# February 2012 EPRESS

## Questions from Directors

### *I have a client who is coming in again next week for a new try at intake. Last time, he was angry, spoke loudly to me, and didn't want to sit down. I didn't expect this behavior, so I suggested that we have this meeting next week, after he had a chance to read our program packet. What can I do to avoid this problem next time?*

This can happen to any program, so first, don't take it personally. Remember that clients are often experiencing a range of emotions, like fear, anger, mistrust, confusion, anxiety, and sadness.

A client's "reactance behaviors" can reflect those emotions. Pacing, stammering, shakiness, and breaks in eye contact can indicate increasing anxiety. When anxiety builds into defensiveness, you might see yelling, words that are intimidating (like cursing or threatening), pressured, loud, or extremely controlled speech, or intense staring. Rapid movements (like banging on a desk, throwing something), suddenly standing, or moving toward you – and then actual assaultive behavior – indicate the peak of escalation. Such aggression is not common, but the earlier behavior is quite common. So you were right to try to regain control by rescheduling the appointment.

Now your job is to have the client understand the visitation procedures and see the visitation process as a positive step for the family. How can you do that? Remind him or her that being at the program is complying with the judge's order or the case plan. Suggest that the supervision will help defuse any future allegations of misbehavior with the child. Emphasize that your role is to allow the parent to maintain a healthy relationship with his or her child. Tell the parent all the things that they have done *right*. I recommend beginning all this in a *brief phone conversation* so that you have re-established cordial interaction before the client comes in for the intake. Remember the phase "we are working together." Make sure you keep your end of the bargain.

Once you have set the stage for a successful intake, it is fine to indirectly refer to the past behavior to try to avoid it in the future. For example, you may say "I want to make sure I explain this so that we don't have any misunderstanding. I'm here to help. Be sure to let me know if I'm not clear, or if I need to explain anything further."

In the future, if you sense that a client is anxious, clarify your role in a supportive and understanding way. Use active listening. You might try: Nodding, saying "Sometimes it's like you

don't know where to turn, and you get frustrated," or "Gosh, what you heard is wasn't what I meant to say. Let me try that again," or "Our clients get upset sometimes, but we're here to show them how to be successful."

When a client is angry or defensive, say things like "I hear what you're saying, but I need to talk about it calmly," or "I get confused when we try to talk about lots of things at one time. Which topic do you want to talk about first?" or "Shouting won't help either of us. If things don't calm down a bit, we will need to reschedule," or "Gosh, I don't know you well enough to know whether or not to be frightened when you stand up like that. Can you sit down while we work together to try to figure this out?"

If you need to reschedule an appointment because the situation has become too tense to be productive, say, "We both want what's best for your family. I don't want anything to happen or for you to say anything that could make things worse for you or for me. Let's stop for now."

Note: Like every social service provider, supervised visitation programs want clients to work toward specific goals. One goal in every single case is to have a successful intake. This takes preparation and planning. If you have the sense that a client may be anxious before he or she even shows up, try the telephone call approach. Then when the client comes in, you can say "Oh, yes, Mrs. Drake, I enjoyed talking to you on the phone. Now we can finalize the intake process for a successful start to your schedule here."

## *We have a new client whose file says that his child has severe asthma. I've never dealt with asthma before. Is there anything I should know?*

I'm glad you asked. We have had multiple children with asthma over the years. There are a few issues with these kids (or parents) at visits. Here are the basics:

- Asthma is a common chronic lung disease. The person's airways are very sensitive. They react to stimuli or triggers.
- Triggers include cold air, allergens, exercise, irritants, and infections. Allergens can be cat or dog dander, dust mites, or mold. Irritants can be smoke, sprays, or strong smells.
- The airway linings become inflamed – they are swollen. The airways become narrow, and breathing becomes difficult.

You should determine what the child is allergic to, and have a conversation with the custodian about what the child should avoid at visits. This same conversation should be had with the visiting parent. If the child should not be running around during visits, don't send the parent and child onto the playground. Be sure the monitor and staff don't wear strong perfume. Dust the visit room – and vacuum thoroughly. Avoiding a problem is the easiest approach. However, the child may have an asthma attack during a visit, so prepare for that also. Have the child's medicine on hand (from the custodian). If the child is old enough to discuss the issue at child intake, have a straight-forward discussion with him or her about the asthma, and gauge his or her own ability to help control it. Also determine whether the visiting parent understands the

issue and how to respond. The best case scenario is that the visitor can and does respond to the child's asthma attack if the child can't do it alone. Staff must step in quickly if the child or parent can't respond appropriately.

# Talking to Children about Feelings

We present below a tool used by many social service providers to help children and their parents talk about feelings. It is called the Feeling Thermometer.

After the February phone conference at which we will describe the feeling thermometer, we suggest you do the following:

- Describe it at intake to children and parents
- Talk about how sometimes it's hard to express how we feel
- Ask the child if he or she wants to tell you how he or she feels
- Show the child how you feel on the thermometer, and choose the words to describe your emotions
- Talk about all the emotions and feelings on the thermometer and what they mean
- Ask the child what he or she does when he or she has these emotions
- Offer a copy of the thermometer to the parent, who can put it on the refrigerator at home.

**HOW CAN THIS HELP?**

Finding a word that describes how people feel can help the user evaluate his or her feelings and can help assist the user in changing potentially negative feelings. The "What can I do to feel better?" bar gives children and adults some suggestions to feel better.

**WHY DOES THIS HELP?**

The thermometer empowers people. It teaches them words for emotions, and suggests affirmative ways to change those emotions. This can be used to help children as well as adults and assist them in gauging their feelings. Specifically:

**Children -** The engaging colors help give children a mental picture of how they are feeling. They can gauge their feelings from Red-Green and can learn how to improve these feelings.

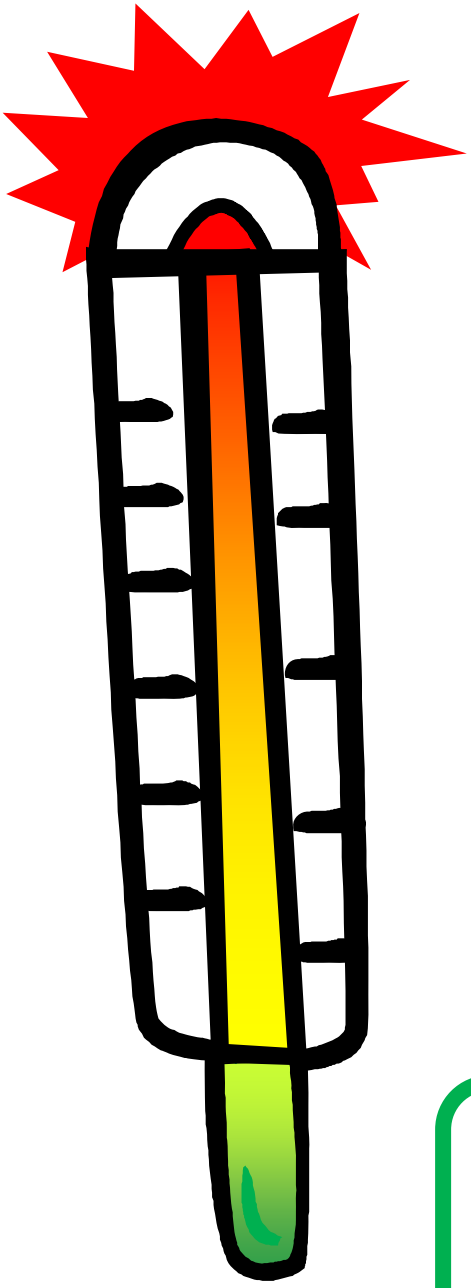
**Adults** - Reading the thermometer will be simple, and translating the colors and feelings can help any parent gauge their feelings with simple key words – like 'Anxious' and 'Relaxed'. Using these simple key words may help parents teach their children about feelings and how to feel better. When a child is acting out or misbehaving, it may make sense to ask that child how he or she is feeling, so that the child can take a moment to assess his or her emotions and learn to deal with them over time.

This thermometer has been adapted from the Autism thermometer. Versions of it are used by the military, therapists, teachers, and social service providers across the globe.

# How am I feeling today?

**What can I do to feel better?**

**What words describe how I feel?**



STOP and ask for help!

Angry, Furious, Very Sad, Anxious

Take deep breaths, count to ten, do something else, find a quiet space

Frustrated, Anxious, Annoyed, Upset

Think of something happy, find something fun to do

Nervous, Worried, Confused

Smile! You are feeling GREAT!

I feel good!

Happy, Relaxed, Content, Ok

## What should I do?

# Post Traumatic Stress Disorder and Supervised Visitation – A Refresher Course

**In the News:**

As you may have heard in the news, an Iraq veteran suffering from PTSD killed a park ranger in Mount Rainier National Park earlier this month. Benjamin Barnes, a father, had returned from Iraq. He was having trouble returning to civilian life, and the mother of his child was worried. Barnes had many weapons and was easily irritated, angry, suicidal, and depressed (side effects of PTSD).

In November, a guardian ad litem recommended communication and parenting classes for both parents, and **supervised visitation** until Barnes completed domestic violence and mental health evaluations.


On New Years' Eve, Barnes is believed to have hidden in Mt. Rainier National Park after shooting four people at a house party, injuring two critically. Barnes then allegedly shot a park ranger, and was later found dead.

It is important for social service providers and staff working with those in a supervised visitation environment to be aware of the signs, symptoms, treatment, and concerns associated with PTSD. Training about PTSD can help to

- Define symptoms
- Learn about who may be affected
- Lean about risk factors
- Understand protective factors
- Learn how supervised visitation staff may be able to help
- Learn about treatment options for those who are suffering from PTSD, both in and out of the military.

Because of the relevance of PTSD in supervised visitation, the Clearinghouse on Supervised Visitation provides a full training on PTSD.

**What is Post Traumatic Stress Disorder?**

Post Traumatic Stress Disorder (PTSD) is a psychiatric disorder that may occur after an individual witnesses or experiences a traumatic event such as:

- Military combat
- Violence
- Natural disasters
- Domestic violence
- Violent crime
- Sexual violence
- Other life threatening experiences.

PTSD sufferers may have "flashback" type experiences, nightmares, or depression and have difficulty sleeping. These symptoms can seriously impair day to day life. (One In A Million, 2011).

**Who May Be Affected?**

Many people experiencing PTSD have a military or law enforcement background.

- A study in 2004 found that 1 in 8 troops returning from Iraq had PTSD symptoms.
- Between 15-30% of the armed forces who served in Vietnam are thought to suffer from PTSD.
- One in 6 (around 17%) of veterans who served in Iraq and Afghanistan are thought to suffer from PTSD, although some estimates are even higher.
- 38% of soldiers, 31% of Marines, and 49% of National Guard members report psychological concerns like PTSD and traumatic brain injury.
- 7-19% of police officers have duty-related PTSD.

Non-Military individuals can also experience PTSD, especially victims of **domestic violence:**

- One study found that 35% of domestic violence victims were found to have PTSD as a result of their victimization.

- PTSD is the most common anxiety disorder associated with domestic violence.

*Facts about Military Families*

- Nearly 400,000 troops returned home from Iraq during the holidays in December of 2011.
- Many of these troops had not been on one deployment, or two, but some had been on 13 deployments since 2001, when the United States military entered Afghanistan (Newswire, 2011).
- Returning home to civilian life can be a huge adjustment for many troops and their families.
- Close to 8% of individuals in the military are single parents (nearly 11% in the Army).
- There are around 84,000 military couples, people who are in the military and also related to a military member.
- 36,000 of these military couples also have children together

*PTSD and Substance Abuse*

PTSD is strongly associated with substance abuse.

- 34.5% of men who had a history of PTSD reported dependence on or the abuse of drugs at some time.
- This compares to a rate of 15.1% of men in the general population.
- 26.9% of women with a history of PTSD reported dependence on or the abuse of drugs at some time.
- This compares to a rate of 7.6% of women in the general population.

### *Stressors for Families with a Deployed Member*

Families are often stressed and upset with deployment, and role adjustments in families must be made to compensate for the temporary loss of a family member while he or she is overseas. Needs and roles are renegotiated and adjusted once the military member(s) returns to the household. This can cause significant stress,

especially when there are mental health issues surfacing concurrently (Ruzek, 2007).

- Divorce rates have risen by 42% since 2001 in military couples.
- Divorce plans or separation plans increase with each month of deployment, and the stresses of the deployment can cause familial and marital dissonance.
- Unrealistic expectations, changing roles, and realizing the changes in both spouses during deployment are common stresses that could contribute to relationship problems.
- Additionally, PTSD can be a huge stressor affecting relationships (Newswire, 2011).

Divorce and other family stressors may be contributing factors necessitating families' use of supervised visitation. PTSD may cause further stress in families, or violent family dynamics (in both military and civilian families) can contribute to issues in supervised visitation. Some families in supervised visitation may have experienced traumatic events, through domestic violence, sexual violence, abusive relationships, or events secondary to the relationship.

**Risk Factors for PTSD**

Several factors can heighten the negative experiences of PTSD, including:

- The length of time someone is exposed to domestic violence
- The severity of the violence
- The violence beginning at an early age
- The victim's assessment of the violence (his/her perceived level of threat).
- Lack of early intervention

*"The most important thing we can do for service members who have been in combat is to help them understand that the earlier that they get help when they need it, the better off they'll be"* – Charles Hoge, researcher at Walter Reed Army Institute of Research (Associated Press, 2004).

## Responses to Trauma

Responses to trauma vary from person to person, and event to event.

- Immediate responses to trauma include fluctuations in heart rate and blood pressure and other physiological responses.
- Symptoms of PTSD usually begin to develop three to twelve months after a traumatic event has occurred.
- Symptoms of PTSD can vary from person to person, in both character and intensity.
- Some of these symptoms include intrusive memories (memories of the past event(s) that are recurring). This can include flashbacks, dreams, or reliving the event.
    - They are often caused by triggers (the sound of a car backfiring, seeing a story in the news similar to the trauma, etc).
- Another symptom of PTSD is avoidance.
    - Examples include feelings of hopelessness, memory loss, avoiding once enjoyable activities, experiencing difficulty concentrating, having trouble maintaining close relationships, avoiding thoughts about the event, or emotional numbness.
- Anxiety or emotional arousal can also be symptoms of PTSD.
    - This can include anger, irritability, guilt, shame, trouble sleeping, trouble concentrating, being easily frightened, self-destructive behavior, hallucinations.
- Other afflictions such as sleep disturbances (lack of sleep, or sleeping more often) or eating disorders can also come along with PTSD.

PTSD can cause many adverse effects.

- Personality changes, employment issues
- Relationship problems
- Physical symptoms (increased heart rate or sweating).

These events can cause even more stress for the individual and those around the individual, including spouses, ex partners, children, and families.

**Women and PTSD**

Women can also have symptoms of PTSD from an experience of

- Sexual assault
- Physical assault
- Domestic violence
- Other traumatic events.

Women are increasingly being affected by PTSD due in part to their deployment to overseas wars.

- Female veterans have about the same rates of mental illness as male veterans.
- Women in the military are often more likely to be isolated because they may not be seen as 'real soldiers' by family members and friends.
- This isolation may cause them to suffer alone with unacknowledged feelings and experience.
- Women also comprise a minority of the military and veteran population in the United States, despite growing numbers.

**PTSD Causes**

PTSD is not the fault of the person suffering from this illness. PTSD has often been discussed as the fault of the sufferer, but research has revealed this is not true. Exposure to trauma can alter brain chemistry, and PTSD is probably caused by a combination of factors, including brain chemistry, hormones, genetically inherited traits, an inherited predisposition to mental illness, and life experiences. People suffering from PTSD are not to blame for the development of the disorder.

Besides brain chemistry, certain risk factors can make the development of PTSD more probable.

***Risk Factors:***

- Being hurt in a traumatic event
- Seeing someone else killed or hurt
- Having a history of mental illness

- Feeling extreme fear or hopelessness
- Having little social support after the traumatic event
- Dealing with extra stress after the event

All of these events can heighten the risk of PTSD. It is important to help to identify these factors when you are working with someone you may suspect has symptoms of PTSD.

**Protective Factors for PTSD**

- Seeking support from others, such as friends and family
- Having a coping strategy
- Attending a support group.

Social workers and social service workers can use these protective factors when evaluating individuals in situations where PTSD symptoms are present or may become present.

**PTSD Treatment**

- Therapy and/or medication are often used to treat PTSD.
- Treatment should be conducted by trained professionals who understand PTSD.
- Treatment can be either in a group setting, or for an individual.
- These individuals should be in a place where they can meet and learn that their experiences have been shared by others, and engender a sense of community, instead of isolation.

In addition to seeking medical/mental health treatment, an individual with PTSD symptoms can also utilize other support systems, like family and friends.

- Talking with others who have been through trauma can also help individuals realize that symptoms will most likely ease with treatment from a professional.

- Learning more about PTSD, practicing relaxation methods, and exercising can also help ease the symptoms and impact of PTSD.

Ignoring PTSD will not make it go away. If someone suspects that a colleague or employee has symptoms that may be related to PTSD, they should try to help him/her. Not all people who see trauma have PTSD or have symptoms of PTSD. However, everyone who is suffering from PTSD can benefit from treatment. Without PTSD treatment that is accessible and effective, PTSD can lead to an increased likelihood of self-medication (use of alcohol or drugs), and/or a higher risk of suicide.

As a care or case manager, the staff working with an individual with PTSD symptoms can help the individual find local services, and be aware of the signs and symptoms of PTSD to help intervene before it is too late.

Domestic Violence centers can also help most survivors of domestic violence who have been suffering from PTSD. A list of certified programs is available at www.fcadv.org.

Anyone considering harming him/herself should contact the 24-hour hotline, the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), TTY: 1-800-799-4889; or 911.

If the person is a child, call the Child Abuse Hotline at 1-800-96-ABUSE.

For more crisis telephone numbers available locally, please visit suicidehotlines.com/florida.html

For the complete PTSD training, please visit:
http://familyvio.csw.fsu.edu/LEF/Resources_LEF/verizon_ptsd.pdf

References:

Associated Press. (2004). *1 in 8 returning soldiers suffers from PTSD*. Retrieved from MSNBC: http://www.msnbc.msn.com/id/5334479/ns/health-mental_health/t/returning-soldiers-suffers-ptsd/#.TwX96DVbc5c

Newswire, P. (2011). *Troops Returning From Iraq Face New Battle at Home*. Retrieved from United Business Media: http://www.prnewswire.com/news-releases/troops-returning-from-iraq-face-new-battle-at-home-136472433.html

Oehme, K., & Cassels, L. (2011). *Post-Tramatic Stress Disorder - An Introduction for Supervised Visitation Program Staff.* Retrieved from Clearinghouse on Supervised Visitation: http://familyvio.csw.fsu.edu/SV/PTSD%20Sup%20Visitation.pdf

One In A Million. (2011). *PTSD Fact Sheet*. Retrieved from http://www.oneinamillionunlimited.com/ptsd.asp

Powers, R. (n.d.). *What About the Children?* Retrieved from US Military: http://usmilitary.about.com/cs/genfamily/a/familycare.htm

Ruzek, J. e. (2007). *Treatment of the Returning Iraq War Veteran*. Retrieved from US Department of Veterans Affairs: http://www.ptsd.va.gov/professional/pages/treatment-iraq-vets.asp

# Trauma Histories in the Child Welfare System

**Facts about Trauma Histories**

Experiences of trauma, whether in the past or currently, can affect a parent's ability and confidence when it comes to parenting. It can also affect parents' interactions with child welfare staff and the court system.

- Between 30 and 60% of children who were maltreated have caretakers who have also experienced abuse and violence

Trauma-informed services, including mental health services, are becoming more available for families who need them, and judges can work with families who have been affected by trauma.

**Signs of trauma include the following:**

- Avoidance, especially of things that remind them of the trauma
- Feeling emotionally disengaged or numb
- Agitation
- Nightmares, recurring memories, etc.
- Hopelessness and helplessness

- Acting extra watchful, alert, edgy, or sleepless

**Effects of Trauma on Parenting**

Not all parents are affected by trauma in the same way. But trauma can affect the way parents are able to take care of and protect their children. Trauma reminders and posttraumatic reactions may cause a parent to:

- React impulsively to children, instead of calmly and thoughtfully.
- Make inappropriate safety judgments, either over-protecting or putting children in dangerous situations.
- Not recognize children's emotional needs
- Have difficulty bonding and creating trusting relationships with others
- Have difficulty controlling emotions
- Act impulsively instead of making plans
- Suffer from a lack of support, due to stress like poverty, racism, or substance abuse

**How Judges, Attorneys, and others can use a trauma-informed approach**

It is important for supervised visitation and child welfare workers, legal professionals, and mental health professionals to be aware of parents or children who exhibit signs of trauma, or posttraumatic reactions.

- Being in court can trigger thoughts of trauma
- The child welfare system can remind the parent of the traumatic experience(s)
- The legal process can make parents feel out of control, which can make posttraumatic feelings stronger.

Workers can advocate for the safety of children and families by identifying needed services for parents suffering from trauma. When a professional knows that he or she are working with a parent who has faced trauma, he or she can consider the following:

- Empower parents by asking what their needs are as far as services are concerned.
- Suggest services that may be helpful to families and parents.
- Encourage positive relationships with healthcare providers, if a parent has one.
- Conduct a trauma-informed assessment of the parent and his or her relationships with each child.
- Use evidence-based treatment practices, and communicate with local professionals to pinpoint these practices.
- Educate the court with the process of evidence-based trauma treatment for adults.
- Be aware of Posttraumatic Stress Disorder and substance abuse occurring together. This is more common among women, and can be used as a way to self medicate.
- Be aware of barriers to services, such as language differences, cultural issues, poverty, disability, or homelessness. Also be aware that these populations have a higher risk of experiencing trauma.
- Maintain a supportive relationship between professionals and parents.
- Build on the strengths of the parents'.

Those working with parents who have faced trauma can face what is called compassion fatigue, when they may become stressed or uneasy when trauma experiences are retold in courtrooms or counseling sessions. It is important for professionals to realize that services are available for secondary stress/compassion fatigue.

Source:

The National Child Traumatic Stress Network (2011). *Birth parents with trauma histories and the child welfare system: A guide for judges and attorneys.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_guide_judges_final.pdf

# TRAINING THE TRAINER
## *A Clearinghouse Mini-Guide for Program Directors*
## *Updated for 2012*

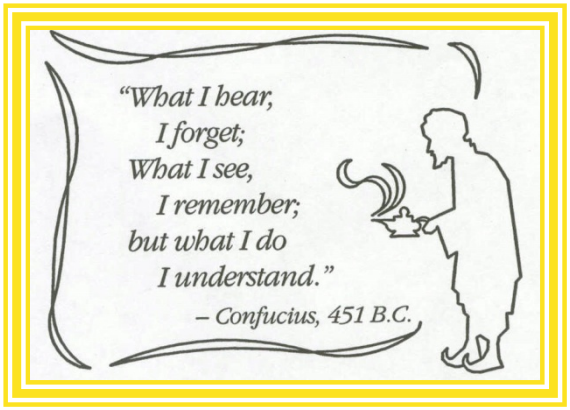
This instruction guide will help directors learn the basics of being an effective trainer.

The Clearinghouse has produced a large collection of training material and continually releases new material online. However, even though some of the manuals can be self-taught, it is extremely important for program directors to offer in-person trainings for new staff using our materials. Don't just leave staff to take all their training online. Each program director should learn how to train his or her staff on Clearinghouse materials. We'll be happy to help!

### What is a Trainer?

A trainer has many roles. Below are examples of the tasks performed by trainers:

- ✓ Researcher
- ✓ Organizer
- ✓ Designer
- ✓ Motivator
- ✓ Facilitator
- ✓ Networker
- ✓ Manager
- ✓ Assessor




**What are the components of a successful training?**

There are many components of a successful training session. We break it down into five parts. A trainer must do all of the following:

1. Understand how adults learn and what motivates them.
2. Obtain training experience from a variety of sources.
3. Understand all training material thoroughly.
4. Use a variety of methods, media, and approaches to teach the material.
5. Learn to improve training methods by responding to feedback from training sessions.

**Successful training is how your learners feel about what THEY CAN DO as a result of the learning experience.**

**Advice on how to be an Effective Trainer**

The trainer's goal is for participants not only to learn the material but to use it effectively. Here are some tips how to be a successful trainer:

- **Attend trainings.** Be knowledgeable about the subjects you plan to teach. Take notes. What was effective about the training you took? Incorporate these things into your own sessions and develop your own style! What would you have done differently? Avoid things that were unappealing to you.

- **Be current**. Have up- to- date resources and references on subjects you plan to teach. The more you know, the better trainer you will be.

- **Use online training courses.** There are many free training materials online. Go to "YouTube" and watch video trainings. http://www.youtube.com/ Search "How to a Give Presentation"

- **Attend monthly meetings.** The Clearinghouse hosts meetings every month. You will pick up pointers and valuable information each time.

- **Stay informed.** Changes occur all the time. Be familiar with new developments. Read all of the E Presses and the Director Memos. **http://familyvio.csw.fsu.edu**

- **First time presenting.** Choose a subject that can be taught in an hour or less!

- **Present with enthusiasm and dedication!** Participants will notice and so will you.

**BE PASSIONATE!**

**If you simply read the material aloud, your training will be boring and dry.**

**If you present the material as interesting and compelling, your lessons will be absorbed!**

**Plan Every Training Session Carefully and Thoroughly**
**Pick a subject on which to train. Plan a timeframe.**


**Then commit yourself to a compelling training!**

## TIPS FOR TRAINERS

**Organize your material in small, simple lessons.**
Most classroom-based instruction can be *dramatically* improved by reducing the amount of

content. You don't want learners to leave feeling overwhelmed.
Include reference material and handouts.
Contact The Clearinghouse if you have questions about the material.
http://familyvio.csw.fsu.edu or call 850-644-6303

**Start quick and finish big!**
People get bogged down with long introductions and history. Get them engaged, the quicker the better! When ending your session, don't fizzle out, leave them on a high note. You will never ask yourself how effective your session was.

**Keep your lectures to the absolute minimum.**
Never talk more than 10-15 minutes at a time without doing something interactive. There are other, more effective ways of learning and retaining information than lectures. Use a combination of exercises, presentations and mini-lectures. REMEMBER: If you're short on time, ALWAYS cut the lecture, not the exercises.

**Tailor materials to your audience.**
Choose cases ahead of time that reflect the training material. For example, if you are training on the topic of substance abuse from the Clearinghouse training manual, use a real case example from your file that reinforces the material.

Use local statistics and news stories. This will reinforce your message and it will be more relevant to learners. Invite guest speakers with expert knowledge to explain how specific cases can be complex and difficult to understand. You can also set a "google alert" with the phrase supervised visitation to collect stories on SV to use in your trainings.

**Plan to incorporate various types of presentations into your training.**
Don't assume that just because you said it, they got it!

PowerPoint/slides are great visuals and give you the option to project the written material on the screen. Handouts of your slides are helpful and give the participants the opportunity to take notes.
Graphs, pictures, and short video clips keep your presentation interesting

Small group activities will engage learners and encourage them to discuss what they've learned. Games, interviews, mock cases and role playing are just a few examples.

Short films and DVD provide an effective way to supplement the material.

**CONSIDER YOURSELF A PERSON WHO CREATES LEARNING EXPERIENCES!**

**ADULT LEARNING BASICS**

Program Directors should to understand the basics of adult learning. Here are the fundamentals:

A. **Adults learn best through a combination of learning strategies including auditory, visual, tactile and participatory.** Presentations should stimulate as many senses as possible in order to increase successful learning. Adults prefer active involvement in learning as opposed to passive listening. Learning has to be applicable to their work or other responsibilities to be of value.

B. **Adults are goal oriented:** Adults usually know what goal they want to attain from the learning and respond best to a program that is clearly defined.

C. **Adults appreciate education that is organized and well paced.** Information should be presented in an organized, concise manner so the learner can create their own flow of understanding. Optimal pacing should challenge adult learners just beyond their current ability or knowledge to avoid boredom and create acceptable intellectual challenge. Anchor information to existing knowledge.

D. **Adult learners are relevancy-based.** Adults prefer information that will focus heavily on the application of the concept to relevant problems.

E. **Adult learners bring varied experiences.** Adults should be encouraged to voice their opinions, related past experiences and knowledge. Open discussions are networking and useful sharing of valuable experiences. The use of open-ended questions helps draw out relevant knowledge and experience.

F. **Adults care about their learning environment:** The learning environment must be physically as well as psychologically comfortable. Avoid long lectures and periods of interminable sitting with the absence of practice opportunities.

G. **It's all about motivation!** If the participant does not recognize the need for the information it will not be of value to them. You can motivate participants by enhancing the reasons for learning.

## According to adult learning theory research, adults remember:

- 10% of what they read
- 20% of what they hear
- 30% of what they see
- 50% of what they see and hear

- 70% of what is repeated
- **<u>90% of what is repeated and performed</u>**

HELP PARTICIPANTS DEMONSTRATE AND PERFORM

THEIR NEW SKILLS

## The Components of Memory

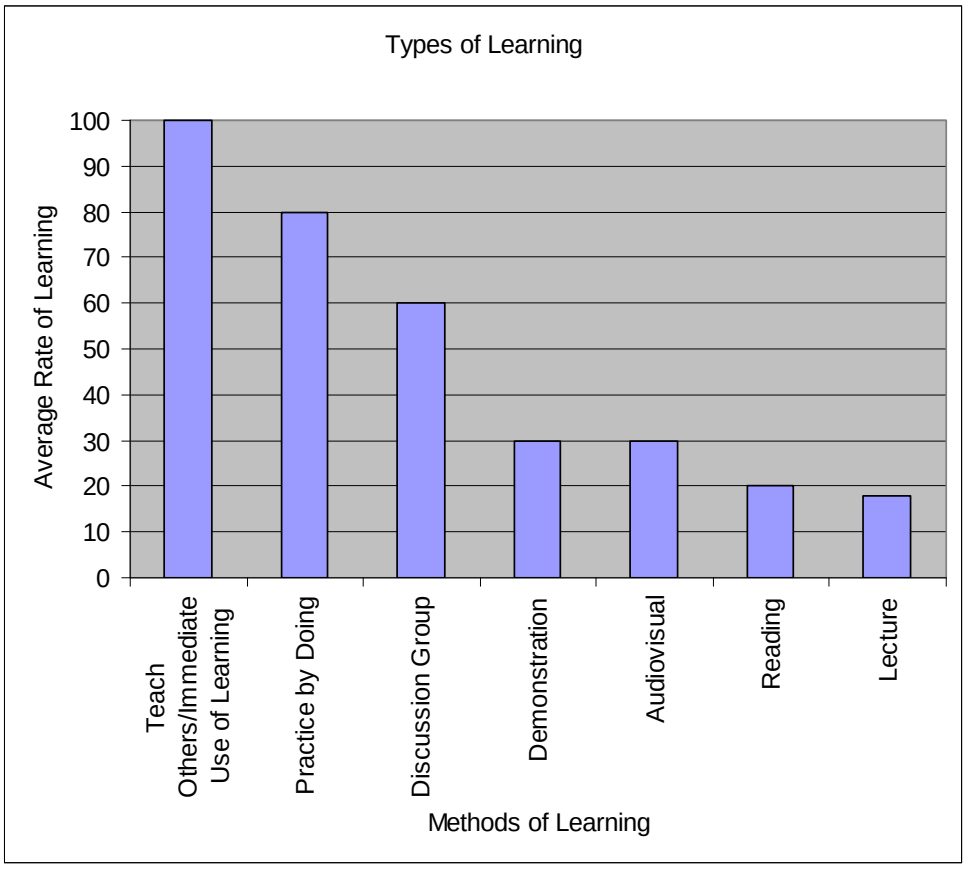
There are six components of memory. Each component means different things to a trainer. Adults tend to remember things that:

1. **Stand Out** – Make your information dynamic!
2. **Link to the known** – "Anchor" the information. Provide information that builds on what the learner already knows.
3. **Are written down or recorded** –Use handouts. Make it easy for participants to take notes.
4. **Are reviewed** – Periodically reviewing information will increase learner retention. Quizzes at the end of each unit, group activities, and closing exercises will help you review information with participants, thereby increasing retention.
5. **Use primacy** – People tend to remember beginnings and endings and are more likely to forget what happens in the middle. Information heard in the early stages or towards the end will be more easily remembered. Make your key points early and in the end of the presentation. The training manuals written by the Clearinghouse are structured in this fashion.
6. **Are recent** – Remember that newly gained information, such as that at the end of the training, will be more easily recalled than earlier information


**Keep these facts in mind when implementing your training sessions.**

## HOW ADULTS RETAIN INFORMATION

Of course, the initial transference of information to the learner is only the first step – retention is the key. How do you help adults retain the information you are giving them? The following chart demonstrates the average retention rates for various learning methods




**Average Rate of Learning**

| Method | Retention Rate |
|---|---|
| Teach Others/Immediate Use of Learning | 100 |
| Practice by Doing | 80 |
| Discussion Group | 60 |
| Demonstration | 30 |
| Audiovisual | 30 |
| Reading | 20 |
| Lecture | 18 |

Some studies have found that adults learn most effectively in the same way that children do – through active participation in learning. Active learning makes important points more meaningful and allows participants to practice newly acquired skills and knowledge. In light of

this, it's recommended that trainers lecture or discuss the material with the participants first, and then help them to practice the skills and facts covered in the lessons.

## An original idea that generates enthusiasm will go further than a great idea that inspires no one.

**Be creative! Make it fun to learn**

The most memorable trainings are those in which the participants have fun and connect with other people. Here are a few ways to facilitate that connection:

- Use ice-breakers, whether or not the people in the training room know each other. Here are some old favorites:
    - As you do introductions, ask each person to tell one thing that made them smile that day.
    - Deserted Island. Have each person tell who they would want to have with them on a deserted island and why.
    - Story Time Game. The facilitator starts a story by saying a sentence. It then goes in a circle, each person adding a sentence onto the story-after repeating each sentence that's already been added.
    - Magic Wand. Ask participants if they had a magic wand what would they choose to change? Pass a "magic wand" around or any other cool magical item, and generate some energy!
    - The Pocket/Purse Game. Everyone selects one or two items from their pocket or purse that has some personal significance to them. They introduce themselves and do a show and tell for the selected item and why it is important to them.
    - Birthday Game. Have the group stand and line up in a straight line. After they are in line, tell them to re-arrange the line so that they are in line by their birthday. January 1 on one end and December 31 at the other end. The catch is that they must do all this without talking.
- Team Up. Break up the room into teams of two, three, or four people. Give them assignments so that they work together. Use the case examples in the modules to get them discussing solutions to real problems. Have one member of each group come to the front of the room to speak for the group when the room is ready to exchange feedback. Working together is more fun than working alone for many people.
- Give participants a semi-review and wake-up exercise when covering material that requires heavy concentration. Have everyone stand up and form a circle. Toss a nerf ball or bean bag to a person and have them tell what they thought the most important learning concept was. They then toss the ball to someone and that person explains what they though was the most important concept. Continue the exercise until everyone has caught the ball at least once and explained an important concept of the material just covered.

- Be sure to offer refreshments if the session goes beyond an hour. Participants will need a few moments to absorb the concepts.
- Break up monotony with the unexpected. Sounds get people's attention and can easily be recorded. Play the music for "jeopardy" after you ask a question or ring a bell for a correct answer. Think of something gentle, but surprising. Make people smile!

References:

Billington, Dorothy D. "Seven Characteristics of Highly Effective Adult Learning Programs." Ego Development and Adult Education, 1988. http:www.newhorisions.org/lifelong/workplace/billington.htm.

Conner, Marcia L. "How Adults Learn." Ageless Learner, 1997-2007. http://agelesslearner.com/intros/adultlearning.html.

Lieb, Stephen "Principles of Adult Learning." *VISION*, Fall 1991. http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-2.htm.

Zemke, Ron and Susan "30 Things We Know For Sure About Adult Learning." *Innovation Abstracts*, 1984. http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-3.htm.

## Training Evaluation Forms

After you have conducted a training, you should distribute training evaluation forms to the participants.

We have attached a sample form below. These forms help trainers do the following:

- Determine how participants responded to the training
- Identify areas of strengths/weaknesses of the training
- Gauge whether participants enhanced their job skills
- Gather information to help improve the trainer's presentation.

When circulating such a form, remember to do the following:

- Give participants time to fill out the form
- Collect the form in a manner that allows anonymity to the participants
- Review every form. You can and should learn to be a better trainer over time.

Feel free to amend the following SAMPLE to your program's needs.

# Sample Training Evaluation Form

Please circle the score that most closely represents your views.

1. To what extent have the objectives of the training been achieved?

| ***Fully*** | ***Adequately*** | ***A little*** | ***Not at all*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

2. To what extent have your personal objectives for attending the training been achieved?

| ***Fully*** | ***Adequately*** | ***A little*** | ***Not at all*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

3. To what extent has your understanding of the subject improved or increased as a result of the training?

| ***Fully*** | ***Adequately*** | ***A little*** | ***Not at all*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

4. To what extent have your skills in the subject of the training improved or increased as a result of the training?

| ***Fully*** | ***Adequately*** | ***A little*** | ***Not at all*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

5. To what extent has the training helped to enhance your appreciation and understanding of your job as a whole?

| ***Fully*** | ***Adequately*** | ***A little*** | ***Not at all*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

6. What is your overall rating of this training?

| ***Excellent*** | ***Good*** | ***Fair*** | ***Poor*** | ***Not sure*** |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

7. To what extent would you recommend others, with similar needs to your own, to attend this training?

| *Would highly recommend* | *Might Recommend* | *Would probably not recommend* | *Would definitely not recommend* | *Not sure* |
|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 |

## Trainer Evaluation

8. Please rate each trainer by circling the relevant score for each :

Trainer One: _____

| | | *Excellent* | *Good* | *Fair* | *Poor* | *Not sure* |
|---|---|---|---|---|---|---|
| (a) | Knowledge of subject | 4 | 3 | 2 | 1 | 0 |
| (b) | Organization of sessions | 4 | 3 | 2 | 1 | 0 |
| (c) | Obvious preparation | 4 | 3 | 2 | 1 | 0 |
| (d) | Style and delivery | 4 | 3 | 2 | 1 | 0 |
| (e) | Responsiveness to group | 4 | 3 | 2 | 1 | 0 |
| (f) | Producing a good learning climate | 4 | 3 | 2 | 1 | 0 |

## Optional Additional Questions: (leave room for free responses)

**What did you like most about the training?**
**How can we improve this training?**
**Are there any additional topics/issues you think we should add to this training?**

**The TECHNICAL ASSISTANCE INDEX has been updated for 2012. It is attached to this E Press!**