: Family

What occurred during visit (talk, reading, hobby, etc.)

Date      Activity

Consultation needed by visitor on the following problems:

Date of next visit \_\_\_\_\_ I plan to:

(Use reverse side for additional comments)

Please return this report immediately  
to your agency supervisor.

## SESSION XI

### Recreation

1 hour

Recreation is an activity or experience that a person engages in during his free time because he wishes to do so and with no outside compulsion of any type. He recreates to meet inner desires and urges for enjoyable, creative activity, self-expression, relaxation; to achieve immediate and direct satisfactions. Recreation is an activity engaged in for its own sake and not for any reward beyond itself. The attitude which characterizes participation determines whether it is recreation.

#### A. What recreation means and why it is needed

##### 1. Definitions

Recreation means to recreate

Recreation is all those things a person chooses to do in his free time for the sheer joy and satisfaction derived from the doing.

##### 2. Values in the recreational experience

Fun and release of emotions

Enjoyable and memorable experiences

Maintenance of individual capacity for mental, social and emotional health.

Variety and change of pace in regularly scheduled activities of daily living.

Development of new skills and discovery of latent talents

Opportunities for individual and/or group participation

Development of self-esteem through sharing of skills and service to others.

Deepening interests and involvement in activities which can allay anxiety and self-concern.

An appropriate substitute for over-strenuous prolonged conversation.

##### 3. Personality - Effect upon quality of service

Attitude toward personal use of free time

Attitude toward sickness and health

Attitude toward age and sex differences

Attitude toward racial and cultural differences

Attitude toward need to change or be more flexible

Participation in activities serves to identify, what we are, who we are, where we want to go.

4. What sponsoring agencies consider in planning

Degree of interest and support of activities per se

Recognition of the value of participation in recreation for the visitee (patient) by medical personnel serving the patient

Role and status of visitee in family or friendship constellations

Facilities available at the place of the visit

Available budget, supplies and equipment for activities

The length of the visit and its relationship to the patient's schedule of activities of daily living.

The season of the year and weather conditions.

Resources for transportation and trips to the community

Invitations to, other individuals with special talents on occasion.

5. Clues to visitee (patient) interests

Articles in surroundings

Treasured items as mentioned in conversation

The happy periods or occasions in the visitee's experience

The physical structure of the individual

The mental alertness of the individual

What the visitee reads

What the visitee enjoys on the radio and TV

What is learned through listening and observing the interpersonal relationships of visitee, with friends and family.

6. How the Volunteer Friendly Visitor provides recreation service

Converses with visitee to learn of previous interests and hobbies

Shares personal interests and hobbies with visitee

Stimulates visitee to share his interests and hobbies

Instructs or makes arrangements for instruction of visitee in skills and knowledge which meet his interests and capacity

Makes arrangements for visitee to participate in community activities

When feasible makes arrangements to bring community activities to the visitee

Procures the necessary supplies and equipment in accordance with agency policy and procedures

Keeps recreation records as a part of overall recording of services

7. Knowledge and skill helpful to the Volunteer Friendly Visitor in carrying out responsibilities

Skill in establishing good relationships with visitee

Knowledge of history, geography, literature, mathematics, drama, music, art, science and sports

Knowledge of community resources which could be shared with visitee, when cleared with supervisor

Ability to demonstrate a skill or technique having to do with recreational activities

Ability to stimulate visitee interest and participation

Ability to accept visitee's limitations and capacities

Ability to communicate effectively

Knowledge of appropriate resources and supplies for programming

8. Some practices to be avoided in programming

Gambling for money

Use of money as prizes

Fortune telling

Overemphasis on refreshments and routine games

**B. Recreational activities for inclusion in a friendly visit**

**1. Methods to be used in sharing ideas**

Distribution of lists and activities

Presentation of charts, photographs and other visual aids

Displays of recreation supplies and equipment, books, games, etc.

Use of slides showing visatee and visitors in activities

Brainstorming technique with trainees contributing ideas as they occur to them

**2. Discussion as to appropriateness of some activities vs. others**

For the older person

For the chronically ill

For individuals with other needs for special consideration

**3. Practice in acting out a situation involving the visitor's approach to a visatee to decide what to do during a subsequent visit or visits**

Trainees are divided into five teams with a leader for each

Leader chooses a situation which is described on a piece of paper and reads to his group. (This is short case history. . .see attached)

Group decides how to act out a situation, chooses participants

Each team has two minutes for demonstration

Brief discussion follows

- I. The agency has received a request from the medical social worker in the hospital for a Volunteer Friendly Visitor for the "T" family. Mrs. "T" aged 40, has two teen-aged handicapped children, Ann 14 and Jack 16 years old, both with muscular dystrophy. They are both in wheelchairs. The father deserted the family when the children were small. Family income is marginal. The mother has no household help. Both children require complete physical care, except for washing and feeding. The mother is tied to the house for twenty-four hours a day because she cannot leave the children alone. She has few friends.
- II. Mrs. "J", a 68 year old widow with arthritis lives with her unmarried daughter, Mary, a high school teacher in her late 40's. Recently Mary was transferred to a new school district, so the family moved to a new neighborhood. Mrs. "J" is alone most of the day. She is frequently forgetful, and irritable because of her discomfort and isolation. She rarely leaves the house and has lost contact with old friends from her church and neighborhood. Miss "J" is usually tied up with extra curricular school assignments. A Visiting Homemaker comes in for two hours each day to prepare a noon meal and keep the house in order. The Homemaker discussed the situation with her supervisor. After talking with the daughter, she decided to assign a Volunteer Friendly Visitor to visit Mrs. "J".
- III. Mrs. "C", aged 40, is a widow, formerly an active volunteer in community projects and civic affairs. When she became ill with multiple sclerosis, her activities became very limited. All of her close relatives are overseas. A Visiting Nurse has come in twice a week for the past two months. She has found Mrs. "C" lonely, and fearful of the future. The nurse thinks a Volunteer Friendly Visitor might be good for her morale and help to distract her from thinking of herself and her problems.
- IV. The "B" family lives in a comfortable home with Susan, aged 11, an only child who has had poliomyelitis. She wears full length braces. She has been homebound for six years. In spite of the fact that the family has provided an over-abundance of books and games, Susan has remained isolated and bored. The parents have been afraid to have other children come to visit for fear that Susan will feel that she is different because of her handicap. The physician at the medical center is aware of the overprotection and isolation of the family and has recommended that a Volunteer Friendly Visitor might be helpful.

Joy of Service

## Foreword

"There is an unknown potential in the volunteer -- a fragment of the insufficiently topped creative forces which lie in the general population... In the volunteer is the potential leader, the person who can grow in competence and inventiveness, who combining identification with the agency and its goals, and a different and fresh perspective can help us . . ."

Albert Comanor, A.C.S.W.  
Professor  
Department of Social Welfare  
San Francisco State College

## Note to Instructors:

The purpose of this session is to acknowledge the contribution of both time and effort made by the volunteer in attending this Training Course.

Altruistic motivation for volunteer service may spring from many sources.

It should not be depreciated. It is a boundless source of energy sorely needed in the community to extend existing health and welfare services.

The rewards of volunteering are many, though frequently intangible.

Examples should be given by the Instructor of the positive aspects to the individual volunteer.

## VOLUNTEER FRIENDLY VISITOR PROGRAM

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