

Using Experiential Techniques In Hospice Volunteer Training

Lois L. Hipp and Donna Davis

In the hospice field, we all share a problem: volunteers with good intentions who want to help yet are able to comprehend neither the patient's and family's anticipatory grief reaction nor the patient's experience of helplessness. It is difficult to understand how living and dying affects human beings. But the consequences of volunteers' not understanding these issues are: (1) unintentional insensitivity in word or deed to the patient's and family's positions and (2) less effective, or even counter-productive, service to clients.

Volunteer administrators of hospices everywhere face this problem. Eva Schindler-Rainman calls it the "management of meaning,"¹ how to make meaning felt in the life of the volunteer. The meanings hospice volunteer administrators must "make felt" are some of the deepest and often most dreaded in our culture.

EXPERIENTIAL TRAINING A POSSIBLE SOLUTION

It seemed to me, as Coordinator of Volunteer Services at a hospice organization serving an intermediate-sized city and its suburban environs, that if we—the staff who provide training—could let the volunteer (or paid) staff trainees "walk in the moccasins" of people facing both physical dependency and the imminent end of their own lives, we could paint a living, experiential picture that would be far more valuable than many thousands of words from a teacher.

I developed and provided part or all of that experiential training to 150 patient/

family service volunteer applicants and 25 paid staff (nurses and social workers); 29 volunteers and five paid staff have received all three modules of my current experiential training program since January 1986. A detailed description of that training will follow.² From our first training series in early 1984 to the present writing in the spring of 1987, we have discovered three major benefits to experiential training in preparing hospice volunteers.

BENEFITS OF USING EXPERIENTIAL TRAINING

1. Experiential training of this type is a *reliable screening tool*.
2. This experiential training is a *powerful, measurable way to sensitize volunteers to hospice clients' needs and feelings*.
3. Since there is evidence that 'low death anxiety correlates with a sense of purpose in life and greater duration of service in hospice volunteers,'³ *the "death experience" training appears to be one highly effective preventive measure against hospice volunteer burnout and attrition.*⁴

HOW TO DO IT

In addition to the organizational, physical, sociological, psychological, financial, and legal information which must be conveyed to our patient and family service volunteers during the eight-session training, we consider *essential* three experiential learning modules: non-verbal communication skills, a simulated dying experience, and a simulated handicap/helplessness experience.

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Non-Verbal Communication Skills

For those who work with hospice patients, there often are times while someone is dying when we can communicate only with our hands or our eyes. This training module consists of exercises relying on eye contact alone and hand contact alone, as well as the more traditional active listening sessions.

In the eye-contact-only exercise, each trainee is paired with a stranger while listening to soft, neutral music. Each must maintain eye contact and—without speaking—identify a need the other has (*e.g.*, love, peace, strength). Then—still only by eye-contact—send to the other some of the quality they need. When the pairs describe the experience to the whole group, participants frequently remark that they are amazed at how much the stranger-partners understood about them.

As a screening tool, this exercise quickly shows the volunteer administrator which volunteers cannot handle eye contact and its concomitants, trust and intimacy. A further check in a closely-monitored volunteer-patient contact, and an exploratory discussion with the volunteer, can lead to a more appropriate placement within the agency.

Less difficult and threatening, the hand-contact exercise explores ability to communicate feelings through the hands. A range of exercises with eyes closed is prescribed for paired volunteers (different pairs from those in the eye exercise) who may only rely on the hands for sending and receiving communication.

The ostensible purpose of the hands-only exercise is for the trainees to become acquainted with an unknown other person through touch, exploring texture, coolness and warmth. The carefully sequenced tasks of the hand-contact-only exercises are (1) become acquainted, (2) communicate a "good feeling" through the hands, (3) to music, "dance" in pairs with hands, (4) communicate anger ("pretend the other stepped on your fingers"), (5) "make up" with the other person, and (6) say goodbye.

Processing after each task reveals such critical issues as (1) how trainees respond to being led by another (dance task), (2)

how trainees express tenderness and affection (in making up session) and (3) who has difficulty literally "letting go" of hands (in the parting session). Problems with the last task are processed both in the group and in one-to-one counseling. Not being able to let go may reveal either an unfinished grief process not discovered in the initial screening or poor self-esteem/feelings of inadequacy. In the latter case, the volunteer can be placed and utilized if those feelings can be resolved.

For the trainers, this hand exercise sequence helps screen for volunteers who may have problems with self-disclosure and openness. For example: a "non-stop giver" had a partner who revealed the deficits of his behavior when she commented after the hands exercises that she felt frustrated when the "giver" did not let others explore his space.

Both these non-verbal communication sequences help the volunteer administrator place people more appropriately. A hospice family with greater emotional needs receives a more sturdy, centered volunteer. A more fragile volunteer will be assigned a family with lower emotional needs.

Facing One's Own Death

For our hospice volunteer applicants who wished to work in direct patient and family services, it was essential that their training help them understand the content and process of the anticipatory grief experienced by the dying patient and the family. Experiential training, an exercise in facing one's own death, seemed to be the most effective route.

The exact steps in that training were chosen carefully. We had volunteers from many religious and cultural backgrounds; as a non-sectarian organization we wanted to retain that status and reputation. We had the care and nurturing of willing but sensitive human beings generously volunteering their time, talents, and psyches to us for training and service. How to proceed?

Facing and anticipating one's own death usually happens over a period of time with our hospice patients. Within our eight-session training period we initiated the experience, let it "incubate" with our

volunteers (processing as we went), and completed the experience in three weeks.

In our training program, by the time we begin the "experience in dying," our volunteers have already learned various relaxation and guided-imagery techniques. These skills will be directly useful in their work with patients, to help relieve boredom and induce relaxation. (The skills are also helpful in reducing job stress for themselves.) Using these same techniques, we begin the exercise.

Trainees are to relax and imagine themselves in a doctor's waiting room, looking around at the pictures, colors, furnishings, magazines; hearing the sounds of the sick, the well, and the office activity; and smelling the odors. They are to be conscious of how they feel emotionally as they sit there. Then their name is called and they go to the examination room, again to wait, look, hear, smell, and wait some more. The doctor comes in. They hear him or her say, "I'm sorry, but all our treatment has been ineffective. There's nothing more we can do." The doctor tells them they only have three weeks left to live. *Immediately* the trainees are to return to the reality of our classroom and to write down their feelings and responses to questions on the "Exercise in Dying" worksheet (appended).

In a small group (no more than ten), the volunteers discuss their feelings and responses. Then their three week assignment is given. Each volunteer is to imagine that he or she has only three weeks to live. The focus of this exercise is to be *the limited time, the mortality*, not the disease. The assignment, within that framework, is to look at and be conscious of their feelings about what is going on around them: relationships; what is and is not important in daily life, in one's total life; what is needed for a sense of closure in their lives; how and where they would prefer to die.

Each week (two sessions per week), the trainees discuss in the group what applicable meaning this exercise is evoking in their situations. Responses have included: contacting family members and friends to do some healing in relationships, verbalizing loving feelings more

frequently, a decrease in the significance of petty issues at work, greater kindness to self and others, talking the limited-time possibility over with family, facing family members' refusal to participate in a limited-time-to-live simulation, doing small things they have always wanted to do (three weeks precludes big trips or projects), writing a will, writing poetry. One young woman got married after long postponement of the event. Making changes to improve the quality and meaning in one's life always occurs as an outgrowth of this experience. For some it happens immediately; for others, later in the three week period.

The trainees form strong bonds during the course of this death-experience exercise. For example, it was training class members, not friends or family, whom one volunteer chose to witness his will. It would be interesting to develop some measure of the strength of this bonding compared to that in other shared experiences.

At the end of the three week death experience, we have a "dying session" in which trainees are carefully guided through a creative visualization encounter with a figure which they will identify as their own death. First, the trainees are led through a physical relaxation process. They are then to clear their minds and go to a place that is *safe*, peaceful, and beautiful; a place to learn to be safe, comforted, and protected. (It should be noted here that the senior author is certified in hypnosis techniques—or hypnotherapy—as it is called in some states. She is skilled at leading individuals and groups in guided relaxation sessions and understands the care needed in selecting the music and words used in guided imagery.)

Next, the trainees are to imagine seeing a figure of a person some way off, coming closer to them. At first they cannot recognize the figure. Then, they realize it is the personification of their death. They are asked to attend to the appearance of their death, noting colors and shapes they see and feelings they have in the encounter. They are to look into the face of this being and, specifically, into the eyes. Each is to ask one question of their death and to listen for the answer. The volunteers are

told that their death has a message for them and are asked, "Is there anything else your death has to say to you?" Finally, it is suggested to the trainees that they now hear their death say it cannot stay with them this time but has to go. Then they watch their death go the way it came.

Immediately, volunteers are brought back to present reality. There is always an immense quietness and calmness in the group. There are some tears. The trainer, constantly monitoring the group throughout this exercise, has scheduled it before lunch time so that there is time for private attention to anyone needing it.⁶

Before any discussion begins, the participants are asked to fill out the form titled "The Presence of Death" (appended), which gives them an opportunity to record the physical and other qualities of their death as well as their own feelings about the encounter. It is interesting to note, and worth further investigation, that within a class, the trainees will often see their death as the same kind of figure. Some classes see it as a woman; others, a Jesus figure; rarely, an individual will see only light, despite the suggestion that it is a figure.

Discussion of everyone's experience follows the completion of the form. Despite the range and variety of belief systems/religions to which our volunteers subscribe, the experience has almost without exception (one in 34 trained in this technique)⁷ been felt as an encounter with an entirely loving being who accepts them without judgment. One person, who after this experience sat with silent tears flowing strongly down her radiant face, later shared it with her husband. She reported that it was the most profoundly intimate and inspiring experience of their marriage.

As we know, volunteers who work with hospice patients are less subject to burn-out and more likely to persist in their work, if they have low death anxiety. As Madalon Amenta has pointed out, purpose in life and, with it, self-confidence and an awareness of the spiritual significance of life, correlate highly with low death anxiety.⁸ Amenta's work proves the

theory of Viktor Frankl, who suggested to the social and medical sciences that an overall sense of meaning and purpose in life are positively related to an individual's ability to accept and find meaning in suffering and death.⁹

The persistence of the 29 patient service volunteers and five patient service employees we have trained since January 1986, using all three of our experiential techniques, has been excellent. One year later (January 1987), 24 (82.7%) of the 29 volunteers trained remained active in high-stress patient-care service positions, while five of the five (100%) paid staff so trained remained active.

Three of the volunteers dropped out of the training before completing it, none were staff-screened out after training, two were self-screened out after training (requesting other placement within the hospice setting). Eighteen months after training (June 1987) the 24 (82.7%) volunteers persist while one staff person has left due to elimination of the position, not in response to job stress.

These are good results, you may say, but who can handle leading such delicate guided-imagery sessions as those in the dying simulation? Although I have the benefit of training in guided imagery and certification in hypnosis, I believe that well-selected individuals may do this work effectively, even without such formal training. An individual with sensitivity, an ability to help people process both negative and positive feelings and experiences, and an awareness of trainees' emotional states can lead the guided imagery sessions required for the dying experience simulation, provided she/he exercises great care in choosing the language and music to be used.

Handicap Simulation

For volunteers as well as paid professionals in the human services, the attractiveness and power of being in a position to give to another are sources of self-esteem and, often, the impetus for joining a helping organization. The dangers of that kind of motivation are the person's (1) eventual disappointment at not being appreciated as expected (which leads to attrition¹⁰) and (2) potential inability to

have a relationship with the client that is helpful on an interpersonal level. Moreover, unconscious insensitivity on the part of the volunteer (or paid staff) can exacerbate the client's sense of helplessness and loss of self-esteem.

To sensitize volunteers to the needs and feelings of the dying patient, we adapted an exercise used in other human service agencies: the handicap experience. From 9 a.m. until 1 p.m. in the last daytime training class, two trainees are selected to take the role of quadriplegics. The remainder of the class population serve as their respective families. By this point in the training, the trainers know who has most difficulty "receiving"; these people are favored for selection for the handicapped role.

The instructions are these: the handicapped persons have use of all their senses but no movement of arms and hands or legs and feet. They take the role of the ill family member. They and their "families" are to sustain their roles continuously through the four-hour period, including a break and lunch hour. The trainers will take the role of a hospice team and can be called upon for problem-solving or advice.

As the lecture or panel scheduled for the current session begins, progresses, breaks, and resumes, we note the dynamics of the interreaction between the "family" and the "handicapped person." The family members' reactions are as deep and telling as the disabled persons'. Among the former, some respond to the handicapped person with presumptuous dominance and others with outright rejection. Indeed, in one training class a volunteer who had actually lived for years with a profoundly disabled family member *never asked* the "handicapped" person what he/she needed or wanted, although the former was very active in providing services for the "invalid," including hands-on care. Where the response is dominance or rejection, the humanness of the handicapped individuals are denied as family members often speak of the wheelchair-bound in the third person directly in front of them. Whatever limited control the disabled might have exercised by remaining part of their families'

decision-making team is denied them. In effect, the handicapped persons *ceased to exist* as an integral part of the families.

The responses of the handicapped persons to their situations change rapidly and markedly. Initially, volunteers think their role will be easy. However, during the break, when their needs are strong (for a beverage, a cigarette, or bathroom assistance) but their family members have parked and left them (sometimes facing a wall), the meaning of their dependent state begins to dawn.

These situations, compounded by the exclusion from the family which the handicapped person experiences, quickly generate the full range of grief reactions. We see denial: "You don't mean I *always* have to be in this situation, even during break?!" We see and hear anger. Bargaining shows up: "If you let me out of this chair for five minutes, then I'll play again." The volunteer in this role withdraws, physically shutting him/herself out of the action, depressed. Finally, he/she resigns, muttering "if I can only just get through lunch time . . ."

It is important to note here that resistance to the fully helpless role is larger than we on the hospice staff initially expected. Every "handicapped" role-player in these trainings has refused use of the bathroom during the four-hour session, in order to avoid accepting help in so private a matter. At lunch, *most will do without food* rather than allow themselves to be fed. Further, on two occasions when the "handicapped" trainee has been wheeled outside during a break or lunch-time and has been conscious of being seen by a non-trainee (from some other activity in the building), the volunteer trainee has become upset and verbalized significant discomfort at being viewed as actually disabled: "I really felt diminished."

When the experiential part of the exercise is over, and the volunteers can leave their wheelchairs, they tell their "families" how they felt. A few, of course, shared their feelings openly earlier, during the role play. A woman accuses, "You never once talked to me at my eye level!" Another talks about how he felt ostracized by his family, "I felt like I didn't really

exist anymore." It becomes clear that helplessness profoundly affects the emotions. The family members are defensive: "You never asked me!" "I didn't know." They learn to ask, to reflect, to listen.

The original training objective for this module was to have some volunteers experience "receiving" in order to understand the feelings of the disabled or dying person. When the family dynamics information surfaced in this experiential training, we saw we had a training tool that was most effective both for our original purpose: to sensitize volunteers to how dying, for the patient, affects the emotions; and for teaching volunteers how living with a dying person can affect the feelings and behavior of the family members.

CONCLUSION

Experience is a powerful and effective teacher. Using carefully designed, guided, and monitored non-verbal communication exercises and simulated dying and handicapped experiences can be an excellent screening and training technique for volunteer (and paid) staff who are to work directly with hospice patients and their families.

In addition, we found that, of the 29 volunteers and five paid staff we have trained using all three of these techniques, those 24 volunteers and five paid staff who were actually placed as direct patient and family service workers have had an excellent record of persistence in their positions. After 18 months, there was a 82.7% retention of the 24 volunteers who completed training and were placed in patient care services. We had an effective 100% retention rate for the five paid staff (one left simply due to elimination of her position).

Note also, the inexpensive nature of this kind of training. The main cost is the copying of several worksheets and informational handouts (appended to the end of this article). That "bottom line" fact is a significant factor in whether or not volunteer administrators can actually implement such training recommendations.

We recommend carefully planned and executed experiential training such as this for hospice volunteers in order to (1) assist volunteer administrators to screen

volunteer applicants, (2) sensitize volunteers to the needs and feelings of the dying patient and his/her family, (3) decrease attrition among patient/family service volunteers, and (4) provide significant opportunity for the trainee to mature in acceptance of his/her own death¹¹ and, thus, increase the quality of his/her life. In learning how to die we learn to live.

We have found this experiential training to be inexpensive, effective and powerful.

FOOTNOTES

¹Schindler-Rainman, Eva. Volunteer administration: new roles for the profession to 'make a difference', in *The Journal of Volunteer Administration* 5:2 (Winter 1986-87), p. 15.

²Curriculum appended.

³Amenta, Madalon M. Death anxiety, purpose in life and duration of service in hospice volunteers. *Psychological Reports*, June 1984, 54, pp. 979; 981.

⁴Ganster *et al.* believe the most harmful work stressors to be "job and role characteristics laden with ambiguity and conflict." Ganster, D.C., Fusilier, M., and Mayes B.T. Role of social support in the experience of stress at work. *The Journal of Applied Psychology*. February 1986, 71 p. 110.

⁵Pattison says "to help with dying, we must first face death for ourselves". Pattison, E. Mansell. *The Experience of Dying*. New York: Prentice-Hall, 1977, p. 317.

⁶Of 34 trainees (29 volunteers and five staff) over the last year and a half, only one ever found the dying experience disturbing. We discovered that she had scleroderma but had not been screened out because the volunteer coordinator interviewing her had not obtained that information. This volunteer's image of her death had said—contrary to the trainer's direction—that it *was* time for her to go with her death. Counseling and follow-up with this volunteer applicant resulted in her remaining with the patient care service unit, where she served in several short-term crisis-intervention situations over a period of 18 months.

⁷In all our dying-experience sessions, only one trainee—who requested training

for "personal growth", not volunteering—saw his death in a very negative form. He was not shaken by it but was concerned that he was the only participant who saw his/her death in that way. We discovered that, although it was not yet considered terminal, the trainee's mother's medical condition was very serious at the time of this exercise.

⁸Amenta, *op. cit.*, pp. 979-980.

⁹Frankl, V.E., *The Doctor and the Soul*. New York: Knopf, 1965.

¹⁰Rubin and Thorelli found that egoistic motives, such as wanting to "give" (and the concomitant desire to be recognized for same) are negatively associated with longevity in a program, because of the disappointment of expectations such volunteers or staff feel. Rubin, A., & Thorelli, I.M. Egoistic motives and longevity of participation by social service volunteers. *Journal of Applied Behavioral Science*, 1984, 20:3, p. 232.

¹¹A volunteer whose cancer had been in remission for several years faced its reappearance some time after becoming a volunteer at our hospice. Subsequently she learned this illness was terminal. Soon afterward she told our staff she could not have faced this news as well without the experiential training.

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APPENDIX A

Hospice of Hillsborough, Inc.

VOLUNTEER TRAINING COURSE

Tampa P.M. — 4/14/87 — 5/19/87

U.S.F. Episcopal Center

1st Session — 4/14/87 — Orientation/Communication Skills I

Trainers: Lois Hipp, Volunteer Service Coordinator
Geri Bommarito, Volunteer Coordinator

2nd Session — 4/21/87 — Anticipatory Grief/Family Dynamics

Guest Speakers: Lois Mazur, LCSW
Anne Thal, LCSW

3rd Session — 4/25/87 — Communication Skills II/Relaxation Skills

Guest Trainer: Karen Rusk

4th Session — 4/28/87 — Bereavement

Guest Speaker: Majorie Carlson, LCSW

5th Session — 5/5/87 — Bereavement Risk Assessment/Spiritual Needs of the Dying

Guest Speakers: Lois Mazur, LCSW
Father Jerald Stadel, Rector
St. Catherine's Episcopal Church

6th Session — 5/12/87 — Funeral Practices and Procedures/When Death Occurs

Guest Speakers: Charles Segal, Funeral Director
Beth David Chapel
Mary Lesperance, R.N.

7th Session — 5/16/87 — Communication Skills III/Interviews with the Dying

Guest Speakers: Bobbi Chamberlain
Bill Dennis
Roger Rollins

8th Session — 5/19/87 — Personal Care Skills

Guest Trainer: Sandra Rex, R.N.

9th Session — 5/26/87 — Charting/Closing Interviews

APPENDIX B

VOLUNTEER TRAINING GUIDE

Orientation:

Welcome Trainees
Introduce Attending Staff
Staff Speakers
Review Training Outline
Announcements:
1) Driver's license and auto insurance
2) Class attendance
3) No smoking in bldg.
4) Class sharing & confidentiality
Get Acquainted Activity (*)
Hand Outs:
Training Outline
Farewell to Sunday Best
(*) Life Story
You Can Choose

Communication Skills I:

Introduction to Active Listening
Flip Chart
Round Robin Exercise*
Home Assignment**

*Use two groups for large classes

Hand Outs:
Communication Leads
First Learning: To Hear
**Reflection of Feeling Exercise
Roadblocks to Communication
You will also need: Flip chart

Anticipatory Grief:

Introduce Speaker
Hand Outs:
Reminiscences of a Hospice Volunteer

Family Dynamics:

Introduce Speaker
Hand Outs:
Suggestions for Dealing with Families In Crisis

Spiritual Needs of Dying:

Introduce Speaker
Hand Outs:
Religion
Spiritual Distress

Communication Skills II:

Briefly Review
Appropriate Use of Questions
Problem Solving
Staff Demonstration
Role Playing*

Non-Verbal Communication

- 1) eye contact
- 2) touch contact

*Use 2 groups for large classes

Hand Outs:

Attitudes in Listening
Listening
The Problem With Questions
Without Words

You will also need: Role Playing Cards, Cassette Player & tape

Relaxation Skills:

Guided Imagery
Foot and Hand Massage

Hand Outs:

You will also need: Cassette Player & Tapes, Hand Lotion

Personal Care Skills:

Introduce Speaker

Hand Outs:

Body Mechanics
Volunteer Health History

Bereavement & Bereavement Risk Assessment:

Introduce Speaker

Hand Outs:

Funeral Practices & Procedures:

Introduce Speaker

Hand Outs:

Florida Death Certificate
Jewish Funerals

When Death Occurs:

Introduce Speaker

Hand Outs:

Living Will

Communication Skills III:

Review of Active Listening
Staff Demonstration
Role Playing (with cards or personal experience)

Hand Outs:

You will also need: Role Playing Cards

Charting:

Explanation of Medical Chart
Need for documentation
Show Video
Explain how to document

Hand Outs:

Patient Care Notes
You will also need: T.V., Video Cassette

Closing Session:

Closing interviews
Volunteer Advisory Council

Hand Outs:

Volunteer Contract
(H) Training Evaluation
Volunteer Opportunities
Standards for P/F Volunteers
You will also need: Certificates, Volunteer Pins

SPECIAL NOTES

3rd Session:

Exercise In Dying

Hand Outs:

Exercise In Dying
Facing Death
You will also need: Cassette Player & Tape

6th Session:

- 1) Ask two volunteers to be patients
Begin wheelchair exercise
- 2) Interviews in Dying (Tampa only)
- 3) Confronting Death Exercise

Hand Outs:

The Presence of Death
You will also need: 2 wheelchairs, pillows/straws, Cassette Player & Tape

Miscellaneous:

- 1) Give out "My Funeral" at session prior to Funeral Practices & Procedures
- 2) Distribute Pot-luck Sign Up sheet session prior to event.
- 3) Request volunteers bring hand lotion/pillows session prior to relaxation skills.

APPENDIX C

FACING DEATH

Thoughts and Feelings About My Own Death

Directions:

Please answer the following as truthfully as possible. Indicate your first impression. Do not try to find false clues or psychological tricks for there are none here. There are no right or wrong answers—only your answers. This information is not required to be turned in. Time permitting, we will discuss this exercise during the training sessions.

I. *What is Life?*

- A. Has life been good to you?
 Real good; So, so; Not so good.
- B. Have you already accomplished your life's goals?
 Most of them; About half; Less than half.
- C. Is life interesting to you?
 Mostly so; Once in a while; Seldom.
- D. Has God been fair to you?
 In most cases; Once in a while He isn't; Seldom.
- E. Would you like to relive your life?
 Most of it; About half; I like it the way it has been.
- F. Are you usually happy?
 Most of the time; Seldom; A good portion; Half and half.
- G. Does your religious faith contribute to your happiness?
 Major part of it; Sometimes; Never.
- H. How often do you feel you would have chosen another vocation if you had it to do over again:
 Seldom; Most of the time; More times than not; Never.
- I. Have you the feeling that God has punished you in life?
 Never; Once in a while; Often.

II. *Religion and Life*

- A. What happens to "ME" in death?
- B. What does death hold for you?
 Limbo; An end; An adventure; An escape.

III. *Social Considerations About Death*

- A. At what age do you expect to die? _____
- B. Where do you expect to die?
 In your own bed; In a hospital;
 In an accident situation; In a nursing home.

- C. What person would you like to have with you at the time of death?
 Closest relative of my choice; Clergyman;
 Any person (e.g. doctor, nurse, friend, etc.); No one.
- D. What person would you feel free to talk with concerning death?
 Closest relative of my choice; Clergyman;
 Physician; Friend.
- E. How do you expect to die?
 During a surgical procedure; In an accident; From lingering illness;
 From a heart attack; From natural causes.
- F. In terms of your closest human relationship, do you desire
 To die before him/her; To die after him/her;
 To die with him/her.
- G. Have you made a will?
 Yes; No.
- H. In terms of the person whose death would be most difficult for you,
 1. Why would this person's death be so devastating?
 2. Would this person's death affect your life's goals?
 3. Would this person's death thrust an inconvenience on you?
 4. How much does this person contribute to your self-image?
 5. What mechanism would you expect to use to overcome the loss of such a person?
 6. What do you think would be the extent of your grief reaction?
 7. Has this person ever talked with you about the possibility of his/her death?
 8. Would you want to be with this person when he/she died?

IV. *Evaluation of Self-Image*

- A. Having completed the previous questions, write below a short obituary for yourself for the time when you expect to die.
- B. Write a eulogy for yourself. Set it in the time frame you have projected for your death.

LIFE AFTER DEATH

A Thinking and Feeling Experience About Life After Death

Your responses are +, -, or 0, depending on whether you think and feel positively (yes) about the statement (+), negatively (no)(-), or aren't sure (Maybe)(0).

1. My life continues forever after death.
2. I fear death.
3. I shall maintain a recognizable identity after death.
4. I shall be able to communicate with loved ones who are still in the body after I die.
5. I believe that I shall reincarnate.
6. God utterly destroys the wicked after death.
7. The manner in which I live now will affect my life after death.
8. Suicide is sometimes the right thing to do.
9. Prayer for the departed is valid and good.
10. My view of what happens after death has an important influence on my relationships to those who are closest to me in this life now.
11. I believe that euthanasia is right.
12. I believe that life after death has been proven.
13. I believe that there is development and progress after death.
14. I shall meet and recognize persons of repute and those of earlier generations after death.
15. Persons who die mentally sick will go into the next life mentally ill.
16. My relationship to God now is important for life after death.
17. I shall be united with a loved one after death, even if he or she had no specific religious faith in this life.
18. I wish to have my body cremated.
19. I want to survive after death.
20. Unborn babies survive and grow after death.

APPENDIX D

EXERCISE IN DYING

1. Knowing I have only a limited time to live:

a) makes me feel _____

b) my biggest regret is _____

c) I am most thankful for _____

d) to bring some closure to my life I need to _____

2. Would you rather not know you are dying? Yes No

3. Where would you like to be when you die? _____

4. Would you like to be alone when you do? Yes No

If no, whom would you like to be with you? _____

5. What is the most unacceptable way for you to die? _____

6. What is the way you most prefer to die? _____

7. How has this exercise affected you? _____

APPENDIX E
THE PRESENCE OF DEATH

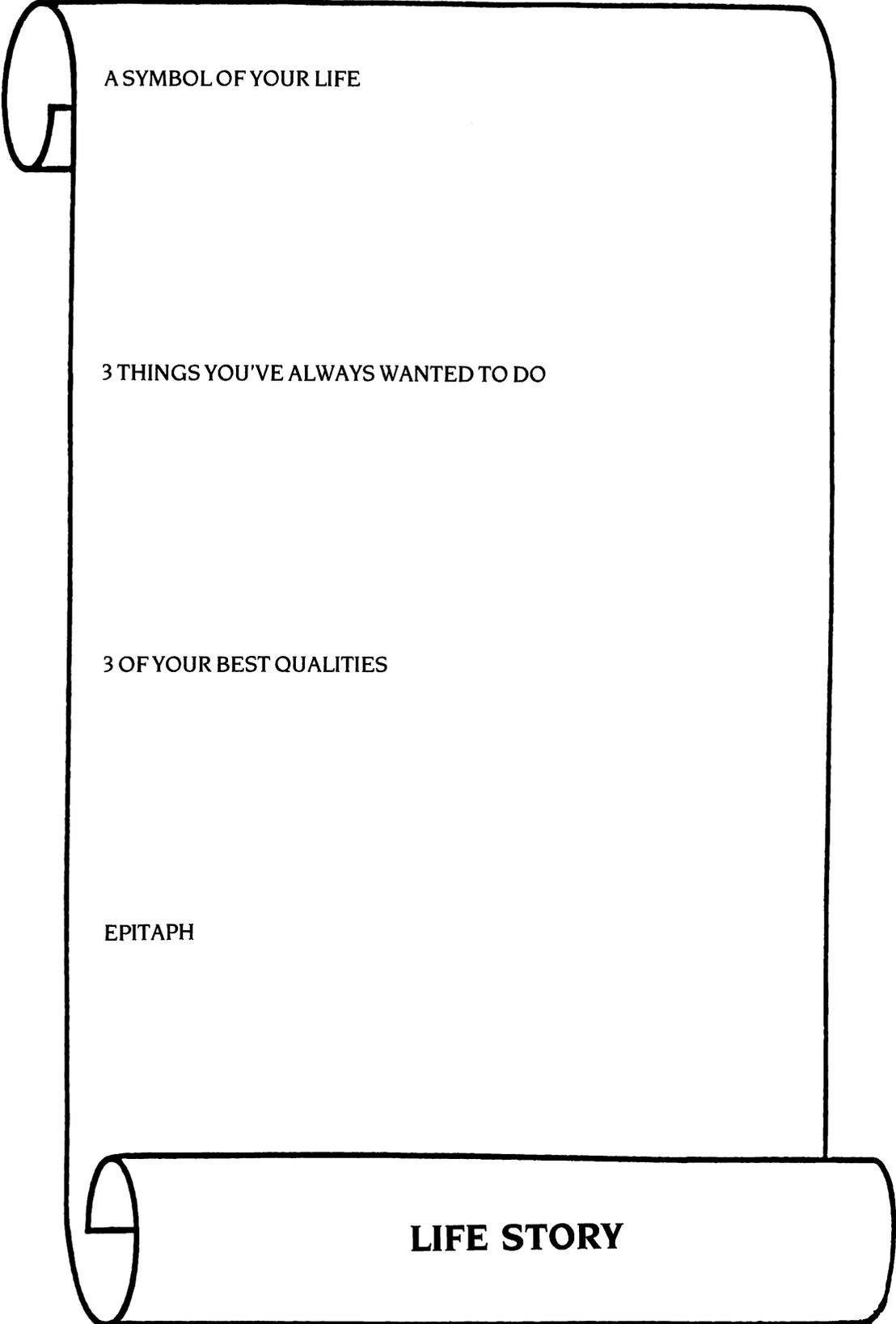
Describe Death physically as Death appeared to you:

Describe what qualities Death had:

Describe how you felt about Death:

Additional comments, if any:

APPENDIX F



A SYMBOL OF YOUR LIFE

3 THINGS YOU'VE ALWAYS WANTED TO DO

3 OF YOUR BEST QUALITIES

EPITAPH

LIFE STORY