FINDING HOPE IN AN INSTITUTIONAL SETTING:

SPIRITUAL SUPPORT GROUPS

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Thesis Submitted in Partial Fulfillment of
Requirements for Doctor of Ministry Degree

Hebrew Union College-Jewish Institute of Religion
Graduate Studies Program
New York, New York

April 18, 2005

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ACKNOWLEDGEMENTS

It has been my good fortune to have two mentors from the Doctor of Ministry program who have helped to shape this project in complementary ways: Rabbi Hesch Sommer and Douglass Clark. They have been inspiring and astute teachers as well as exemplary professional role models. I have learned much from them, as well as from Sr. Vivian Joyce and Dr. Carol Ochs.

I am indebted to The Jewish Home and Hospital where my project was conducted. Not only did the institution contribute financially, but it also gave me the flexibility to pursue my studies and the time to write up this project. I am especially appreciative of Ellen Pearl, the Therapeutic Recreation Leader and my co-facilitator whose insistence and assistance were instrumental in undertaking this project. I am also beholden to the patients who were part of this study.

I thank Jennifer Ossakow, the rabbinic student, who helped administer the evaluations and took notes during the sessions. David Szony was a quick and thorough editor. Rupa Patel provided much-needed technical and production support.

My son, Jacob Meier, reached new levels of maturity as he took over some of the household chores, asked less of me, responded to my cries of computer frustration and offered moments of empathy as I struggled to complete this.

Most important is my husband, Jim Meier whose support was unending and who unfailingly guided me through conceptual impasses and times when I suffered from writer's block He went beyond any of my expectations for support. This manuscript would never have been completed had it not been for his endurance, patience and loyalty.

He is my rock and pillar and a champion at supporting his wife's endeavors, which are manifold.

First, last and always is my gratefulness to the Holy One, the Source of all that has enabled me to do this work and from which I derive being and eternal blessing.

This project is dedicated to the memory of mother, Jean (Shaindl) Lederman Edelstein, *z"l"* (of blessed memory), whose 10th *yartzeit* (anniversary of death) will occur on the day this manuscript is to be delivered. My appreciation for her increases as I age.

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INTRODUCTION

Cast me not off in the time of old age; when my strength fails, forsake me not" Psalms, 71:9).

Western society has not dealt kindly with its elders. The demands of modern life in a technological age have gradually eroded the traditional support systems for the elderly, and, as a society we have not developed adequate replacements. We lack sufficient services for all who are seriously ill in our society, much less those facing special challenges near the end of their lives.

Immigrants from Asia and Africa are shocked to see children in the United States place their parents in long-term nursing facilities rather than caring for them in their own homes. Yet as these groups assimilate, they too admit their parents to institutions rather than care for them at home. And second- and third-generation elderly American parents, fiercely independent and extremely respectful of privacy, do not want to move in with their children, fearing that they will an intrusive, possibly burdensome, presence in their lives.

How best to safeguard those who are elderly and too sick to sustain themselves is a complex problem that has no simple solutions. The cost of medical care in the United States, and the fact that the "baby boomer generation" will be retiring soon – with some already requiring geriatric medical attention – indicates that we are rapidly heading towards a severe crisis in geriatric medical care. Apart from the obvious necessities for shelter, food, healthcare and other physical requirements, the elderly, like everyone else,

have family, personal, social and financial needs and issues to deal with... They also have spiritual need and yearnings that institutions too often treat as an afterthought or neglect entirely.

BACKGROUND

The Jewish Home and Hospital Life Care System, where I work (hereafter referred to as JHHLCS or The Home), is among the largest facilities for the elderly in the New York metropolitan area, with three nursing homes (1,500 beds) and a full range of other senior adult care programs. JHHLCS attempts to address some of contemporary society's problems of the aging sick population by providing a continuum of care: long-term nursing home placement, temporary rehabilitation, and assisted living. Its living-at-home and day care programs, which are expanding, allow those who are well enough to remain in their apartments, aided by home attendants and medical staff visits. Senior day care enables the elderly to spend the day at the facility engaged in activities and to return home after lunch or dinner.

Since many of these people are indigent, JHHCLS relies heavily upon fundraising and reimbursements from private insurance companies as well as the government. Facing constant threats of reduced funding and impacted by steadily diminishing resources, staff and clients experience recurrent stress. Residents and patients who are particularly frail, lonely and otherwise vulnerable may feel acute loss when staff, e.g., the CNA (certified nurse's assistant), who toilets, bathes and dresses them are let go. If present fiscal realities persist, many of these types of facilities may not be able to maintain a level of acceptable service.

Working in The Home as the Chaplain responsible for the spiritual life of all clients, including family/friends and staff, I encounter the daily concerns faced by the residents who live –there – e.g., waking to another morning and then waiting for a nursing staff attendant (who may, or may not, speak English) to take care of the individual's most basic needs: going to the bathroom, diaper changing, washing, dressing and eating. Few individuals are happy about relying upon others for these functions and some express displaced anger toward the staff. A few residents would just as soon be dead and wish each day were their last. For the nursing staff to face these residents on a daily basis is difficult and sometimes leads to emotional burn-out.

Long-term care facilities usually have psychiatrists who are part-time, and only provide medication and not counseling; social workers, meanwhile, are inundated with paper work and phone calls and complete and despite their best intentions rarely have time to counsel patients. Everyone's case load is burgeoning and probably is larger than the person can handle well. It is apparent that the chasm of loneliness and fear in the resident's life cannot be filled by the steadily shrinking staff. To further complicate matters, residents of nursing homes generally suffer from the limitations that can be imposed by advanced age. As one observer put it:

> By the time people enter into nursing homes and care communities, they have generally experienced some loss of function, be it impairment or disability or generalized aging. This can include reduced vision and hearing, limited mobility, short term memory loss, dementia and the entire range of physical and mental challenges known to humanity (Hamlen, 2004, p. 325).

Thus as I observed this predicament, I sought a means to create an environment in which the clients were able to emotionally support one another while sharing common spiritual and emotional concerns. I conceived of and developed as my demonstration project a spiritual support group. This group would embody clinical and religious practices to help bridge the gap between the clients' vast spiritual and emotional needs and the minimal resources devoted to this aspect of their well-being.

This paper describes this demonstration project, detailing the underlying issues and concerns that led to it, while also providing an analysis of insights from religious and clinical literature that have been used in running the groups. It also details the methodology and the results of the project activities. Chapter I defines the clients and their needs. Chapter 2 posits the religious and clinical principles upon which the underpinnings of the project are based. Chapter 3 illustrates the methodology. Chapter 4 depicts each of the four groups that comprised the project and Chapter 5 describes the successes, disappointments and future steps.

THE RESIDENTS

The people admitted to JHHLCS, who constitute a broad cross-section of backgrounds and needs, bring with them the legacies of their lives -- their unresolved personal emotional issues, a familial and other social network and the remnants of their personal spiritual and emotional resources and material possessions

Although a very small portion of JHHLCS residents go home once their health has stabilized, the vast majority reside there permanently until they die. Many have

experienced diminished control over their own lives and some never even get to see the world outside again.

A substantial number of residents have families, especially children, and friends who visit regularly and provide emotional support. Children who admit their parents to The Home sometimes feel guilty for not being able to care for their parents at home, are repulsed and frustrated by the environment and are overwhelmed by medical and end-life decisions thrust upon them. They may also experience undue pressure about finances, while they stand by helplessly observing their parents' deterioration.

Optimally, parents and children will have the opportunity to resolve long-standing conflicts at this time. Borowitz (1999) describes how, when roles are reversed and children become their parents' caregivers, this can lead to an enriched relationship. However, quite a few of the residents' children, even those who live near the facility, sever ties with their parents. Following their parents' admission, with power-of-attorney in hand, these children may never step foot in the facility or even call again.

Other residents, never married or partnered, rely upon aged siblings and friends, and/or distant relatives, e.g., nieces and nephews or cousins whom they rarely see. These individuals, who usually are intermittently in touch over telephone, have been given the legal authority to make life-and-death decisions for their relatives. And then there are extremely aged, sometimes over 100, who are the sole survivors of their families and friends, having lost children, spouse(s) and siblings.

For these individuals, who have lost contact with anyone outside the facility, the institution becomes their last home, as the residents, staff and volunteers become their only "family." Within this mixed multitude quite a few make a splendid adjustment, especially grateful for the nurturance they receive: the medical attention, the regular nutritious meals and the clean environment.

Amid the endless variety of individual situations, there exists an almost ubiquitous feeling of sadness, fear and isolation with occasional sparks of joy. For most residents, their emotional burdens are as great as their physical limitations. After all, they have been compelled to give up their own homes and move the entirety of their lives into a private, double or four-bedroom apartment, their possessions reduced to only what can fit into three drawers, a night table and a four-foot- wide closet. Those in non-private rooms sleep within six feet of a complete stranger, who may not speak the same language, may not speak at all, and/or who may be dying. The two residents are separated by a thin opaque curtain. Privacy becomes a concept of the past as residents are forced to adjust to roommates, staff and other strangers walking into their rooms at any hour of the day or night.

It is no wonder that so many retreat into their past to retain some connection to reality as they knew it. Their memories are dearer than their current lives which consist of TV, bingo and the frightening alien world around them that smacks of sickness and death. As one observer of nursing home life observes "There is a lot of evidence that the elderly feel isolated, even in the midst of communal life. Chronic pain, limited functioning, the losses of mobility, freedom, family and friends, and ensuing depression

can make it difficult for aging people to reach out and connect yet again with other people" (Hamlen, 2004, p. 334).

Thus, individuals, some former pillars of society, are forced to give up lives they led for sixty or more years and are thrust abruptly into an environment where they are in close proximity with others from diverse economic, social, cultural and educational backgrounds, not to mention the extremely ill and the severely demented. At worst, these circumstances are an anathema to them which they never overcome; at best, they will need a period of adjustment. These elders, of whom the Jewish tradition writes that their "gray hair is a crown of glory" (Proverbs, 16:31), often are in a state of shock and plead overtly and covertly for emotional and spiritual support. I often hear: "How could this have happened to me? I want to go home. When will I go home? This is not where I live; I live at home. I feel like I am in prison. I have no friends here! I'd rather die than live here for the rest of my life." This litany expresses deep, often palpable, anxiety and despair about their present and future. Bartel describes the "spiritual suffering" they endure:

> When one can no longer trust those nearby, spiritual suffering is experienced. When beauty is absent from one's life, one suffers spiritually. When one's hope is gone, spiritual suffering can be acute. Much as physical pain signals an injury to the physical body, spiritual suffering can be seen as an indication that one or more spiritual needs are threatened or going unmet. While physical suffering can include a threat to one's mobility, spiritual suffering includes threats to one's belief and purpose in life. It is often experienced as 'spiritual dissonance,' where the dissonance lies between one's faith and critical events in one's life. Spiritual suffering is found clearly in those difficult times 'when individuals are unable to find sources

> of meaning, hope, love, peace, comfort, strength and connection in life' (Bartel, 2004, p. 194).

For those who were active members of a religious community or who included religious ritual in their daily lives before admission to The Home, continuity of worship and a relationship with the chaplain can significantly help their adjustment. Nevertheless, according to Hamlen (2004), while many value religion, their intention to participate in religious practice can recede as a result of physical and/or mental impairment. Involvement in spiritual practice may be too complex a task for them. Even those who are regular worship attendees at JHHLCS often stop coming to services when their health declines, despite the fact that staff picks them up and brings them back to their rooms.

Some just forget what the service is about, but may get very aroused when a prayer is sung to them in another context. Others wind up going to religious services of a different because they have lost sense of day or time but associate the room where services are held as a worship space. Thus, regular synagogue goers absent from Shabbat may appear at Sunday services and vice versa. At the same time, at this stage, when residents make the transition from an active life to an inactive one, dependent and ultimately terminal one, the chaplain is the only staff member who can help them experience the presence of God in their lives.

Many sleep while attending services; others do not have the ability to hold onto the prayer booklets; quite a few cannot see, although these publications are typed in a 20-point font. Another group cannot hear despite their hearing aids. Then there are the shouters, who regularly interrupt and the "mover- abouters," who wheel themselves in

and out of the room during the entire service. The variations are almost infinite. Within the multiple impediments these souls yearn to connect with tradition and God.

THE PATIENTS

The Home houses two floors of transient residents who have been admitted to the rehabilitation unit following hospitalization or some other critical medical crisis (ages range from mid 50's to low 100's). Members of this subgroup (hereafter referred to as patients, as distinct from the permanent residents described above) usually return home as soon as their medical condition is stabilized. The patients comprise the "hospital" population and fill 78 of 514 beds, with the balance designated for the permanent residents.

Some patients remain on the rehabilitation unit for as little as two weeks before returning to their apartments, while others stay for up to a year. A number are transferred into the residential units and some die. Despite the differences in their condition and expectations upon entering The Home, the patients exhibit many of the same anxieties as the residents. They are consumed by uncertainty about their future e.g., how long they will remain in the facility, what will happen to them when their insurance is used up.

Finally, the patients are overwhelmed by the need to develop tactics to cope with the physical realities of rehabilitation: the arduous schedule of therapies and treatments; the emotional and spiritual uncertainties about their health; the possibility of not recovering and having to adapt to life with major physical incapacities such as paralysis,

amputation, and blindness; and how well they will be able to take care of themselves when they get home.

Some worry that they might lose their mental faculties. Often most difficult for them is their loss of self as they are compelled to depend on others – family and friends - whom they may have cared for at one time, and the staff - who are total strangers and often from foreign countries. It takes most patients several days to comprehend where they are and why they are there. Once they understand, most want to go home.

Given that medical and social work staffs that are stretched to the limit due to constant cutbacks, when one adds to the mix patients with various stages of dementia – "the cognitive impairment, memory, and functional loss that accompany [it] create special challenges" (Hamlen, 2004, p. 327) – and those afflicted with mental illness, the picture is grim. The disorientation of both many patients and residents brings to mind this parable:

> There was once a man who was very stupid. When he got up in the morning it was so hard for him to find his clothes that at night he almost hesitated to go to bed for thinking of the trouble he would have on waking. One evening he finally made a great effort, took paper and pencil and as he undressed noted down exactly where he put everything he had on. The next morning, very well pleased with himself, he took the slip of paper in his hand and read: 'cap' – there it was, he set it on his head; 'pants' – there they lay, he got into them; and so it went until he was fully dressed. 'That's all very well, but now where am I myself?' he asked in great consternation. 'Where in the world am I? He looked and looked, but it was a vain search; he could not find himself.' And that is how it is with us,' said the rabbi (Buber, 1994, p.30).

There are moments on the rehabilitation unit when, despite the flurry of activity and the additional staff – there are proportionally more than on the resident units), patients feel terrified, alone and angry. Religion is often the last thing on their minds; they simply want to get better so that they can go home. Nonetheless, their emotional state often adversely impacts their physical condition, which, in turn, can impede progress in rehabilitation.

CHALLENGE TO THE CHAPLAIN

"Since maintaining a healthy and sound body is among the ways of God – for one cannot understand or have any knowledge of the Creator if he is ill – therefore, he must avoid that which harms the body and accustom himself to that which is healthful"
(Maimonides, 1989, p. 66).

Judaism has a vast and deep belief in the power of physicians and science. In modern times, medicine's goal is to eradicate disease, so that humans can live longer lives than ever. Today, faith in science has supplanted faith in religion - the majority of Jews make far more visits to doctors than to their rabbis. For many, the continuity of life has become an end it itself, unrelated to knowledge of the Creator, as the Rambam indicates above.

Most of us take adequate bodily functioning for granted, as we ignore physicians' admonitions to pursue healthy lifestyles. Belief in therapeutic interventions has mostly eradicated the self-discipline required in both a proper diet and regular prayer. Yet when Jewish seniors are admitted to The Home, many are shocked at having lost the ability to sustain themselves because they have been under a doctor's care, taken medication, had

surgery, etc. It is impossible for them to accept the reality that their bodies have broken down to a point where they need round-the-clock care.

Along with experiencing a physical breakdown, patients suffer a decline in morale, for they often have lost whatever modicum of faith they had. When things were going their way, they could easily believe in God, but once they got sick, their faith evaporated. What will maintain them as their bodies and souls evanesce? Each new professional that enters their room must find ways to help them to come to grips with their new reality.

Once I grasped the situation, I resolved both to find a way to establish relationships with all the patients and residents and to try to support them through what is likely the most difficult period in their lives. Believing that physical and spiritual health is intertwined, I concluded that the spiritual support I offered would abet the healing process. Martin Buber captures my sentiments: "What is meant by unification of the soul would be thoroughly misunderstood if 'soul' were taken to mean anything but the whole man, body and spirit together. The soul is not really united unless all body energies are united...A man who thus becomes a unity of body and spirit -- he is the man whose work is all of a piece" (Buber, 1994, p. 25).

One of my challenges was to find ways to capture the largely unaffiliated Jewish population (42%), the Catholics and Protestants (38%), and those of others faiths as well as non-believers others outside of a traditional service milieu (10%). Although many newly admitted residents and patients refrained from incorporating religious practice into

their lives when they were healthy, they were more likely to be receptive to some kind of informal religious gathering at The Home, for:

> Religion and spirituality play vital roles in the lives of people across the lifespan, especially in times of crisis. A recent study suggests that the increased use of religious/ spiritual coping strategies is directly related to the severity of illness...studies have found that higher use of religion/spirituality as a coping mechanism is related to lower levels of the negative affective symptoms... associated with stress and illness among hospitalized patients. Religious beliefs offer the additional benefit of hope, particularly for people with serious illness. Faith invites the suffering person to search for meaning and perspective through a source greater than one's self and, in doing so, gain a sense of control over feelings of vulnerability (Fogg et al., 2004, p. 225).

I took to heart in my professional life the teaching: "As God is gracious, so I should be gracious and compassionate...These are the deeds which yield immediate fruit and continue to yield fruit in time to come: honoring parents doing deeds of loving kindness...visiting the sick" (Babylonian Talmud, Shabbat, 127a, 133b), I wanted to visit each person individually, going to one residential floor (average of 30 beds) a week, while also attending to both rehabilitation units (76 beds). I did not realize that to do so would have required 106 visits in 18 hours.

That plan fell to the wayside after one month, when I realized that my 22.5-hour work week greatly limited my ability to meet my goals. I now knew that I would never get to see all the residents and also visit the patients in any meaningful way. Even if that were physically possible, it would have been emotionally draining. My biggest dilemma was: on whom should I focus greater attention, the transitory patient or the permanent resident?

In many instances the patients, as a result of the emergency nature of their admission, experience an intense need for comfort. It quickly became clear to me, as Byrne (2002) has written, that although the specifics of each patient's case vary, the vast majority of those admitted experience some degree of crisis. In contrast, the residents, by and large, have acclimated themselves to the environment, after their initial sense of disorientation has dissipated. They are more likely to be enduring long-term feelings of frustration, helplessness, boredom, confusion and loneliness,

Furthermore it is difficult to actually visit the patients in their rooms, for their days are occupied with a variety of therapies and treatments, as well as meals and other ordinary activities, which often cause them to be occupied or out of their rooms, and may leave them exhausted, with a strong need to rest. It is not unusual for a chaplain to spend half an hour going from one room to another on a rehabilitation floor without visiting any new admissions because they are sleeping or somewhere else in the building.

Some become irritable when yet another staff member approaches them, even when it is the chaplain, whose purpose is to provide consolation. They may respond to him/her with a torrent of emotion and intense need, refuse the visit, or insistently react to the chaplain as one of the medical staff. At least once every time I am on the units someone shouts out to me "Nurse, nurse." Many patients seclude themselves in their rooms except when they must be taken out for medical treatment. They refuse to communicate with other patients and limiting their interactions only to staff and visitors (if they are fortunate to have them).

Maimonides understood their circumstances when he wrote: "He should have the intent that his body be whole and strong, in order for his inner soul to be upright so that [it will be able] to know God. For it is impossible to understand and become knowledgeable in the wisdoms when one is ...sick, or when one of his limbs pains him" (Maimonides, 1989, p. 58). Many patients illustrate the Rambam's statement, in that they compartmentalize their physical health and are not open to utilizing religious or recreational resources to aid their recovery. They refrain from offers to participate in religious and other activities contending that they must get well first – as if there were no integration between the physical and spiritual.

Furthermore they may avoid associating with other patients out of denial of their own condition or from embarrassment. This tendency towards social isolation may only intensify their depression, ultimately creating further problems of depression and low-morale for them, as well as for the staff who are not necessarily trained to deal with emotional/spiritual issues. How should one deal with these ailing recluses? "A person is obligated to show great care for orphans and widows because their spirits are very low and their feelings are depressed. This applies even it they are wealthy...One should not...aggravate their feelings with harsh words" (Maimonides, p. 132). The patients at JHHLCS may not necessarily be orphans or widows, but they fall into the category of those who require sensitive consideration. While they may not have lost a family member to death, they have lost their health and dignity. There is urgency and sometimes a desperation surrounding their circumstances.

Thus, I came to recognize that it was imperative for me make contact with the patients because "The chaplain occupies the unique and important position as one who companions the patient in his or her wholeness as a human person. Providing space for the patient to 'be,' the chaplain facilitates the possibility of growth and integration as illness threatens to annihilate the person's sense of self" (Byrne, 2002, p. 260).

INITIAL SOLUTION

In an effort to fulfill the *mitzvah* (commandment) of *bikur holim* (visiting the sick), and to resolve the conundrum of spreading myself and my staff too thin, I began to consider various ways to maximize my effectiveness at The Home. I concluded that the vast number of patients and residents (and perhaps staff, too) would benefit from some kind of formalized contemplative prayer time outside the weekend Jewish, Catholic and Protestant services. My concern was the same as Hamlen's (2004), when she posed the question: How will we meet the spiritual and religious needs of this aging institutionalized population?

The thought occurred to me to create a daily afternoon prayer time for residents and staff fashioned after the Jewish *mincha* (afternoon prayer service; traditional Jews pray three times a day: early morning, mid- to late afternoon, and evening.) Naively believing that the Social Work department would be interested in my undertaking, I shared my idea with the Director of Social Work, hoping to get her "buy-in" and the involvement of her staff. Unbeknownst to me, the staff's caseloads were so high and their jobs so paper-intensive, that none of them was interested enough even to discuss my intentions with me.

Eventually one of the therapeutic recreation leaders (hereafter referred to as TR Leader), whose job is to provide a social and recreational activities for the residents and patients, was interested in and volunteered to be part of my experiment. She identified a group of women on one of the residential units where she was assigned to participate in the first service.

Next, I focused my energies on translating my vision into reality. I worked hard to create a prayer book that reflected and included selections from the Jewish afternoon liturgy. For good measure, I included a few inspirational songs in both Hebrew and English.

The day of the first service arrived. Never mind the ringing phones, the pervasive background TV, the din outside the room and occasional shouting of a demented attendee. The day finally arrived for our first service. I eagerly distributed the prayer booklets, on which I had worked so hard, to the nine women seated in a circle around the TR Leader and me in the unit's all-purpose room. Upon facing them, however, I was chagrined to realize that there were only a few Jews present, and, even among them, not one was familiar with or alert enough to recognize the prayers in English, much less in Hebrew.

In fact, much of what I had included in the booklet was meaningless to the group. Nevertheless, due to my inexperience, I tenaciously clung to the booklet, adhering to my original vision for several weeks. To my surprise, the residents continued to come. Despite the inappropriateness of the prayer material, the women responded enthusiastically. Their response led me believe that I was on the right track. Yet it took

me awhile to forego my original proposition and to offer them what they really needed. The more I listened to and observed them, the easier it was for me to relinquish my prayer booklet. Over time, the TR Leader and I introduced more discussion about their lives, peppering these conversations with a few prayers and songs from the booklets.

Soon the group became more emotionally oriented and spontaneous; ironically the less I prepared, the more successful the meeting. This diverse group of women ranging in age from 75 to 101, Jewish, Protestant, Catholic, white and Afro-American reminisced about their childhoods. We talked about relationships with siblings and parents, dreams, careers, spouses and disappointments. The topics varied from week to week and arose from their remarks. We regularly attracted a core group of eight residents, a few of whom were aphasic and one who was demented. These meetings were so successful that the TR Leader and I expanded the program to another unit on which the TR Leader worked.

The second unit was a greater challenge, for there were several residents who were demented, and more residents in general were seriously ill and hard of hearing; fewer were able to maintain a consistent conversation. Still, we persisted and continued to offer the "Rabbi's Discussion Group" on the two residential floors for several months.

One very poignant incident occurred after a session on the second unit. I had felt rather frustrated during the hour because of the residents' limited verbal responses and was questioning myself about the group's validity and my leadership. On the way back to my office an Afro-American teenage male volunteer, who had been present for the session, followed me.

"Rabbi, what you did for those old ladies was really important. I 'm really glad I was there. Can I ask you a favor?"

"If it's something I can do, I'd be happy to," I replied, totally shocked by his observation and sincerity.

"Could you pray for my little brother, Richard? He's really sick."

"It would be an honor for me to pray for your brother," I responded. I offered a prayer on the spot. He thanked me and kept walking down the stairs.

At that moment the power of what we had been doing during the group amazed me. I realized that we had crossed generational, racial, gender and religious barriers to comfort and support one another. There was solace even in the moments of silence we shared. How wise Dittes (1999) is when he points out that the counselor need neither demand nor even expect a response, but accept the counselee "as is." I had just learned that concept through this young man.

Following the teenager's comments, the group took on new and deeper meaning for me. As a result of my new awareness of the impact the group might be making on the residents in ways that I had not imagined, I was intent upon finding methods to enhance communication with the less verbally expressive population.

The TR Leader and I continued to meet with "our ladies," even after she was reassigned to the rehabilitation unit and taken off the two residential floors. Unfortunately several months later, due to scheduling conflicts, we had to terminate the

resident groups. To this day, several residents still ask me if I am coming to their floor to pray and talk with them. A daughter of a participating resident recently told me how much her mother missed our sessions.

Clearly the groups were meaningful to these residents and were an effective way for me to maintain contact with them without meeting with each one individually. However, this did not resolve the problem of sufficient hours, staff or volunteers to visit the patient population. Also, as my reputation grew, the social workers and TR Leaders referred an increasing number of depressed patients to me. Finally after several years at JHHLCS, I realized that The Religious Life Department, which I directed, was spending a disproportionate amount of energy on the transient rehabilitation population. Since we had so few hours to devote to making visits among us, we decided that we should allocate a greater portion of our time on the residents, who are our permanent community, and should reduce efforts to minister to the patients.

The other chaplains and I reached this conclusion because we experience the residents as our congregants, and, similar to a synagogue or church, about ten percent of them attend religious services. In addition we still need to minister to those who are too sick to go off their floors and to those who are bed-ridden. Despite this decision, we had no specific plan, other than relying upon volunteers, for dealing with the patients.

When I described our dilemma to the TR Leader, she agreed again to experiment with the prayer sessions with me on the rehabilitation unit, despite the transitory nature of that population. This also struck me as an ideal demonstration project which would enable me to integrate counseling principles, especially of group dynamics with spiritual

enrichment. In the spring of 2004, we began to experiment with what we called the "spiritual uplifting hour," adapting what we had done previously to the new set of circumstances. My goals were to:

- Bring patients out of their rooms to socialize with one another
- Provide them with the opportunity to describe personal situations and to elicit feelings about problems with which they were grappling on a daily basis
- Validate their feelings through mutual affirmation;
- Promote spiritual connection with a Higher Power,
- Create an atmosphere of acceptance and hope through, prayer, blessing and song
- Bring God's presence into our circle for that hour.

For, as Buber writes:

> Where is the dwelling of God?...God dwells wherever man lets him in' this is the ultimate purpose: to let God in. But we can let him in only where we really stand, where we live, where we live a true life. If we maintain holy intercourse with the little world entrusted to us, if we help the holy spiritual substance to accomplish itself in that section of Creation in which we are living, then we are establishing, in this our place, a dwelling for the Divine Presence (Buber, 1994, p. 41).

RELEVANCE OF THIS PROJECT TO THE WIDER MINISTRY

Although the seeds for this project began to germinate in Winter 2003, the Doctor of Ministry Program gave me a platform and opportunity to explore my preconceptions. This systematic study allows me to better understand the theoretical roots, evaluate what

we are doing, and formalize some of the activities in which we engage. In so doing, I am better defining how the underlying principles and practices can be applied to other settings with appropriate modifications.

Most human beings, regardless of their age, benefit from participating in a group with others who are dealing with issues similar to their own. The healing power of peer support and identification with others' problems has been well-documented. For example, Yalom writes, "Group therapy not only draws from the general ameliorative effects of positive expectations but also benefits from a source of hope that is unique to the group format...Members are inspired and expectations raised by contact with those who have trod the same path and found the way back" (Yalom 1995, p. 5).

The addition of spiritual emphasis through prayer and discussions about God, adds an entirely new dimension to group process. Within the groups I have been leading, I have observed people as diverse as a 68-year-old African-American maid from North Carolina, with only a sixth grade education, reach out her hand in commiseration to touch a blind, 89-year-old Austrian Jewish Holocaust survivor, a professor of theology at one of New York's Jewish seminaries. The two of them, along with three others among a group of 11, talked about a common loss during one session of the "Circle of Healing" I facilitated. The pain and pathos in the room were great as one patient after another spoke of the death of his/her child. One woman, who expressed profound faith, stated that of the five children she bore, three had died.

The group process as well as the prayers allowed these vulnerable strangers to open up to one another; whereas they had not shared these painful stories with individual

staff who had interviewed them upon admission. Furthermore, the patients expressed great relief at discovering others in like situations, which enabled them to comfort one another in ways that only those who have experienced something so devastating can.

Yalom (1995) identifies 11 factors that make groups successful. Five in particular are germane to the spiritual support group:

- Fostering hope
- Universality
- Imparting information
- Altruism
- Catharsis.

I believe that a spiritual support group can be an important part of many other institutions, regardless of religious affiliation, such as: other long-term care and assisted-living facilities, hospitals, the military, synagogues, churches, and religious schools, in short, wherever people are willing to gather to pray and converse outside of a formal service. The psychotherapeutic process combined with the spiritual helps us to remember that if we accept that we are created in God's image, then community life becomes essential to our experience of life. Through the relationships that evolve out of community (group), participant's self-understanding is enhanced (Byrne 2002).

Providing space and time to talk, to pray and to sing for an hour on a weekly basis, without requiring a commitment from the participant beyond one session, has the potential to attract those who would ordinarily not risk joining a long-term psychotherapy

group. I have seen individuals who, initially reluctant to share their personal story, participate when we read prayers, sing familiar spiritual songs and offer blessing. It is the rare group member (except for the physically disabled) who remains aloof throughout the hour-long process. As Yalom describes the galvanizing power of groups: "Many patients, because of their extreme social isolation, have a heightened sense of uniqueness...After hearing other members disclose concerns similar to their own, patients report feeling more in touch with the world...'We're all in the same boat.'...Patients are enormously helpful to one another...they offer support, reassurance, suggestions, insight" (Yalom, 1995, p. 6, 12).

I envision a hospital chaplain bringing together mobile patients of all faiths to participate in a similar group, which could prove meaningful to such cohorts as cancer or post-surgical patients. Pulpit rabbis and ministers across the denominational span could offer similar groups, possibly based on common themes, at their houses of worship. For example, when I was a pulpit rabbi, I offered a spiritual support group for the interfaith families. It had some of the elements of the JHHLCS group and was well-attended.

In an attempt to replicate the group, I spontaneously held an abbreviated (45-minute), one-time group for high school students who came to JHHLCS to volunteer at Chanukah. Sensing that a follow-up discussion to their unit visits would be useful, I invited the students and teachers to describe what they encountered and to share their feelings after their experiences. They were eager to have the opportunity to talk about what happened and how they felt. After their sharing, we sang a few songs and I ended with a blessing for them. Their response was so enthusiastic that I am currently making

arrangements with the school to implement a community service project at The Home which would include a spiritual support group for the students.

Religious schools also could adapt this type of group as an elective such as "alternative prayer" for adolescent students, many of whom struggle with emotional turmoil and resist prayer. Having interacted with this age group both as a mother and a teacher, I believe that offering teenagers the opportunity to experience religion in a spiritual way that would also encourage sharing common concerns is worth trying. The students could contribute prayers and songs that they have written and/or select their favorites to share. This would surely exemplify Yalom's assertion that "People need to feel they are needed and useful" (1995, p. 13). Finally, the facilitator of the group, like the pastoral counselor, should have the ability "to witness and reflect feelings... The witnessing is an act of intense energy and focus, astute and attentive...[that] lets the facts, the situation, the problem wash by and attends instead to the feelings implied...passes over the content" (Dittes, 1999, p. 64).

I believe that it is the pastoral counselor's responsibility to foster connections among isolated individuals. When the participants of a spiritual support group are able to experience the sacred within themselves and feel unity with the group, it opens up the possibility for them to feel closer to God. Spiritual support groups have the potential power to help those who feel hopeless overcome their despondency. This type of group can happen on a psychiatric unit, in a nursing home, in a classroom – it is up to the pastoral counselor to lead the way towards creating community and a welcoming space for the Schechinah (God's presence on earth). As Buber articulates:

The Baal-Shem teaches that no encounter with a being or thing in the course of our life lacks a hidden significance. The people we live with or meet with, the materials we shape, the tools we use, they all contain a mysterious spiritual substance which depends on us for helping it towards its pure form, its perfection. If we neglect the spiritual substance sent across our path, if we think only in terms of momentary purposes, without developing a genuine relationship to the beings and things in whose life we ought to take part, as they in ours, then we shall ourselves be debarred from true fulfilled existence (Buber, 1964, p. 39).

CHAPTER II. RELIGIOUS AND CLINICAL PRINCIPLES

RELIGIOUS PRINCIPLES

"A time to be born, a time to die" (Ecclesiastes 3:2).

My commitment to this project stems from the desire to support the most vulnerable at the end of their lives. The Jewish principles of *avodah* (service to God); *B'tzelim Elohim* (created in the image of God); *tikun olam* (repairing the injustices in the world); *gemilut chasidim* (performing acts of loving kindness); *tefilla* (prayer) and *kehillah* (community) underlie this project.

AVODAH (SERVICE TO GOD)

"The situation which has been assigned to me as my fate, the things that happen to me day after day, the things that claim me day after day - these contain my essential task" (Buber, 1994, p. 38).

I have chosen to remain at the JHHLCS because its residents and patients provide the opportunity to encounter the ultimate range of human life and death experiences on the deepest levels. The work also grants me a way to serve the One (God) in what I feel is the most meaningful way possible, despite and because of the trials I face on a daily basis.

In contrast to chaplaincy, where my days are spent observing and interacting with physical and mental deterioration and death, my previous job as a pulpit rabbi had been fun most of the time. In fact, there were moments then when I felt guilty about getting paid to do something from which I derived so much pleasure. At JHHLCS, not only do I

feel that I earn my wages, but also I must constantly remind myself of God's presence in my daily interactions; otherwise, I would run out the door.

Buber's (1994) statement elucidates my dedication to my vocation and this project.

> Judaism regards each man's soul as a serving member of God's creation, which by man's work is to become the Kingdom of God; thus no soul has its object in itself, in its own salvation. True each is to know itself...but not for its own sake – neither for the sake of its temporal happiness nor for that of eternal bliss – but for the sake of the work which it is destined to perform upon the world. (p. 34).

In youth we are filled with hope for what we will accomplish in life, and for who we will become as we mature. We become aware of our gifts and expect to conquer the world. Then we encounter realities, such as the need to support ourselves, ill health and death of loved ones, plus innumerable other experiences which teach us that we are not so special after all. Time, hardship and experience tend to diminish our sense of uniqueness. When we do not have a relationship with a power beyond ourselves, our sense of individuality can further erode as our life becomes increasingly routinized and meaning dissipates. We must grapple with our own reality to retain a sense of uniqueness. Buber (1994) writes:

> Every person born into this world represents something new, something that never existed before, something original and unique. 'It is the duty of every person in Israel to know and consider that he is unique in the world in his particular character and that there never has been anyone like him in the world...Every single man is a new thing in the world and is called upon to fulfill his particularity...that this is not done, is the reason why the coming of the Messiah is delayed.' Every man's foremost task is the

> actualization of his unique, unprecedented and never-recurring potentialities, and not the repetition of something that another...has already achieved. (Buber, 1994, p. 16)

The elderly, in particular, are at great risk of losing a sense of their sense of individuality and uniqueness. Many who are institutionalized, in particular, have essentially given up, believing that they cannot alter what occurred in the past nor change themselves at this late stage of their lives. Their days may seem unending and unvarying, despite "reality orientation boards" posted at the nursing stations, which state the day, date and next holiday. Thus in addition to feeling aimless, the aged institutionalized feel helpless to affect their present and future destinies, as well as their relationships to their families and to God.

To reclaim their identities, the elderly can participate in life review, a process that encourages reflection on their past. When it is most successful and combined with spiritual direction, life review can offer the chance for them to accept themselves. This process provides them with a lens through which to look back over the positive and negative aspects of their lives and can help them come to terms with significant individuals towards whom they bear enmity. It also can help them to confront and overcome other obstacles that have hindered their ability to experience their uniqueness.

Ideally, when reviewing the past from a spiritual perspective, one is open to looking back and deriving at least a modicum of satisfaction from one's life, while coming to terms with regrets. The next step would be to open up to the future, trusting in its potential to heal the soul and to feel at home with God before death. I believe that it is never too late for an individual to assess his/her relationships with other human beings

and God in order to achieve inner peace. This is the highest form of *avodah* (service to God) one can perform in old age.

During my first few months at The Home, one resident, Harold, who was extremely needy, demanded a great deal of my attention. He was in his late 60's and suffering from advanced Parkinson's disease. He confessed to me that he had been abusive to his wife and children, and had also been a drug user and womanizer. One day Harold begged me to call his son for him. I dialed the number, asked his son to hold on and handed the receiver to Harold. He begged his son to visit him. After a very brief conversation, Harold gave the phone back to me with tears in his eyes, saying that his son had something to tell me. In fact, his son shouted at me, asking if I knew what a bastard his father was and demanded that I never dare contact him again. He did not want to have anything to do with his father. He swore that he would never forgive his father and hung up.

Harold, who was crying, and I then talked for a while about the likelihood that his son would never forgive him, and that he might never see his son again. Together, we came to the conclusion that despite all the terrible things he had done during his life, he still could ask God for forgiveness and also try to forgive himself. Ultimately, Harold left my office with greater equanimity than when he entered.

A person can leave a legacy of abuse and suffering, or one of love and care. He/she can accumulate wealth, create beautiful art or make important scientific discoveries. Yet, regardless of one's accomplishments, sickness and the proximity of death are the great human levelers. At the final moment, when we stand before God, who

do we want to be? Whether we are aware of it or not, God is available to us, for "All men have access to God, but each man has a different access. Mankind's great chance lies precisely in the unlikeness of men...God's all-inclusiveness manifests itself in the infinite multiplicity of the ways that lead to him, each of which is open to man" (Buber, 1994, p. 17).

I try to assist my patients through life review to reclaim their unique connection to God, for I resonate with Buber. "Everyone has in him something precious that is no one else" (Buber, 1994, p. 18). The challenge is to find that something, take ownership of it and carry it through sickness and old age. The question then becomes: is it easier to transcend sickness and fear of death when these anxieties are placed within the perspective of a full life? To take it a step further, does the one who has lived life richly by allowing him/herself to connect deeply with other human beings and experiences pave the way for a profound relationship with God? Quoting a *tzaddik*, (righteous person), Buber (1994) says, in relation to that which we encounter during our lives: "Our task is precisely to get in touch, by hallowing our relationship with them [things and beings that touch our hearts] with what manifests itself in them as beauty, pleasure, enjoyment" (p. 19).

B'TZELIM ELOHIM (CREATED IN THE IMAGE OF GOD)

"And God said, let us make man in our image, after our likeness...And God created man in His image, in the image of God he created him; male and female He created them. God blessed them" (Genesis 1:27).

Judaism encourages us not only to emulate God, but also to transform ourselves through carrying out designated tasks, which is a life-long process. My position at

JHHLCS has given me the good fortune to encounter new dimensions of the Jewish dictate, dimensions which bring the highest spiritual rewards in direct inverse proportions to the challenges I face.

My days are frenetic: rushing through hallways, greeting Yetta and Mr. Johnson, explaining that it is not Shabbat, denying someone medical assistance because I am not a nurse, preparing for a Memorial Service, directing staff and students, meeting with family members, and then sitting at my desk, dismayed at my unread email. But then, I get summoned to the room of a dying resident and find myself face-to-face with a wizened, toothless, demented, aphasic, deaf woman whose humanity is a mystery to me. As I stop to catch my breath and fight the instinct to run away from the misery before me, God looks at me from out of her eyes. "I see you," I say to myself. For a moment, time stands still. I am one with God and comprehend the unity within the universe. Then, in a flash, the recognition fades, I am on to the next task, and again I am a whirling dervish, forgetting what I just knew so deeply and intimately.

What am I seeking? What am I seeing? From what am I fleeing? Since God is not embodied, I can only conjecture about the Holy One. My understanding, which evolves as I age, derives from my imagination and Jewish tradition, and tells me:

> [Our Sages] taught...Just as He is called 'Gracious,' you shall be gracious; Just as He is called 'Merciful,' you shall be merciful; Just as He is called 'Holy,' you shall be holy...A person is obligated to ...resemble Him to the extent of his ability (Maimonides, 1989, p. 26, 28).

Rabbis Abramson and Touger (1989) comment on Maimonides' H*alachah 6*:

> The Rambam set out to describe the mitzvah of following God's ways...he perceives this to mean developing our personalities by emulating the qualities which the Creator reveals...other Talmudic and Midrashic sources interpret the commandment to imitate God in a different light. Note Sotah 14a: [Deuteronomy 13:5 states]: 'You shall walk after God...' [it means] one should follow the qualities of God. Just as...God visited the sick...; you, too, should visit the sick; God comforted the bereaved...; you, too should comfort the bereaved...for the 'resemblance of God' to be complete, it is not sufficient merely to perform positive deeds. Rather a person must undergo internal change by developing his character (p. 26-27).

In my personal life and in my chaplaincy, I attempt to follow the Jewish sources on emulating God's ways. At work, when I encounter and attempt to comfort the disconsolate sick and dying, I also experience intense intimacy with the Holy One (God). The ephemeral experience of the divine amid the anguish and odor of excrement is what makes the work so challenging as well as sacred and immeasurably worthwhile.

The glimpse into *ein sof* (without end), one of God's names, is what motivates me to do this work. It is the call to the Eternal and the desire to re-experience this phenomenon that compels me to hold the limp, cold hands of dying strangers. In those moments when our hands are intertwined, we are at one with God, and I feel our centrality to the universe, recognizing how we are created in the One's image. This knowledge has enabled me to locate the kernel of holiness within the shell of suffering.

> The resemblance of man to God bespeaks the infinite worth of a human being and affirms the inviolability of the human person...the characterization of man as 'in the image of God' furnished the added dimension of his being the symbol of God's presence on earth. While he is not divine, his very existence bears witness to the activity of God in the life of the world. This awareness inevitably entails an awesome responsibility and imposes a code of living that

> conforms with the consciousness of that fact, (Sarna, 1989, p. 12).

Once I identified this reason for my work at The Home - to find holiness within the worst possible circumstances - I confronted a new challenge: to attempt to: *"walk in His ways"* (Deuteronomy 28.9). As Maimonides (1989) wrote:

> The mitzvah [commandment] is 'to imitate God's ways'...'to imitate Him, blessed be He, according to our potential.' The implication...is that man has a constant obligation to carry out all of his deeds and guide the progress of his emotional development with the intent of imitating God (p. 26).

At JHHLCS, I continue to wrestle with what I actually see before my eyes, which is often terrifying and repulsive, and what I experience when I close my eyes – sacred revelation. In addition to my own desire to understand and feel part of God, I also wish to help my congregants at The Home welcome God into their lives, so their last days are filled with serenity through the realization that, *"The spirit returns to God who gave it"* (Ecclesiastes 12:7).

TIKKUN OLAM (REPAIRING THE INJUSTICES OF THE WORLD)

"You shall do what is right and good" (Deuteronomy, 6:18)
"To perfect the world under God's sovereignty" (from the *Aleinu* prayer)

Judaism is based, in part, upon on a precept that we have a sacred mission to be God's partners in the ongoing creation and perfection of the world. This obligation manifests itself in much of Jewish law, especially in regard to moral behavior in business, interpersonal relations, war, and the establishment of a system of social justice.

The Kabbalistic tradition speaks of special vessels that held the lights of creation. However, some of the vessels could not tolerate the light's power and were shattered. Much of the light went back to its source, but the balance broke, and shards of the vessels fell to the earth along with the sparks, which became entrapped in material existence. Ultimately they spread evil throughout the universe as manifest in human behavior (Scholem, 1974). Our job is to pick up those sparks and restore them to the Eternal through moral acts, which ultimately lead to living a life of holiness. Our behavior thereby either impedes or promotes the elimination of evil and healing of the universe, thus advancing or delaying the Messiah's arrival (Matt, 1983).One of the most significant ways in which we repair the world is by caring for others. As a contemporary Jewish philosopher writes, "*Compassion for another stems from such a gentle stirring of the soul" (Borowitz, 1999, p. 69).*

We are directed to be compassionate in various ways. Throughout the Torah we are admonished not to place "stumbling blocks" or obstacles before the blind, orphan and widow – essentially those who are most vulnerable. We are also commanded not to gather grain or produce from the corners of our field for those who cannot feed themselves. Of particular importance within the context of this project is that we are told within the Ten Commandments (Exodus 20:12) to honor our father and mother so that we may live a long life. Finally, the Jewish tradition mandates *hidur p'nai zaikain* (respect the elderly), which was in fact the original basis for the Jewish Home and Hospital. Established in 1855, it was envisioned as a place where destitute elderly Jews could live when they could no longer manage on their own.

Sadly, in contemporary Western society, both Jews and non-Jews have marginalized those who cannot care for themselves. The elderly sick constitute a large portion of this group. *Tikun olam* fulfills many of the precepts of Judaism, including acts of *tzedakah* (righteousness) as well as *gemilut chasadim* (performing acts of loving kindness) which compel us to be partners with God in caring for the aged sick members of our community as well as others who are not able to sustain themselves. Yet respecting the elderly through shelter, nutrition and medical care does not fulfill wholly the concept of *tikun olam.* Another dimension, to which I devote myself, is the non-material sphere: the spiritual and the emotional. I accomplish this through individual contact and personal bonding within a variety of group settings, including several Jewish and general activities as well as religious services.

I recall the first time I led *Yomim Noraim* (Days of Awe: Rosh Hashanah and Yom Kippur) services at JHHLCS as a pivotal moment in my chaplaincy. Having been accustomed to officiating at a large synagogue crowd of several hundred men, women and children dressed in their best clothes, I was dismayed by the small tattered group before me in wheel chairs; the pervasive odor of urine and feces; the lack of responsiveness to the prayers; the sleeping and the steady stream of interruptions. It seemed as if only a few were cognizant of what was taking place. Why was I here? I could barely contain my own anguish during this time that was the holiest of the Jewish year. I wanted to run out of the room and never come back

When I walked around the room with the Torah scroll, many were too feeble to lift their hands to touch the precious object, although I maneuvered it to make it easier for

them. For me it became increasingly heart-wrenching to grasp their hands to help them to touch the velvet cover, particularly since most seemed unaware of my actions. Then as the next woman's turn came, and I mechanically took hold of her flaccid wrist to brush the worn cloth, she looked up at me and smiled. My eyes filled with tears, for she looked just like my mother *z"l"* (of blessed memory).

At that instant, I realized that she easily could have been my mother. This sudden knowledge made me understand why I was there. Everyone in that room, as well as elsewhere in the facility is/was someone's mother, father, son, daughter, sister, brother, or other close relative. They all were human beings created in the divine image who equally deserve respect. Despite my uncontrollable torrent of tears, from that moment on I understood my task, and I led the service as if I had been the rabbi of The Great Synagogue in Jerusalem. In retrospect I recognized that, in my narcissistic self-absorption, I was robbing her, as well as the others there, of their dignity. Surely this was their Rosh Hashanah too, as it was every Jew's throughout the world. My responsibility as a rabbi, and as God's partner in *tikun olam,* was to make this Holy Day meaningful for them. This experience and numerous others equally as profound with which I have been blessed since working at JHHLCS have led me to the following theology of aging.

As we age and gradually (or suddenly) lose important parts of our physical selves and the core of our former identity -- health, beauty, intellectual and physical prowess, ability to accomplish, shrinking possessions, to name but a few -- we are given the opportunity to expand our souls. I like to think of the ever-widening gap between our youthful healthy selves and our older diminished bodies as an invitation from God to fill

the empty space with an expansion of the divine presence in our lives. The larger the chasm, the more room there is for the sacred. God's purposeful design enables us to make room for and get closer to the Holy One, to ease our passage from focusing on doing to concentrating instead on being, from individuals who have based our identities upon productivity and ownership, to souls who are preparing to merge with the One when we die. I learned the invaluable latter concept from Schachter-Shalomi and Miller (1995) and remind my congregants at JHHLCS that even as "be-ers," they can participate in *tikun olam* by being kind to one another and to the staff.

The elderly (and not so elderly) who undergo medical crises and are placed in a rehabilitation facility are overwrought with concerns about their physical well-being. Because of the tenuousness of their health, they often fall into depression and find themselves in a desolate spiritual land, questioning God's existence.

This issue is rarely addressed in any substantive way. Psychiatric support is limited to initial evaluations and medication, deflecting the patients' essential questions: "I've always been a good person. What did I do to deserve this? Why is God punishing me like this? If there is a God, why did He let this happen to me? I used to believe in God, but since this happened to me, I don't believe anymore." Rabbi Harold Kushner (1981) reminds us that "The misfortunes of good people are not only a problem to the people who suffer and to their families. They are a problem to everyone who wants to believe in a just and fair and livable world" (p. 6).

Every stage in the continuum from birth to death must be treated with care if we are to honor the sanctity of each human being. In other words, healing the world requires

us not only to address the ongoing and living, but also to foster the dignity of the transition to the unknown. If we are to create a just world and invite the Messiah to return, then we must take better care of the elderly by validating their fears and affirming their existence -- whether of life, with its concomitant anxiety and anguish, or imminent death.

> *"In the (margin of) R. Meir's Torah scroll, at the verse 'And behold, it was very good' (Genesis 1:31), there was found written: "And behold, death was very good"* (Genesis Rabbah 9:5) p. 243.

TEFILLAH (PRAYER)

> *Refuat ha nefesh oorefuat ha guf (Heal the body and heal the soul)*
> – From the Misheberach, Jewish prayer for those seriously who are ill.

There are instances in life when we are left "speechless." At these times, we are so overcome with emotion that we are immersed in our feelings and cannot find words, or perhaps we are too choked up to bring forth our voice. These occasions may be times of elation or of desolation. Concerning the latter, James Fowler (1987) notes:

> Human experience includes those dangerous and difficult times when the sky does fall and the world does indeed come to an end. The figure of disorientation may be taken psychologically and sociologically. It includes all facets of our common life and experience. The times of disorientation are those when persons are driven to the extremes of emotion, of integrating capacity and of language. In the company of Isaiah, we are undone (Isaiah 6:5). There is no speech, and there is no safe reality about which to speak. The loss of an orderly life is linked to a loss of language, or at least to the discovery of the inadequacy of conventional language (p. 205).

This is a when prayer can come to the rescue, for it provides us with language with which to approach God. We do not need to speak aloud when our deepest desires are directed toward the One. Our feelings are driven, as it were, by sound waves. God does not need the specific articulation, but does need to know the underlying feelings. "The *Zohar* (Exodus 20a, the primary document for Jewish mysticism) heaps lavish praise on the spontaneous prayer that arises directly from the human heart...Rabbi Berachiah said: 'When people pray and weep and cry so intensely that they are unable to find words to express their sorrow, theirs is the perfect prayer, for it is in their heart, and this will never return to them empty' (Landes, in Hoffman, ed., 1998, p 2).

On other occasions, we require concrete language to connect us with reality. That is when we need to see the words before us, for we are blinded by emotion. This is when fixed liturgy works best. Prayer, whether spontaneous – wordless and silent torrents from our heart – or annunciated aloud from a prayer book surrounded by community, is a vehicle to express our deepest feeling to the Other (God), for "A man's prayer is not heard until he places his very life into his uplifted hands...A man's prayer is not heard until he makes his heart [soft] like flesh" (Bialik, 1992, p. 526).

Prayer is one of the most efficacious ways to alter a person's mental state and to stimulate comfort and hope. In 1 Sam.12-20 the despairing Hannah continued to trust in God and devoted herself to prayer long after others would have given up. Her prayers were not scripted, but came from the depths of her heart. Perhaps the spontaneity and the intensity of her prayers healed and strengthened Hannah, enabling her to conceive, or her story may simply be an allegory to illustrate the transformative potential of prayer.

The pertinence of prayer in healing has become a hot topic over the last several years; the subject even made the cover of *Newsweek.* Studies have shown that when someone prays for another in need of healing, the sick have a higher recovery rate. According to O'Conner, et al. (2002):

> Spirituality is receiving considerable attention in the medical literature. Much research has been devoted to exploring spirituality and religion's impact on health. One perspective drawn some of the evidence maintains that spirituality and religion can be a positive determinant of health...Some argue that family physicians ought to pray with and for patients if both...are agreeable (p. 227).

The Jewish *miseberach* (blessing) for health is a prime example of this belief. In a communal setting a blessing is recited as part of the prayer service, and congregants have the opportunity to offer names of people who are in need of a "complete healing." While prayer may not cure the sick, I believe, from several years of observing the seriously ill, that it helps them to cope better with their adversities,

> We have been taught: 'To love the Lord your God and to serve Him with all your heart' (Deut. 11:13.) What service is the service of the heart?' You must say it is prayer." [Babylonian Talmud, *Taanit*, 2A] Both R. Yohannan and R Eleazar said: Even if a sharp sword is actually resting on a man's neck, he should not hold himself back from praying for (God's) mercy." (Babylonia Talmud, *Berachot,* 10a). "R. Hama bar Hanina said: If a man sees that he prays and is not answered, he should pray again. Scripture says, 'Wait through for the Lord, be strong and let thy heart take courage; yea, wait thou for the Lord. [Ps. 27.14] [Babylonia Talmud, *Berachot*, 32b] (Bialik p. 334).

The Jewish tradition, which mandates three structured prayer times a day for men, teaches that prayer is a vehicle for connecting with God. Even if one does not believe, one is directed to pray in order to be fluent in prayer, in the event that one finally does

believe. Traditional Judaism requires a *minyan* (quorum of ten men) to recite specific prayers. Liberal Judaism has dispensed with the male requirement, but usually requires ten people. This stems from a principle that it is imperative for people to pray together, which is particularly important during times of trouble, such as mourning, when an individual is in urgent need of solace. As Carol Ochs (2000) says: "The Torah suggests that we were created to be in community, that only in community do we sense the presence of God, and that only in and through community can we become holy (p. 154).

Landes (1998) refers to Maimonides who contended that "the establishment of a fixed prayer by the Men of the Great Assembly meant an end to giberrish *(shishush)* to which most people are prone ["Laws of Prayer," 1:4] (Hoffman, ed., p 3). Praying is viewed by Maimonides as a group activity that requires a *minyan.*

In his chapter "Prayer" Michael Fishbane (1987) talks about its centrality to Jewish spiritual life, citing early rabbinic sources including the Talmud which refers to prayer as "'More precious than sacrifices' [Babylonian Talmud, *Berachot* 32a; Kuzari, 5:5]. Judaism does not consider prayer to be either a casual or superfluous adjunct, but rather the nurturant wellspring of its entire active life and an inherent component of it" (in Cohen, Mendes-Flohr, ed., p 724). Over time, prayers and the act of praying became fixed and formalized within Jewish daily life, providing little opportunity for individual expression. Landes (Hoffman, ed., 1998) talks about the individual call to God and its institutionalization in Jewish liturgy:

> *Halacha* [Jewish law] thus recognizes, no less than the Zohar, that prayer *begins* in a cry...but it provides a prepared liturgy as an institutionalized vehicle for

> articulating that cry. That is why the main characteristic of the *Amidah* [the central prayer in all Jewish services] is the *bakashah* [petition], which includes and entire array of petitions that invariably touch closely upon personal issues such as health...by confronting the daily *Amidah,* the Jew must confront his and her life and turn that life to God (p. 7).

Halachic (Jewish legal) texts require us to recite the prayer for healing on a daily basis (Babylonia Talmud, *Megillah* 17b and *Avodah Zarah* 8a). The prayer for health in the Amidah, "Heal us and we will be healed" also offers us the opportunity to include the names of others who are ill. The briefest prayer for healing occurs in Numbers 12:13, where Moses pleas with God to cure his sister Miriam from leprosy. "Heal her now, God, please."

Despite the importance of prayer in Jewish tradition, and its power to offer consolation and strength, few Jews at JHHLCS are familiar with it or are comfortable praying. One reason for this is the low affiliation rate of the Jewish population on both resident and rehabilitation units. While approximately 8-10% of the Jewish population attends Shabbat services at the facility, very few had been regular synagogue members prior to admission to JHHLCS. It is not unusual to hear: "I or my mother/father never went to synagogue before coming here." Some, who had been participants in synagogue life earlier in their lives, dropped their memberships due to ill health and/or lack of affordability. Even among most of those who had been synagogue-goers, their attendance was limited to the High Holy Days. It is unusual to encounter one who had been a regular Shabbat attendee, much less a daily *davener* (one familiar with Jewish liturgy).

A second reason is that a vast majority never learned Hebrew. Many believe that as a result of this gap in their knowledge, they do not know how to pray. While most acknowledge praying privately, few are knowledgeable or even aware of the prescribed Jewish liturgy. Some even decline when I offer to pray for/with them in the solitude of their room. Their Christian counterparts, on the other hand, seem much more comfortable with the concept of prayer, the act of praying and being prayed for – even by clergy of other faiths.

Recently a patient recounted the events that led her to JHHLCS. One day, her leg began tingling. Alice fell to the floor unable to get up for several hours and prayed the entire time. Eventually she was able to get up and to call 911. She believed that God had answered her prayers, enabling her to take those actions. She wound up in the hospital and was diagnosed with a stroke that left her paralyzed on one side. Upon admission to the hospital, and later The Home for rehabilitation, she felt God's presence even more vividly.

Alice believed that her prayers were answered and that her faith reinforced her efforts to heal. She shared this story with others around her in a matter-of-fact way, often referring to Jesus, and her conviction that he wanted her to get better. This belief emboldened her to work as hard as she could at physical therapy.

Her testimony to others in the group was more meaningful and relevant than any teaching I could have offered. She was not the preacher trying to invoke belief in his/her flock, but rather one stroke victim among others, whose suffering was eased as a result of her prayers and faith. Jesus did not make her stroke disappear and undo her paralysis, nor

did she necessarily expect that to happen. But praying gave her strength to face her debilitation and hope to recover from it. Prayer, following the expression of sorrow, helps to mitigate pain, and it brings us closer to the One as we extemporize from the depths of our souls.

Complementing the Jewish tradition related to prayer are attitudes about science and death. Borowitz (2002) cogently identifies a paradox in Jewish thinking regarding the extraordinary esteem for physicians, their power and knowledge, in contrast to our faith in God as a healer. He points out that "The classical Jewish theology of medicine is dialectical. God sends illness...yet God also commands doctors, and by extension all of us, to cure those ailments...there is not just one but two effective sources of energy in the universe, God and people" (p. 343).

In describing this dichotomy, Borowitz (2002) reveals the deep-seated ambivalence many Jews have towards praying to God for health. Their faith is more reliant upon the medical staff, especially the doctors, who heal them. Countless jokes about the proud Jewish mother whose son is a doctor attest to the primacy of medicine over religion in contemporary Jewish culture. For a majority of Jews, medicine has supplanted religion, and death is an illness to be warded off for as long as possible, so long as one is able to obtain the proper treatment. Although Jewish sources view death as part of a natural process that occurs to all living beings, nevertheless, many Jews view sickness and its concomitant suffering as undeserved punishment for sin they did not commit. A common refrain is "Why is God punishing me like this? I haven't done anything to deserve it."

Few Jews in the groups at JHHLCS believe in an after-life, in stark contrast to the Christian population. Thus, it is very difficult for Jewish residents and patients to acknowledge their declining health and accept this circumstance as part of the natural flow. There is an expressed proclivity towards getting better, rather than accepting the reality of the inevitable infirmities of aging and ultimately death.

Borowitz (2002) contends that contemporary Jewish thought is changing towards a greater appreciation for the ways in which the soul influences the body, and we can begin to rely upon our own inner divine resources to cope with our limitations and suffering. He points to the plethora of new Jewish institutions -- the network of Spirituality Centers, Jewish Healing Programs and Services, Clinical Pastoral Education, as well as a plethora of publications on health, spirituality and contemporary prayers that have sprung up recently to mobilize the Jewish community towards spiritual healing. But this recent phenomenon has missed the population of Jews at the JHHLCS. With few exceptions, they are as unaccustomed to the word "spiritual" and to the concept of participating in a support group as they are to a woman rabbi. Yet they are open to and accepting of new possibilities. I have received praise even from *Chasidim* (ultra-Orthodox Jews) who have attended my Shabbat services. "You are the first woman rabbi I have ever met. Thank you for such a beautiful service."

As the chaplain I can create an atmosphere in which individuals feel free to pray – in whatever way they can - and encourage them to share some of the responsibility for spiritual sustenance and nurturance for one another. This call to fellowship is relevant to

Jews and non-Jews alike, as these elders take some responsibility for themselves, especially because there are so few areas in which they have control over their lives.

Finally, it is amazing to observe the faces of these sick elderly people as they take turns reading and discussing the prayers I distribute, and creating their own prayers. Ordinary words arranged in a format that we label prayer, that articulate patients' hopes and fears, have an incredibly powerful affect upon them. Fishbane (in Cohen, Mendes-Flohr, ed.,1987) elucidates this phenomenon: "The words of prayer, human language... as God-directed speech...in all their new combinations and figurations symbolize the capacities of language to bind and unbind life and achieve unity at different levels" (p.728).

In response to a particular prayer or reading, some residents or patients exclaim, "That's exactly how I feel!" Rarely does a patient decline the offer of a prayer on his/her behalf or the opportunity to participate in reading (unless he/she does not have glasses at hand) or to discuss a prayer - even if it is simply to dispute the sentiment! These prayers are "voiced or voiceless longing of the heart, the cry for God's presence" (Fishbane in Cohen, Mendes-Flohr, ed., 1987, p. 724). Petitioning by individuals on behalf of themselves and the others in the group expresses not only connection to God, but also love of neighbor. Here the "I" becomes a "we," as concern for self is transformed into compassion and empathy for others in this community.

Fishbane (in Cohen Mendes-Flohr, ed. 1987) adds "Of course, even the petitioner for concrete benefits wants God and acknowledges him; but as the human self's desire is transcended through a shifting of religious consciousness from a self-centered focus on

needs to an awareness of being the recipient of divine existence,...there dawns the realization that God is always present" (p. 726). He goes on to describe how the "I" transcends individual needs to become a "social self whose needs must be related to others (p. 727).

*When you pray, know before who you stand (*Babylonia Talmud, *Berachot*, 31a*).*

KEHILLAH (COMMUNITY)

"Do not set yourself apart from the community" (Pirkei Avot 2:14).

Everett E. Gendler (1987) refers to the Biblical term *kehillah* (community) when discussing a group of individuals who are gathered for a specific purpose. When we recruit a variety of disparate individuals to come together for "discussions with the Rabbi," as the TR Leader often describes our group, they appear to have little in common except for one characteristic: their need for physical rehabilitation. At the beginning of the session, by announcing our goals and encouraging patients to talk to one another, we lay a foundation to include all of those present, fostering "the development of a community whose basis of unity transcends the biological" (Gendler in Cohen, Mendes-Flohr, ed.,1987 p. 82).

Our intention in creating this short-lived community parallels that stated by Gendler (in Cohen, Mendes-Flohr, ed., 1987): "Theologically, human community may be characterized as the divinely initiated counterpoise to solitude" (p. 82). Thus, by the end of an hour, the mixed multitude we bring together becomes a *kehal,* (a group) that, in

sharing their experiences and vulnerabilities, and in praying together, has strengthened all the individuals within it.

The patients on a unit form a temporary community, although the vast majority live in isolation during their stay. This may not be conducive to their wellbeing, for "It is not good for a human being to live alone" (Genesis, 2:18). By offering them a way to commiserate with one another, so they can feel a bond, we attempt to minimize their sense of separateness. This newly-formed *kehillah* then, provides a means for them to rely upon one another in ways that differ from relying only upon the religious authority figure of the chaplain.

In Numbers 11:14 Moses says to God, "I am not able to bear all these people alone, because it is too much for me." God responds to him: "Gather seventy men of the elders of Israel, who you know to be the elders of the people and officer over them and bring them with you." From these verses, the concept of relying upon a group for support takes its shape. Similarly another principle of Judaism, "All of Israel is responsible one for the other," teaches us that every community member is required to care for someone in need. The chaplain alone cannot single-handedly take the responsibility for every soul in the community.

GEMILUT CHASIDIM (ACTS OF LOVING-KINDNESS)

"The world is built on three things: the Torah, serving God, and acts of loving-kindness (Pirkei Avot, 1:2).

"He has told you, man, what is good and what Adonai requires of you: to act justly and to love chesed and to walk modestly with your God" (Micah 6:8).

My earliest memories of my parents include acts of kindness they performed for other people, including strangers. Although we were quite poor (five of us lived on the third floor of a walk-up tenement in a four-room apartment), my father was always "slipping a couple of extra bucks" into his workers' pay envelopes, and my mother was forever bringing groceries and used clothing to families who had less than we. In addition, on one of the shelves of our tiny kitchen stood several *pushkes* (small cans used to collect coins for charity), which my mother filled regularly with change. I can recall my mother making out $3.00 checks for every organization that solicited her. Thus, as a result of observation and modeling, rather than explicit Torah learning, I grew up with a very strong sense of helping others, and my professional life evolved to one that is based upon acts of kindness for others.

"Rabbi Simlai taught: The beginning of the Torah is *gemilut hasadim* and its end is *gemilut hasadim.* Its beginning is *gemilut hasadim* - as it is written, 'And the Lord made for Adam and his wife garments of skin, and clothed them' [Genesis 3:21]. And its end is *gemilut hasadim* – as it is written, 'And He buried [Moses] in the valley' [Deuteronomy 34:6]" (Babylonian Talmud, *Sotah* 14a).

Within the context of our spiritual support groups, not only do the TR Leader and I make contact with each patient present, but also the very nature of the group galvanizes the patients to perform acts of loving-kindness for one another, both at the session itself and at other times. This behavior enables them to retain a sense of their own humanity in addition to meaningfulness in their own lives. Warren Zev Harvey's (in Cohen, Mendes-Flohr, 1987) statement sheds light on the side benefits these acts create for the patients.

"This moral *imitatio Dei* is an ethics based on compassion, but also one based on strength...As the omnipotent Creator sustains his creation in grace and loving-kindness, so we – with our mortal strength - are to emulate him and do acts of ...loving-kindness for those who may be disadvantaged, such as ...the sick (p. 300).

Bikur holim, visiting the sick, is among the most valued acts of loving-kindness, along with clothing the naked, comforting mourners and burying the dead. Its value is difficult to overestimate:

A master said that the Torah's phrase about a man injured in a fight, 'He must walk' [Exodus 21:19] is, by implication, the source of the commandment that we must visit him until he is up and about. As that master also taught, the *bikur holim* of a person the same age as the sick one takes one-sixtieth of the stricken one's illness away with him when he leaves (Babylonian Talmud, *Bava Metzia*, 30b).

The group setting allows the chaplain to fulfill the *mitzvah*(commandment) of *bikur holim* (visiting the sick) while simultaneously providing the same opportunity for all participants to perform it as well. Through their sharing and discussion during the sessions, the residents and patients are able to visit one another while alleviating at least a modicum of the others pain.

We learn from Rabbi Chama bar Chanina (*Sotah* 14a) that in Genesis 1:18, God appeared to Abraham to visit him while he was recovering from his circumcision. At that moment, three men came to Abraham's tent and he jumped up to greet them and to offer them hospitality. Abraham here is modeling his behavior after God's. Just as God

performed an act of *hesed* (kindness) towards Abraham by visiting him when he was sick, so Abraham performed an act of *hesed* through his hospitality to the three strangers. Abraham's action is one that has been used as an example for hospitality in Jewish life.

Furthermore, Warren Zev Harvey (in Cohen, Mendes-Flohr, 1987) refers to Maimonides (Guide to the Perplexed 1, 54; 3, 54) and Baruch Spinoza (Ethics, IV, 37) "true religion expresses itself in the acts of loving-kindness that result directly from man's highest knowledge of God" (p. 301). There is no doubt in my mind that the closer I have gotten to God, the more I have wanted to bring the One's presence into the world through caring for others. "By acts of *hesed* toward others, we give him [God] cause to rejoice, thereby helping him to 'ride upon the heavens.' In other words, we do an act of *hesed* for God" (Harvey in Cohen, Mendes-Flohr, ed.,1987) p. 301.

> Rabban Johannan ben Zakkai said to Rabbi Joshua as they looked at the Temple in ruins: "Alas for us! The place which atoned fore the sins of the people Israel...lies in ruins...Be not grieved, my son. There is another way of gaining atonement even though the Temple is destroyed. We must now gain atonement through deeds of loving-kindness. For it is written, 'Loving-kindness I desire, not sacrifice'" [Hosea 6:6] [*Avot D'Rabbi Natan* 11A] (Harlow, 1985, p. 15).

CLINICAL PRINCIPLES

When I learned about the project I would be required to undertake for the Doctor of Ministry, the idea for a spiritual support group took seed. I believed that, within the context of such a group, I could utilize both my rabbinic spiritual skills and my newly gained knowledge of psychodynamic theory to help the constituents at JHHLCS.

Much of the structure and facilitation of the early groups were based upon instinct. Thus, I was pleased to read about theories, practices and techniques that I had innately incorporated into the group at its foundation. I was also inspired by what I learned from my classes and the literature, for my new understanding has not only enhanced the group process (especially those sessions under scrutiny for this project), but has also helped me to become a better group facilitator and chaplain. Needless to say, the act of learning and integrating knowledge is never-ending.

My original idea for the group arose after reading Erik Erikson (1980). His concept of identity consolidation and his understanding of the various stages of psychological development, even into old age, provide a structural model for the needs of this population, who, despite their "wisdom" grapple with "integrity versus despair."

As we age, we realize that our time to wrangle with life is limited, and our efforts become counterproductive. Borowitz (2002) points to Elizabeth Kubler-Ross's studies of the dying, in which she discovered that those who let go seem to attain a natural, unique peace. His (and my) question is: Can't we achieve this earlier? Within group sessions, I strive to encourage the participants to be aware of, if not to aim toward this kind of transcendence.

For me, the group therapeutic process was grounded in Freud from whom I learned about the value of offering individuals the opportunity to express their deepest feelings. While this particular project does not delve into psychoanalysis, nor claim to help with issues outside the rehabilitation setting, it does encourage patients to share their fears, anxieties and complaints, albeit in a group setting. This opportunity to freely

express one's emotional state, and to receive support from others in an environment where that is generally not encouraged, but rather in one that promotes denial, provides catharsis and validation for these struggling patients. Major concepts for this project were derived from Yalom, (1995) the classic group therapy expert. In his book *The Theory and Practice of Group Psychotherapy*, he devotes Chapter 15 to "The Acute Inpatient Therapy Group." While his premises in this chapter are based on inpatient psychiatric groups, there are many similarities to the patient support groups I facilitate on the rehabilitation units, most notably:

- The group setting does not guard privacy (JHHLCS sessions are held in a public space).
- Rapid patient turnover – some group members attend only once and are discharged, cannot return due to schedule conflicts or sickness, or do not want to return.
- The patients are heterogeneous (They suffer from various illnesses and are culturally, educationally and/or economically diverse).
- The facilitator's time involvement is minimal (In my case, group session is usually the only meeting time with the patient).

Due to the limitations of the circumstances, Yalom (1995) proposes six achievable goals which I will incorporate into the sessions as follows.

1. Engaging the patient in the therapeutic process
2. Demonstrating that talking helps
3. Problem solving
4. Decreasing isolation

5. Being helpful to others
6. Alleviating hospital-related anxiety (p. 459).

The first aim is for patients to engage in the therapeutic group process itself, which, one hopes, they will perceive as useful, so that they will continue to join the weekly sessions during the duration of their stay at JHHLCS. Ideally, participation in the group will enable patients to learn that talking about their problems helps. As Yalom (1995) expresses it:

> They learn that there is relief to be gained in sharing pain and in being heard, understood, and accepted by others. From listening to others, patients also learn that others suffer from the same type of disabling distress as they do – one is not unique in one's suffering...The group introduces patients to the therapeutic factors of cohesiveness and universality (p. 460).

The sessions also help them to reduce the isolation so many experience. As Yalom points out: "It helps individuals share with one another and permits them to obtain feedback...as communication improves, patients are able to make good use of their relationships with other relationships...If patients are helped by other patients, then they are also helped by the knowledge that they have been useful to others" (Yalom, 1995, p. 461-462). Increased interaction with other patients and staff offers them the potential for greater connection. This can strengthen their inner reserves which will help them endure the challenges of rehabilitation.

Furthermore, the group setting provides for peer validation, while it permits participants themselves to take ownership for the process, thus reducing the leader's responsibility. As the session progresses, group members, rather than direct all the

conversation towards the facilitators, begin to make eye contact and engage one another in discussion.

At the same time, the structure of the group, which invites the sharing of stories of struggle, reminds the patients that they are not their illness. Instead, the essence of who they were up until they got sick is elicited, so that they can reconnect to their essential identity – the individuals they were before the onset of crisis. Their unique thoughts and life experiences are as relevant now as they had been in the past. Awareness of this factor enables them to identify and reconnect with their strengths. Sometimes in order to foster and enhance their sense of self, I ask them to share a few words with the group that describe the way they see themselves and thus encourage them to compartmentalize their illness and not to allow it define them.

Similar to Yalom's psychiatric patients, my rehabilitation group members are distressed simply at being in a nursing home environment. Those who are lucid, in particular, are mortified by being surrounded by the demented, the shouts for help that are heard in the hallways from time to time and the amputees. They are also frightened by the prospects of what might happen to them. In addition, patients' new dependency on medical staff, who does not necessarily respond quickly or sensitively, can cause frustration, anger and feelings of helplessness. When these topics are raised, the group members eagerly share their battle stories and feelings.

Although we attempt to provide consistency within the hour session, this is not always possible due to patients coming and going for therapy or visitors who suddenly appear. Still, there is a sequential protocol, described in detail in Chapter 3 that utilizes

Yalom's (1995) concepts as follows: in essence, at each session there is an orientation, during which the goals are described, the staff and the patients are introduced, discussion occurs and patients connect to one another and to staff (p. 471, 474). Yalom (1995) talks about the plethora of different types of groups in which adults in the Unites States participate – about three million in all. He emphasizes that the most important reason members attend these groups is a quest for interpersonal interactions, and that most join because of feelings of "anxiety, depression, guilt, personal crisis, personal problems, and preoccupation with figuring out what's important in life" (p. 482). He then goes on to describe the self –help group, which has many of the characteristics of the spiritual support groups, including therapeutic factors such as: altruism, cohesiveness, universality...instillation of hope and catharsis" (p. 484).

Finally Self-psychology theory feeds into this group structure very nicely; for I aspire to help the patients view themselves as a cohesive whole, eliminating not the illness, but its stigma in their lives. As Berzoff says, "The emphasis is on the person's *subjective* sense of cohesion and well-being rather than on the supposedly *objective* functioning of various aspects or parts of the self" (Berzoff, 1996, p. 173-4).

Since one goal of the group is to allow people to feel free to express their frustrations and sorrows, there is a focus on empathetic listening. Self-psychology believes that "the self can best come to be understood through empathy rather than through insight" (Berzoff, 1996, p. 174). A basic tenet of self-psychology is to "Focus on individual self-definition, fulfillment, and well-being" (Berzoff, 1996, p. 175). This concept underlies the idea behind the type of transient group whose purpose is to promote

spiritual healing: "Self-psychology is considered to be one of the most useful clinical theories precisely because it is very open and positive in its view of human nature and focus on the individual...the self is viewed as having a tremendous desire and capacity to grow if its needs are met.... there is an innate, motivating 'push' towards health" (Berzoff, 1996, p. 175).

When facilitating a group, I set a tone of affirmation, both through my own behavior and my instructions to group members. This attitude coincides with Kohut's view of the role of empathy, which he "elevated it [empathy] to a position of supreme importance and considered it to be the primary clinical tool" (Berzoff, 1996, p. 179).

I also apply Kohut's theory of empathy as described by Berzoff, "The projection of one's own personality into the personality of another in order to understand him better...to *understand* from within the experience of another, no matter what the experience." To clarify Kohut, Berzoff adds, "Much more than a feeling, empathy is a way of *knowing*" (Berzoff, 1996, p. 179). When we listen to one another's stories and pray and sing together, we are constantly inserting ourselves into others' lives.

In our groups, we aim to provide empathy, validation, support and hope.

CHAPTER III. METHODOLOGY

BACKGROUND

The idea for the spiritual support groups grew out of a perceived need to proffer emotional and spiritual nurturance to the patients at JHHLCS. Upon initiating them in Spring 2004, I developed the spiritual sessions out of instinct and trial and error. In selecting this experiment to be the subject of this Demonstration Project, I was presented with the opportunity to focus in a deliberate way on the group's essence, with the hope that the results would both lead to refinements in my own practices, and also that they might prove helpful to others desiring to start spiritual support groups. Accordingly the objectives of this study were to:

- Assess participant reactions to the groups
- Identify the core elements of group's structure and format
- Codify a set of activities to use in group sessions.

My modes of investigation included clarifying the key structural elements of these groups, examining basic theories of group dynamics to refine my practices and undertaking an evaluation of these sessions by systematically obtaining feedback from the participants. In this chapter I will:

- Elaborate on that methodology;
- Describe the evaluation tool;
- Summarize key steps in the format of conducting a group, with an emphasis on flexibility to respond to unexpected circumstances;

- Outline guidelines to inform group leaders on how to deal with special situations.

Yalom (1995) describes three steps for establishing a modified therapy group including:

- Assessing the participants
- Formulating suitable clinical goals
- Recreating traditional techniques appropriate to the first two.

ASSESSMENT

I anticipate that the evaluation tool we will use, along with the TR Leader's and my observations, will enable me to measure the effectiveness of the group process for the participants, as well as provide me with insights into ways to modify the format. I hope that the pre- and post-group questionnaire will validate my predictions that spiritual support groups play a crucial role in:

- Altering the mood of the participants.
- Fostering a sense of community among those patients who are lucid.
- Helping patients manage evident change in their health status.

Following the written evaluations, the TR Leader, the rabbinic intern and I will speak with the patients as we escort them back to their room, asking them whether:

- The group improved their mood. If it did, what, specifically, helped? If it did not, why not?

- They would like to join in the next meeting. If not, why not?
- They would recommend it to other patients? If not, why not?
- The group helped them establish bonds with the other patients?

The oral responses to these questions, my [and other staff's] observations and the written assessment tool, will help us to assess the groups' effectiveness and what modifications we should make.

SCOPE OF GROUP

I believe that I have established goals that are "*appropriate to the clinical situation and achievable in the available time frame*" (Yalom, 1995, p. 452) by limiting the group's scope to dealing with everyday problems encountered at JHHLCS. "In time limited, specialized groups, the goals must be limited, achievable and tailored to the capacity and potential of the group members," Yalom writes. (1995, p. 452). I also share his emphasis that the facilitator should structure the group so as to offer patient as much hope as possible, since they often enter with feelings of despondence.

GOALS

As Yalom (1995) suggests, I will describe the goals to those assembled at the beginning of the session. I will remind patients that their participation directly affects their own and the others' spiritual healing – that they can help one another to cope better with the circumstances and to offer moral support.

To further encourage group members to build relationships among themselves, we will urge them to remain together in the room after the session to continue talking with one another. This is congruent with Yalom's (1995) concept of addressing group members' isolation and sense of futility by utilizing the therapeutic tool of altruism to create a "buddy system."

Some details of what I will undertake and hope to accomplish:

1) I will hold, evaluate and write up four hour-long spiritual support groups that will be attended by the rehabilitation patient population.

2) At the beginning of each session, I will ask each participant for permission to include him/her in the project.

3) I will evaluate each member's mood with a questionnaire, and by observing him/her, prior to the session.

4) I will conclude the group with the same questionnaire and casual conversation.

My goals are for participants to:

- Become acquainted with other people on the rehabilitation unit in order to socialize more with each other;

- Develop a sense of community in order to reduce isolation;

- Talk about issues with which they are struggling during their stay at JHHLCS, and
- Pray and to sing in order to be involved in an uplifting spiritual and emotional activity.

STRUCTURE

In a group like this, new members will always be joining, and at least one person will be terminating (without necessarily being aware that it will be his/her last session) at almost every meeting. In addition, for a host of reasons, several will attend for only one session. Thus, even though there will always be repeaters, the TR Leader and I will consider and treat each session as a discrete group. Since we are also aware of the sense of confusion and crisis with which so many are grappling, as well as the potential for patients to attend only a single group, we will "strive to offer something useful for as many patients as possible during that session" (Yalom, 1995, p. 463).

Support, empathy, acknowledgement and encouragement will be the basic emotional stance I will adopt. I will applaud the patients' most minor efforts and accomplishments - from being able to utter their names distinctly (after being speechless) to progressing from a wheelchair to a walker. Those who come late will be welcomed, and those who leave early will be given a hearty farewell, with the expressed hope that that they return. The ones who leave to go home will be given a special send off with a blessing. The dementia patients will be listened to with the same attentiveness as everyone else.

As The Home is a great equalizer, our group will be too. Here, all participants will be given the same consideration. Regardless of each one's achievements or stature in the outside world, around our table, each patient's professional, socio-economic or other status will be treated as insignificant, and each will have the identical right to express him/herself.

Some individuals within the group will have great difficulty in interacting with others, and a number will be demented. When several of these patients will participate simultaneously, we will try to find methods of communication that will be meaningful to them while maintaining a balance for the lucid ones.

Each group may also well have mentally ill participants. With the support of the TR Leader and the others in the group, I will attempt to deflect inappropriate behavior so as to keep the group focused and engaged. I will rely upon modalities that will utilize members' most basic memories and functioning. We will sing songs that are likely to be familiar (see Appendix) and I will ask simple questions, e.g., "What is your favorite color and why?"

Our attempts at empathically engaging each client will permit us to go beyond his/her flawed cognition. These methods will allow us to tap into primary processes of mental operations that are more primitive. For example, we will urge them to clap when we are singing a song.

FORMAT

What follows is an outline of the group format. At times, I may deviate from it, depending on circumstances.

1) At the beginning of each session, I will introduce myself and will briefly describe the goals for the hour.

2) Other staff/volunteers will introduce themselves.

3) I will invite each patient to introduce him/herself and to describe what brought him/her to rehab.

4) Each person will utilize a microphone.

5) Those who do not wish to speak will be allowed to do so.

6) From the participants' self-introductions, I will select one to two themes to develop further into a group discussion.

7) At the appropriate time, I will introduce a prayer that reflects these themes.

8) I will elicit the patients' reactions to the prayers and to any related issues.

9) At the appropriate time, I will introduce a song that also picks up on the themes.

10) The *misheberach* (blessing for health) will be sung in Hebrew and English.

11) Other activities may include teaching a *niggun* (wordless melody), additional songs, and/or asking members to share a word/phrase that describes their innermost being.

12) The group will conclude with one of the following:

- Each person will describe a blessing in his/her life.
- I will initiate a prayer which each participant will continue with his/her own words. [Is "continuous prayer" the right phrase for this?]
- I will stand in front of each person and offer a private blessing.

CHAPTER IV. RESULTS

INTRODUCTION

Each group followed the same basic format as is described here. They met at 3 p.m. in the dining area/all purpose room of Friedman 3, one of two rehabilitation units. Everyone sat around several dining tables that were pushed together. Each session was staffed by the TR Leader, the rabbinic intern and me. A student social worker observed a couple of the sessions but did not speak. Staff, other patients and visitors sat at tables scattered around the periphery of the room. An adjacent open area was used for physical therapy.

Staff and visitors often walked in and out of the space, sometimes to pick up a patient for an appointment, at other times to look for a patient or for another purpose. Those staff who used the space to complete their paper work or to take a break openly expressed approval of our proceedings by intermittently smiling, laughing, applauding and joining in the singing.

Prior to the session's beginning, the TR Leader and I went to rooms to invite people to join us. Sometimes, a few patients, usually those who could manage on their own, were already seated at the table when I arrived on the floor. We turned off the ubiquitous television set when we began. The rabbinic intern and I distributed the assessment tool and completed it with each participant.

Each week, following the completion of the assessment tool, I adhered to the format as described. I introduced myself, and then asked the TR Leader and the rabbinic

intern to introduce themselves. The TR Leader or I emphasized the community-building aspect of the group and our hope for participants to befriend one another. I spoke about the importance of prayer and invited even those who did not profess belief to try to let go of traditional concepts of God and to think of other ideas such as hope or source of energy. I also instructed participants about the pluralistic religious nature of the group, indicating that I was not there to proselytize. I then invited them to share their name, why they required rehabilitation and something about their lives that would help us to get to know them better. A portable microphone was used by the staff and handed to or held for each of the patients as he/she spoke. Following the group we assessed each participant's response to the group session.

APPENDX contains a compilation of the materials used for each group.

THE GROUPS

GROUP 1: February 2

PARTICIPANTS

A total of nine patients attended this group: Barbara, a veteran to JHLLCS and to earlier groups; Clara, Stuart and Carol, who had also been at previous sessions. Abraham, Eunice, Mary, Anna and Gloria were first-timers.

Barbara, an 82 year-old white Presbyterian, whose husband and son are deceased, had had two previous admissions to JHHLCS within the previous year and a half. During each admission (lasting approximately six to 12 weeks), she attended almost

every group session and had been active in all the therapeutic recreation activities. Unfortunately, she appeared to be deteriorating mentally as well as physically this time as a result of repeated falls, having broken a different part of her body each time. She was less animated and conversational than in the past and seemed a little confused with some memory lapses.

Barbara referred to herself as a "fighter," contending that she had had no difficulty at all in accomplishing physical activities appropriate to her condition. Regarding the evaluation tool, when I asked her about social support, she answered that she had not asked for any support (NA). Her responses were: daily activity (1); social activities (4); feelings (1). She felt very supported by her children and grandchildren, referring to them as the jewels in her life. She indicated no change in her feelings at the conclusion of the group.

Clara, an 86-year-old Jewish widow, had been hospitalized for double pneumonia and then transferred to JHHLCS for rehabilitation. Having been extremely weak upon admission to JHHLCS, she had regained a substantial amount of strength while learning to walk again. She was aware of making progress and was grateful for that. She had attended our group the previous week and had seemed to enjoy it. Her daughter, Cynthia, was present for this group and participated in it, although she did not complete an evaluation form. Clara reported that she was very supported by her children and grandchildren.

Clara, who was gregarious and mentally competent, contributed actively to the discussion and was well-liked by the other patients. She gave a rating of (3) for social

support; (3) for daily activities; (3) for feelings and (2) for social activities. For the final assessment she pointed to (1), saying she felt "much better."

Stuart, who is divorced with two grown daughters, has jet-black hair and was the youngest of the patients at 59. Stuart had suffered a stroke which left him paralyzed on the right side and aphasic. Yet his face was very expressive, and he was eager to communicate despite his limited ability to speak.

This was the second time he participated in the group. Unfortunately, he was not present for the entire hour, having been taken to therapy ten minutes after we began and then brought back for the last 15 minutes. While he was present, however, his animated expression and alertness indicated engagement with the process and the others patients.

His scores on the evaluation were: social support (4); daily activities (2); feelings (3); and social activities (4). When we concluded the group, he pointed to the smiley face (1), and managed to communicate that he was feeling up beat and better.

Carol, an 84 year old African-American woman who was a very devout Baptist, had suffered a heart attack. Following her hospitalization, she was admitted to JHHLCS. Although this was her second time to join us, as with last week's group, she refrained from talking, indicating that she just wanted to observe.

Carol appeared to be confused. She also refused to complete the evaluation form. Despite her reluctance to engage in discussion, her non-verbal involvement was apparent by her facial expression and her singing. Carol was discharged prior to the next session.

Abraham, 91, a newcomer to the group, was admitted to JHHLCS following hospitalization for falls and severe anemia. He had lost two wives and was involved with a "lady friend," who was 25 years his junior. He was mildly demented and seemed to be on the verge of tears when he spoke, yet he articulated exceptionally positive feelings. When asked what he was grateful for, he replied emphatically, "that I am alive."

He rated social support (4); daily activities (3); feelings (2); and social activities (2). At the group's conclusion, he pointed to the smiley face (1) and said he was feeling much happier.

Mary, an emaciated 92 year-old African-American woman, joined the group for the first time. She recently had had an amputation above the knee due to complications from diabetes. Mary was heavily medicated, and thus was relatively inactive in the group. Slumped over in her wheel chair, she said little except when asked to describe something for which she was grateful. Then, she avowed belief in and thanks to Jesus

Her score on the evaluation was: social support (4); daily activities (3); feelings (3); and social activities (3). She also pointed to the smiley face when we concluded, saying she felt much better.

Eunice, another African-American and first-timer to the group, came for rehabilitation because she was falling frequently, and her daughter wanted her evaluated. She was the monologist of the week, sharing her story of childhood in the South, including how her parents encouraged her "to stand up on my own two feet." She had overcome many obstacles to get a license in cosmetology and to open her own beauty

shop. Still working at age 87 when she was admitted to rehab, Eunice was grateful for the values of discipline and self-reliance that her parents taught her

Her assessment of the evaluation was social support (3); daily activities (3); feelings (4); social activities (4). She also pointed to the smiley face when we ended, and reported feeling "uplifted."

Two others, Anna and Gloria, entered the group midway and did not complete the pre-evaluation instrument

Anna, a 75-year-old Jewish woman who came for rehabilitation following a hip replacement, stayed only about two weeks at JHHLCS. Although we had already concluded the introductions, and she had missed the opportunity to learn about the others, she was willing to introduce herself She was mentally competent and pleasant and offered to read a meditation aloud later in the session. At the conclusion of the session, she declared that she had felt uplifted.

Gloria is a very large African-American who suffered a stroke and was partially paralyzed. However, despite Gloria's late arrival, she participated with intensity. Her response to "Describe something in your life for which you are grateful," was effusive and tearful: "My daughter. She came to take care of me when I was sick, and she brought my sister into her home to take care of her. I wanted to stop living, but because of my daughter I want to live again." Her daughter was also in the room. In contrast to Clara's daughter, Cynthia, described earlier, Gloria's daughter did not participate, but sat alone off to the side.

The implication seemed to be that she and her daughter had not always been close. Apparently, her daughter's recent embracing of Gloria had made a dramatic difference in her life. Gloria was also very grateful to the group for including her, and offered God's blessing for all present. Unfortunately, she did not complete any of the evaluation tools, and was too sick to join us the following weeks.

DISCUSSION

Through the introductions we learned that the groups' ailments ranged from stroke to pneumonia to broken hip. Four patients had to learn how to walk again. This led to a discussion about relearning basic body movements and all that it entailed, including humiliation, frustration and dependence upon others. That in turn led me to ask how people coped with this type of situation. Answers included: "prayer;" "just knowing you have to keep trying;" "using my inner strength;" "because my parents told me you have to stick to it;" and "I am a survivor."

Next we read "Sorrow Can Enlarge the Domain of Our Life." I asked if anyone had had a painful experience in his/her life from which he/she had grown. One person talked about the death of her son, which made her appreciate the remaining children and grandchildren even more. Another talked about the death of her husband, and how she had made a life for herself without him. A third talked about her parents' death, and how she owed everything in her life to them. One said that after burying two wives, he wanted to "live, live, live."

We discussed the issue of pain and loss that accompany the death of a loved one, but also how, after the grieving and mourning period, we value what remains in our lives. One patient remarked that everyone present had experienced death, but we were still there to talk about it.

We then sang "This Little Light of Mine," and talked about what the light symbolized. The responses ranged from "hope" to "love" to "feel better." The next song was "He's Got the Whole World in His Hands." Almost everyone joined in the singing, even Stuart, who, unable to speak, tapped the hand that was not paralyzed in time to the music.

Before concluding, I talked about what kept us going. What elements in our life enabled us to keep struggling despite the obstacles? Most attributed their struggle to get better to their families, referring to children, grandchildren and parents. Only one said "just being alive". I ended by singing *"misheberach"* (the Jewish blessing for health).

REFLECTION

This group was particularly strong-willed and optimistic, as well as less overtly religious compared to earlier ones that met before the study. While many participants in previous groups invoked reliance upon prayer and faith as sources of strength, that was not the case here, where only two acknowledged that religion was a source of strength for them.

In addition most patients in this session were much more highly interactive and verbal. Possibly, this was because it was at least the second session for a few of the

participants; it also may reflect the advantage of repeated sessions as opposed to individual ones. Furthermore, these patients had been seeing each other daily at meal time and/or in the hallways. The additional contact outside the group may have fostered a sense of familiarity, creating a higher comfort level at sessions, which led to the increased interaction as well as sense of community.

When we talked about family, Eunice focused on her parents rather than her spouse or children. This type of reference to parents as family is not uncommon for individuals afflicted with dementia. Many revert back to their family of origin, forgetting about the spouse they married and the children they raised.

When we discussed the issue of pain and loss surround a family member's death, one patient remarked that everyone present had experienced death, but that they were still there to talk about it. Significantly, she had recognized and expressed a common experience that was applicable to their current struggle to survive their own illness.

Eight out of the nine participants attributed their desire to get better to their families, referring to children, grandchildren and parents. Only one said she was focusing on "just being alive." Was the motivation to endure the rehabilitation solely a result of others, or were they unaware of their own will to survive?

This session seemed to be highly successful, given that almost all the participants' engaging enthusiastically discussion and the apparent enthusiasm.

GROUP 2: February 9

PARTICIPANTS

Six people were present when we began: Barbara, Clara, Stuart and Mary, who were in last week's group. Two new members were a husband and wife, Albert and Bess – he was a patient, and she was visiting. She did not hesitate to join when I welcomed her into the group, although she had intended for them to attend another activity elsewhere in the facility at that time.

Anna, who had joined the group after we began last week, was involved in therapy in the adjacent area, which enabled her to be privy to most of our initial conversation. She sat down with us about 15 minutes into the session. Cynthia, Clara's daughter, arrived shortly after we began and entered our circle, bringing our group total to eight.

No sooner had we begun than a therapist approached Mary to take her to therapy. Mary refused to go and remained with the group. She was somewhat improved this week although her participation was still minimal.

Barbara occupied the same place at the table as the previous week. She repeated the description of her physical problem as continually breaking bones, though she had forgotten which bone she had most recently broken. After attesting to the high quality of care at JHHLCS, she also proclaimed the value of the group. Barbara then stated that one's religion did not matter – the group's significance was getting to know the other

people, which promoted getting well. She referred to the group's uplifting affect upon her and how grateful she was for it.

Several times during the session her eyes closed, and she appeared to be nodding off. She did not talk except when explicitly questioned, but did join in the singing.

Her assessment this week was (1) social support; (1) daily activities; (2) feelings; and (1) social activities. Her feelings had dropped from (1) last week to (2) this week. The other categories were (1). She reported feeling "refreshed" at the conclusion of the group.

Clara, who sat next to Barbara, had a similar profile to Barbara in terms of age, affability and social/economic background. Clara revealed that after two months at JHHLCS, she was gradually improving. "First I was a zombie. Then slowly but surely I've been getting better. If you try, you can make it." She professed happiness at being part of the group, and thanked God for everything. Clara was actively engaged in this week's discussion and offered the other members a great deal of encouragement.

Her ratings were: (3) social support; (3) daily activities; (3) feelings; and (2) social activities. Her numbers were average, given her enthusiastic affect and the hope and gratefulness she expressed. After the group, she asserted that she felt fine and much better than before.

Stuart appeared to be as alert as at the last session. In the past, the TR Leader had presented the microphone to him because of the proximity of their seats. Since I was closer to him this time, I had to hand it to him. "Let's see if Stuart's speech has improved since last week," I said, turning to the others. Try as he might, he was not able to

articulate clearly. Non-distinguishable sounds broke through his lips, to which the group responded as if they understood what he had said. As was the case at the last session, he moved his lips when we sang.

His scores were (3) for each category. When asked his assessment at the conclusion, he stammered, "better and good."

Mary appeared to be much more alert this week although she did not speak after the introductions. She sat erect in her chair, as opposed to being slouched over last time, made eye contact with the others, and also seemed to be singing. She acknowledged feeling that she had improved and expressed hope and belief that her health would improve.

Mary offered a consistent rating of (3) for all the categories and at the conclusion said the group helped her feel stronger.

Anna disclosed that she had made progress that week, by having graduated to using a walker all the time, and had dispensed with the wheelchair. She continued to be an active participant and source of encouragement to the others as had been the case the previous week. Having entered the group too late to complete the pre-evaluation assessment, her post-group feelings were "wonderful."

Bess, who was new to the group, was visiting her husband, who had been at JHHLCS for less than a week. An attractive woman in her mid to late 60's, she shared that her husband had lost the ability to rise from a seated position and that he had begun to fall frequently, which meant that he was compelled to use a wheelchair all the time and

had to be helped in and out of it. She hoped that treatment at The Home would enable him to become independent again. She also declared that they had many complaints about JHHLCS, and would not remain unless his situation improved.

She rated social support (3) and feelings (4). Because she was not under treatment, the questions on daily and social activities did not apply to her. She walked away before the culmination of the session to speak with one of the medical staff, so she did not respond to the post-evaluation.

Albert, Bess's husband, is a Jewish man in his mid 70's who speaks softly, with a Polish accent. Although he had a stroke 31 years ago, which had disrupted his entire life, he claimed to be grateful for the stroke because, he had turned it into something good; he and his entire family had become devoted to helping the disabled.

Albert professed a deep belief in God and a concern for humanity. As he spoke, his wife whispered that I should cut him off; otherwise, he would monopolize the group. During the course of the session, his contributions revealed a positive attitude, in contrast to his dour demeanor and slumped posture.

He rated social support (5); daily activities (4); feelings (5); and social activities (4). As with some of the others, some variance existed between his scores and the articulation of his feelings. At the end of the group, he admitted to feeling better.

Cynthia, Clara's daughter, a married woman in her early 50's, visited her mother frequently. The most active participant in the group, she offered many insights and comments. Cynthia arrived too late to complete the pre-assessment form, and I did not

catch her in time to complete the follow-up. She announced to the group that she had had a "lousy day" and was so happy that she joined the group, which was "transforming" for her. She thanked everyone for allowing her to be part of it.

DISCUSSION

The TR Leader began by talking about the natural human tendency to be depressed in a rehabilitation environment and how anger is often a companion to the loss of health.

Bess asked people how they dealt with life on the unit. She was angry about the food, particularly since her husband Albert had specific dietary needs to which the kitchen was not adhering carefully enough. The conversation that ensued about food at JHHLCS captured the group's attention and took on a life of its own. We even laughed about matzo balls that fell apart before getting into the mouth! The TR Leader explained that the facility was going through a transition in the food service department.

Those who had been at JHHLCS for awhile commiserated with Albert about his meal problem. Anna, a diabetic, described how she received the wrong foods from time to time, but simply refrained from eating them. Clara admitted that she forced herself to eat because she knew it would help her get better, even though she did not like the food. "You've got to do whatever you can to survive."

Eventually, I transitioned with the questions: "How do you deal with a situation that cannot be solved?" and "How do you deal with the conflict between demanding your rights versus adapting to circumstances outside of your control?" The theme became

taking care of yourself under dire circumstances, and taking control of those things within your power. The group agreed heartily about the challenge posed by obstacles outside one's control.

I then picked up on one of the patient's comments in reference to physical limitations. We acknowledged that not everyone who came for rehabilitation improved, and how devastating it was for the one not getting better to observe others progressing and going home. I pointed out that just as the medical staff was focused on healing the body, the TR Leader and I were concerned with dealing with the non-physical to both support the physical limitations and to transcend them.

I felt it was appropriate to recite the blessing *Asher Yatzer* (we are thankful for the gift of our bodies) and *Elohai Nishama* (we are thankful for the gift of our souls). We talked about how the body and spirit work together to promote healing and emphasized the importance of attending to the spirit and emotions. Clara noted that when she was in a good mood, she did not feel so fatigued. Barbara added that she engaged in activity so as not to think about her pain. We concluded that a strong connection exists between the soul and body and that one's emotions impact getting better.

I elicited comments about the blessings: "We read these blessings first thing in the morning so that when we wake up, we don't take it for granted. We thank God for still being here." Cynthia divulged that she had had a medical problem which required the use of a catheter to urinate. She was immeasurably grateful when freed from the catheter and able to urinate normally again. The others all identified with her story. I then noted that the prayer was said in the morning and was a blessing recited before

defecating. The TR Leader followed-up by raising the topic of constipation and similar difficulties with other basic bodily functions that are usually taken for granted. All agreed that the blessing was germane to their lives, and how important it was not to take basic bodily functions for granted.

We continued by reading *Elohai Nishama.* I interpreted that in the same way our bodies are continually being created by the generation of new cells, even when we are emotionally despairing about our physical deterioration, we are still being renewed. Albert thanked God for his soul, particularly since his body "wasn't in such good shape." There was also the acknowledgement of not knowing from one day to the next whether we would actually get up the next morning. Several participants expressed the relevance of both blessings and the close connection between them.

Finally, I shared the Jewish concept of one hundred blessings a day, and how the practice of reciting the various blessings reminds us of our good fortune, even amid onerous circumstances. I told them that anyone, Jew or non-Jew, could create and recite a blessing for anything for which he/she felt grateful. The blessing could be in any language, but the words had to be said aloud, even if only a whisper to ourselves, for it is precisely the articulation, giving voice to the feelings, that inspires us.

Then I encouraged each one to offer his/her personal blessing. Some expressed gratefulness to God for their lives, others for their families, and some for other things. Albert affirmed that you could be disabled and still be what you want to be in life.

We sang "Kumbaya." Following the standard verses, I asked members to add their own. Several said: "Let us walk again." Another was "Bring us better food." On behalf of Stuart, one person offered: "Let me talk again."

The final discussion related to identifying one's essence. "When all is said and done, what are the one-two-three words that best describe how you see yourselves?" I asked. Responses included "Good," "caring," "gentle," "passionate," "loving," "creative" and "helper."

At the conclusion, I sang the *misheberach* blessing for health and all joined in on the "amen" with great gusto.

REFLECTION

I was struck by the willingness of Cynthia and Bess, the two family members, to participate in the group Their presence broadened the spectrum of issues and enabled the other members to feel some connection to the healthy, outside world, thereby reducing their sense of isolation.

I also was surprised when Mary refused to leave with the physical therapist, especially because she had not been an active participant the last time. However in recalling her expression of deep faith the previous week, I conjectured that, at that moment, spiritual therapy was more important for her than physical or occupational therapy. Still, her testimony was a stark contrast to my observation of her. Several times during the session, she appeared to be sleeping, and she did not talk except when explicitly questioned.

The interruption and removal of patients for physical therapy is a frequent, annoying occurrence. I have grown to accept it, since patients come to JHHLCS specifically for the physical and occupation therapy, but it also seems indicative of the institution's disregard for the role of spiritual and emotional well-being in the healing process. As Israel Kestenbaum (2001) cogently states: "The medical culture has largely marginalized the place of pastoral care in the hospital milieu, and those of us in the field are frequently reminded that it is not a mandated service...The chaplain's place on the treatment team remains ambiguous" (p. 10).

Barbara was also a puzzle to me. Because she was an enthusiastic participant in every activity and never missed a group, I was surprised to see that her rating of her feelings had dropped from (1) the previous week to (2) this week I realized then that the responses at any time were only a snapshot of that moment. After all, one's mood can change from minute to minute, even under the best of circumstances, let alone in a hospital setting.

As I approached Stuart with the microphone, I was aware of my own anxiety when interacting with patients and residents who are aphasic. My heart sank when he could not articulate even his name clearly. Despite the non-distinguishable sounds that broke from his lips, the group responded as if they understood him. What support they gave him! It was moving to observe their encouragement.

When Stuart had such difficulty saying his name, the TR Leader asserted that he was probably tired from all the physical therapy. It occurred to me then that we might be overemphasizing progress in our discussions, especially since quite a few participants

really did not improve. The challenge is to balance uplift and hope with the reality of limited recovery and transcendence of physical limitations. The power of this unique type of group support was palpable when everyone joined in singing of Kumbaya, imploring "Let me talk again" on behalf of Stuart. It was a poignant and powerful moment. I realized that in creating their own lyrics, they were identifying and empathizing with each others' needs.

I also recognized that during the groups, I often relied upon the TR Leader to communicate with and for the aphasic and those who are hard-of-hearing. I examined my anxiety in relating to these two populations, which is not limited to the groups, but around quiet people in general. It is difficult for me to withstand silence because I am a talker. This same episode provided me with insight about the importance of working with another professional whose skills complement my own.

When the group became enmeshed over the details of Albert's food issues, I became concerned about their focusing on facts rather than feelings. But for the participants, food was like manna from heaven, since meals in a hospital setting are a focal point of the day. In a hospital, where a patient is so absorbed in his/her physical needs, food takes on a much more significant role than mere nourishment. The rather pedestrian and lighthearted conversation about food enabled the group to bond and eased them into the more serious discussion that followed. Although I was impatient with their discussing the specific facts (e.g. diabetic and Kashrut needs, change over in kitchen staff), I restrained myself from redirecting them.

In a similar vein to the food discussion, they responded well to the topic of bodily functions, such as constipation and excretions, which often go awry when people get sick and are hospitalized It is a great relief for patients to discuss this taboo topic, as the lifting of the veil helps ease their anxiety or otherwise help their mood.

Finally, the number of repeaters in the group was surely a sign of its meaningfulness to those people who had returned.

GROUP 3: February 16

PARTICIPANTS

When the TR Leader and I had discussed the composition of the group before it began, she mentioned that Clara probably would not attend because she was tired and scheduled to go home the next day. Still, I stopped in Clara's room to ask her to join us. "Of course, I was feeling tired before, but I wouldn't miss the group for anything." When I went to Stuart's room to ask whether he wanted to join us, he nodded yes emphatically.

The TR Leader went to the rooms of two members from the previous week, Carol and Mary, to invite them to join us. Unfortunately, Carol was lying in bed and was too sick to get up. Mary was undergoing some type of treatment in her room.

The group began with six participants. Returning from the previous sessions, Barbara, Clara, and Stuart were present at the beginning. Abraham, who had been at session one, but missed session two because of a conflict with therapy, joined us as well.

Albert entered halfway into the group having been in therapy when it began. Three patients were entirely new: William, Alice and Ilona. At its peak, there were a total of eight participants.

Having learned that Clara and Barbara were scheduled to leave the next day, and given that at least half the attendees were repeaters, I decided to change the format of the session. I took advantage of Clara's exceptional articulateness and enthusiasm by asking her to describe the group's purpose for the newcomers. She said, "What has been so meaningful to me is getting to know all of you. This group helps us to socialize with each other, so that we don't feel all alone. And by talking together like this we help one another to feel better. The group has been the highlight of my week, and I wouldn't miss it for the world."

Clara's ratings before the group were (2) in each category. Following the group, she gave the ratings: (1) for producing a change in feelings, greater connection with others, and obtaining of new information.

Barbara added that it was very important for her to be part of the group, because it brought her outside herself and made her realize that her situation was not that bad, especially when she saw what others were going through. She thought more people should come to the group, which she suggested meet daily instead of weekly. Clara and Barbara's testimony was so cogent that I only added my thoughts about the spiritual element: prayer and song would help remind us of a power beyond ourselves. Barbara participated only a little in the session and appeared fatigued. Her ratings were (1) in each category prior to the group. Her follow up was: (1) for the first three questions and

(3) for revelation of new information, which she connected to the new people in the group.

Since William's participation was to be curtailed due to a therapy appointment, and he was new to the group, we asked him to introduce himself first. Admitted to JHHLCS the past week, he is an African-American male is his late 60's. William had recently suffered a stroke, resulting in paralysis of his right side and slightly slurred speech. He revealed that, since the stroke, "It's been up and down." Although he has family, when questioned about what motivated him to go on, his response was "When your friends are praying for you and rooting you on, it helps." Later in the session, when we discussed obstacles to healing, he admitted that the worst thing was being hard on himself.

William's pre-session ratings were (1) social support; (1) daily activities; (2) feelings, noting additionally that it was taking time for him to get adjusted; and (3) for social activities. I engaged him in the post-assessment before he left, about 10 minutes before we concluded. His post-group ratings: (1) group experience changed his feelings; (5) feel more connected to the other residents and leaders; (3) gained a new insight; (He added that this was because of the other people, which seemed to contradict his response to the previous questions.); (1) revelation of new information. He added that the group should be held more often.

The next one to introduce himself was Abraham, a veteran from session one. I told him that we had missed him last week. As at the first session, he was on the verge of tears when he spoke. When I asked him to share what had brought him to rehabilitation,

he replied, "I guess I had some sort of break down. I'm not sure. My nephew took me to the hospital; then I came here." I asked how he had been feeling in the intervening two weeks since the last group. He said he was feeling much better.

His ratings prior to the group were (1) for all the categories except for social activities which he rated (5). His ratings on the follow-up were (1) for each category.

Approximately half an hour into the group, the TR Leader introduced Ilona, who at that moment was wheeled in by a companion, apparently at the TR Leader's insistence. Rather than continue to pass the microphone around the table to the next patient, as we usually did, the TR Leader immediately handed it to Ilona. Ilona's head was covered with a cloth hat that is often worn by women who have lost their hair while undergoing chemotherapy. I learned later that she wore it due to religious observance. (Traditional Jewish law mandates that married women, out of modesty, cover their hair for all individuals except for their husbands.)

Rather than talk about her life or her medical condition, Ilona revealed that she had only arrived a few days before, and was struggling because she was very frustrated by the facility, particularly waiting for staff to respond to her needs. She added that she did not belong in the group. The TR Leader coaxed her to stay a little while longer, assuring her that she would feel better if she remained.

Barbara pointed out that no one could expect a miracle, and that Ilona needed to take each day at a time and do all the therapy. "If you keep at it and not let it get you down, you will get better."

Clara added: "You need to have patience. When I first got here, I wanted to die. I didn't think I would make it. But after the therapy every day and coming to this group, I gradually got better. Now after almost three months, I am back to myself and can't wait to go home to return to my life again."

Stuart was next. That week, when we handed him the microphone, he was able to enunciate his name and say he had had a stroke. With the TR Leader as an interpreter, he seemed to say that he was happy to be here, referring to the group.

Stuart's pre-group ratings were: (2) in all categories. Regarding the follow-up, he rated (1) for change in feelings and (5) in the other categories.

Alice, a very large Hispanic woman who had had a heart attack, spoke next. She used oxygen and at times seemed to doze. Although she responded when directly asked a question, she did not otherwise join in the discussion. She admitted to feeling very depressed when she came to JHLLCS, fearful that she would not recover. However, once she became acclimated to the environment, she liked it better, with the exception of a disturbing experience with a nurse who was abusive to her, whom she reported.

Alice's ratings before the group: (2) social support; (3) daily activities; (5) feelings; (1) social activities. Following the group she rated questions 1-3 (1). She did not answer 4.

DISCUSSION

We discussed patience and relying upon others for one's own basic needs, followed by our exploring the challenge and humiliation of dealing with the loss of independence and control over one's life. Group members acknowledged the difficulty of this predicament. Stuart stated that he was learning a new way "to be."

I pointed out that for some, their present circumstances would be a temporary indignity to endure, while for others it would be a lifelong challenge. I emphasized that the value of one's life was not so much what each of us could or could not do, but rather our sense of our own inner strength and the power to believe in ourselves as part of the divine spirit. This was not an easy attitude to have, I added, but that it might be worth striving towards. Facing the harsh reality, accepting it and then attempting to reorganize one's life required moving from despair to hope, and was a slow, arduous process and was not an uphill battle, but rather was up and down.

At this point, the conversation turned to Clara's and Barbara's leaving. The TR Leader and I expressed our happiness at their being sufficiently recovered to go home. We also revealed the dichotomy – gladness and yet also some regret -- we experienced when saying good-bye to individuals to whom we became attached and who were integral to the group. Everyone wished them well, and several said they wanted to go home too. Barbara shared that she only wanted to be discharged when her body was healed; otherwise she would wind up in the hospital again.

Just as we were discussing the departure of Barbara and Clara, Ilona started to move away from her place at the table. I urged her to stay, since the group was almost

over, and we were about to read "A Prayer for Prayer." The TR leader recited with great emotion and everyone was visibly moved.

As a consequence of both the quality of the reading and the substance of the prayer, an intense conversation ensued. People talked about the times in their lives when they felt that God was with them and about other times when God seemed so far away. When Stuart pointed to the words "Help me find the words, help me find the strength within, help me shape my mouth, my voice...," everyone who grasped Stuart's reaction was overcome by the poignancy of his desire to regain the ability to speak. Alice said that anyone could read the prayer and find meaning in it.

At this point, Ilona opened up and revealed that she was a Holocaust survivor and had seen everything. She attested that her belief in God was what had gotten her through the concentration camp. Albert, who was sitting next to her, divulged for the first time that he was also a Holocaust survivor. At Albert's initiative, the two spoke to each other very briefly to see if they had been in the same camp.

Ilona was transformed as the others in the group focused on and responded to her comments. Suddenly and enthusiastically, she agreed to stay until the group's conclusion and continued talking. Simultaneously, Albert tried to predominate, but the others were more interested in Ilona and were not responsive to him, effectively forcing him to keep quiet.

He referred to his own guilt feelings towards his family for their having care for him for so many years. At the same time, he bragged about his daughter's professional

accomplishments. As he withdrew with a scowl appeared on his face, Ilona took center stage.

Albert withdrew from the discussion and appeared sullen. His follow-up scores (he arrived too late to complete the pre-group assessment), reflected the mood I observed: (3) in all categories, except (4) in revelation of new information.

The TR Leader acknowledged the suffering that Ilona and Albert had experienced during the Holocaust, and I mentioned that most of the Holocaust survivors admitted to rehabilitation joined our group. I spoke of my admiration for them and their ability to endure. The TR Leader then generalized the concept of persistence, suggesting that all the group members were survivors of illness.

Near the session's end, Ilona grabbed my hands and held them in hers, expressing deep gratitude for the group. She revealed that she was very religious and never missed Shabbos services. I invited her to attend our services. Ilona said she would "If I am up to it. But I will definitely come to this group next week." Her enthusiastic response to our session after her initial reluctance to join marked a dramatic turnaround. This change in attitude was reflected in her post group rating which was a consistent rating of (1).

Next I distributed the words to the song "Somewhere over the Rainbow." I had never before used this song, and unsure of its appropriateness, had been ambivalent about introducing it. To my delight, it was a huge success. First, everyone seemed to know the words and sang along. We then discussed the meaning of "flying over the rainbow," something towards which each of us strives in different ways. I emphasized the

commonality of the desire to be in a land where "troubles melt like lemon drops." We explored how "flying over the rainbow" signified transcending our daily struggles, and I noted how each of us has the capacity to do that if we try hard enough.

I concluded by singing *misheberach*, and we offered a blessing to Barbara and Clara for continued good health and peace.

REFLECTION

William created a red flag for me regarding his family – why did he omit them and refer to his friends as his support? I wondered about the nature of his family relationships, but felt that it would be inappropriate to probe any further within the context of the group.

Although the group followed-up on William's issue of being hard on himself, it was apparent that we could have spent more time on this issue, which resonated with most of the participants. I tried to assess how much depth we could get into in an hour. Also, given the nature of the spiritual part of the group, how far do we probe psychodynamic issues? Thus, timing and emphasis were issues that I had not yet resolved.

Since William appeared to be comfortable in the group and had suggested that it be held more often, I was surprised by his low response to connection with others, and wondered whether this was a result of his being the only African-American in the group. Although I tried to visit with him following the session, I never found him in his room, and he did not return to the group again.

Abraham said that he felt much better, yet I was not convinced because of his teariness and his seeming to be somewhat confused. I did not integrate what he said about an improved mood, for I observed a discrepancy between his affect and verbal message.

When Ilona spoke about her frustration with the facility, I was aware that, occasionally, patients are very dissatisfied with their treatment at JHHLCS. As a staff member, it is awkward for me to deal with this matter, especially because of the public setting in which the group is held and the presence of other staff in the room. Yet I do not want to shy away from exploring the problem, for it is very disturbing to the patients. Believing that staff behavior toward patients and other circumstances at JHHLCS is largely out of each person's control, I chose to focus on the feelings behind the circumstances. Nevertheless, I felt very torn between my loyalty to the facility and my concern for each patient.

The sudden appearance of Ilona, the ensuing attention paid to her, and her dramatic transformation, were noteworthy. I wondered whether the TR Leader's insistence was the key factor in the group's involvement with her, or whether the issues Ilona raised about problems with The Home forged the other patients' identification with her. And despite Albert's narcissism, I was concerned that he had been given insufficient attention.

I believe that the group's focus on Ilona might have been based on its desire to rally behind the TR Leader's efforts to persuade her to stay with us. In addition, Albert

comes across as narcissistic and an attention-seeker, and therefore was the others were disinterested in him.

GROUP 4: March 2

PARTICIPANTS

The group began with eight participants. Two were repeaters -- Stuart and Ilona. Ilona left half way through the group to spend time with a visitor. A third patient, Sigmund, was a readmission familiar with the group process, having been a consistent attendee several months earlier. Rose, Sophie, Lena, Irving and Gordy were new to the group. Katrina, who was non-verbal but not aphasic, joined us later to bring the total to nine.

During the week, Stuart was taken off the rehab unit and placed in long-term care. When the TR Leader told me that he was very depressed about the move, we decided that it would benefit him to be part of the group, so she went to retrieve him from another floor.

This week, his speech was somewhat more comprehensible, and he said more than in the past sessions. During later discussions, he placed the microphone to his lips and tried to speak, but was not able to articulate clearly enough for us to understand him. However, a new revelation was that his stroke occurred five years ago, when he was only 55. Again, I observed his lips moving when we sang.

Despite the TR leader's perception that Stuart was depressed, his pre-evaluation scores were a consistent (2), up from the previous weeks. Interestingly, while he had given consistent (1) ratings for the post-evaluation for the last few groups, this time his ratings were (4).

Ilona was another repeater from Group 3. Whereas she was initially reluctant to stay at the previous session, she eagerly shared her story about being a Hungarian Holocaust survivor. She had moved to Israel after the war and met her husband there. After living in Israel for several years, she had relocated to New York. Since her husband's death six years ago, her sons have been taking care of her. She was very grateful to her sons and quite proud of them. One day, when I encountered her in the hallway, she told me proudly that one of them was the prayer leader at her *shteeble* (small synagogue).

Ilona's pre-session ratings were: (2) social support (she had a constant stream of visitors); (1) daily activities; (3) feelings; and (1) social activities. Because she left in the middle of the session, she did not complete a post assessment. However, she was an avid talker and attentive listener throughout the session, especially when Sigmund, another Holocaust survivor, spoke.

He had been discharged several months ago and was readmitted as the result of another fall. During his previous stay, he had attended every group. His wife was at home with a caretaker, and thus unable to visit him. Sigmund spoke in a high-pitched voice with a heavy German accent that was hard to understand, so that everything he said had to be repeated by the TR Leader or me. He spoke as if in a trance, in a monotone,

looking straight ahead, reciting the details of his past in a manner that indicated he had told his story before many times.

Sigmund had been detained as a prisoner of war in England because he was German, even though he was Jewish. His parents had been owners of the largest women's hat factory in Germany. His posture was rigidly upright and, at age 95, he wore wool dress pants, a pin-stripe shirt, vest and tie in a setting where many wore hospital gowns.

Having had contact with Sigmund prior to his discharge less than two months ago, I was alarmed at how significantly his morale had declined and how he had weakened physically. His pre-evaluation ratings were: (5) social support; (4) daily activities; (4) feelings; and (4) social activities. Having been the focus for a segment of the session, he gave much higher ratings after the group: (2) for change in feeling; (1) connectedness to others; and (2) for gaining a new insight. He left the session in a clearly improved emotional state.

As for the first-timers:

Rose was a very thin, frail, 92-year-old single, Jewish woman, without family. She identified herself as a "woman alone" with many friends, still productive and an ardent New York fan. Rose had worked in the fashion field and then for an international law firm. She was exceptionally alert and engaging, with a high-energy affect, despite her fragility. Her contributions were articulate and positive.

Rose's pre-evaluation was (3) for social support; (3) for daily activities; (5) for feelings; and (2) for social activities. She gave a consistent (1) in the post- ratings. During our follow-up after the group, I asked her if she had any suggestions on how to improve it, or if there was anything she did not like about it. She responded that she valued learning about the other people, and that it was perfect the way it was and "marvelous."

Sophie, a kindly round-faced, alert woman in her early 80's, who was admitted for severe emphysema, was very positive about the care she received at The Home. During her lifetime she had held a variety of retail jobs. She has two daughters and seven grandchildren of whom she was very proud. She seemed absorbed as she listened to the others and participated easily in the discussion.

She thanked us profusely for inviting her to join us. Her pre-session ratings were: (4) social support; (2) social activities; (1) feelings; and (3) for social activities. Her post-session assessment was: (2) change in feelings; (1) for connectedness to others; and (2) for gained a new insight.

Lena, who had been living with her son and daughter-in-law and has two grown grandchildren, and whose admission to JHHLCS was caused by a fall, stated her name and said she was 74, which prompted the TR Leader to laugh. Then Lena revealed that she was really 97 and had said 74 as a joke.

"Joking," she said, "keeps me alive. Laugh and the world laughs with you, cry and you cry alone," she added.

Her words belied her appearance as her head hung over, except when she spoke. She appeared to be asleep, yet would suddenly pop up with a comment, which was often very ironic. "Life is good to me." She described her life as growing up in a small town in Nova Scotia, Canada where there were few Jews. Nevertheless, she had a great Jewish education, learning *Chumash* (the Torah), Hebrew, Talmud and "gamerish," her humorous way of referring to Gemara. Before the session, LB's ratings were (1) in each area. Following the group her ratings were (1) in all categories, with a comment "I feel all goodness inside."

Irving, a 95-1/2-year-old (he emphasized the half) alert, cognitive Jewish widower who still lives alone, was found him by his son lying on the floor. Irving expressed deep appreciation for his son and eagerness for his health to improve in order to return home as soon as possible. As someone who attends his local synagogue regularly, he asked to be picked up for *Shabbat* (Friday afternoon and Saturday morning) services. During the session he was very engaging and animated and, as he sang a Yiddish song, his eyes brimmed with tears. Irving's pre-assessment ratings were: (1) social support; (3) daily activities; (2) feelings; and (2) social activities. The follow up scores were: (2) change in feeling; (2) connection to others; (1) new insight. He expressed appreciation for being included in the group.

Gordy, an 85-year-old German Jewish woman who had lived in England after the war before moving to the U.S., appeared confused. She started speaking in German, and had to be reminded to speak in English after lapsing back into that language several

times. It was difficult to understand her. She participated little during the discussion except at the end when she expressed appreciation for her son.

Her pre-scores were: (4) for social support; (3) for daily activities; (4) for feelings. She got distracted and did not respond to the question about social activities. She seemed confused and even somewhat cynical, brushing her hand in the air to dismiss me when I asked her the follow-up assessment questions. Her post session scores were: (3) for change in feelings; (2) for connection to others; and (3) for gained new insight.

Katrina was wheeled into the group about 10 minutes after it began. The TR Leader was surprised and pleased that she had joined us. Because Katrina did not speak, I assumed that she was aphasic. However, as I wheeled her back to her room, she said very clearly "I did not want to say anything." When I asked her if it was difficult for her to talk, she said that it was not. I continued to question her to try to get to the source of her reticence. She responded that since she had arrived in rehab, she had not felt like talking. I thanked her for joining us, and invited her to participate in the future. The TR Leader later commented that she had not been able to get Katrina out of her room to participate in any recreational activities, so her sitting in on the group was a positive sign, despite her being taciturn.

DISCUSSION

Early on, in response to Rose's claim of being productive, I talked about how stressful it was for people to accept themselves when they were no longer able to accomplish what they had in the past. I referred to Rabbi Schachter-Shalomi's concept

(1995) about reaching a point in life when one transitions from doing to being. That led to a lively discussion in which people revealed the anxiety attached to feelings of unworthiness once they were unable to contribute to society anymore in a way that made them feel useful. The TR Leader shared that Rose was not working, but that her productivity was related to being supportive of others. Several others agreed with her having found her to be very helpful.

I commented that even when people were not able to communicate verbally, like Stuart and Katrina, their caring presence was supportive to the others. This act of being there and listening with concern, as manifest in their body language, their caring presence, was similar to the productivity to which Rose referred. Their willingness to witness and to share their empathy through facial expressions and gestures was a blessing for others in the group. I was thinking about the sacredness of listening and witnessing at that moment. And while Dittes (1999) refers to the pastoral counselor's role as an empathic listener, I could not help but think that these individuals were also serving in that capacity for the others.

Sigmund asked to speak again, a few moments after he introduced himself. He began a monologue about the death of his daughter at the age of 23, and broke down in tears as he told his story. I stood behind him and placed my hands on his shoulders. The TR Leader also approached him. She commented that Sigmund was suddenly remembering things that pained him and that he needed to talk about them. I did not accept the first part of her analysis, having heard his story several times before at earlier

sessions during his previous admission. I suggested that he was feeling very vulnerable at being hospitalized again, and at those times we tend to recall painful memories.

I asked everyone to offer a moment of silence in prayer for Sigmund. The TR Leader suggested that everyone hold hands. Some people were able to do this, while others could not due to physical limitations and distance from one another. I then told Sigmund that we were deeply aware of his pain and loss and empathized with him. I hoped that our prayers eased his suffering. He said that he felt our prayers in his heart.

Another topic arose after Irving spoke about his son. I pointed to the unusual coincidence of three people sitting next to one another, each of whom was blessed with loving and responsible children, and noted that this was a gift one could not take for granted. Those who had children spoke up, remarking on their own luck.

Next I referred to the torment human beings experience, and noted how several in the group, especially the Holocaust survivors, had suffered beyond any experience I could apprehend. I commented that all who were present revealed an inner strength and faith in humanity, as well as in the power of the spirit to overcome adversity.

I referred to a New York Times article (Brody, 2005) on adversity that I had read the preceding night about how the ability to adapt can be learned at any point in life. The TR Leader followed up by pointing by patients in rehabilitation need resiliency in order to continue to live and thrive. I referred to Sigmund's strong faith, which prompted him to join the group each week and which had helped him to endure unimaginable grief.

At that point I distributed the prayer "In Sickness I Turn to You" which Rose read aloud. Everyone thought it was a beautiful prayer, and several people immediately folded it up to take back to their rooms.

Following that I read two selections from *Pirkei Avot* (1979). "He [Hillel] said: If I am nothing to myself who will be for me? And if I am for myself only, what am I? And if not know when?" (p. 17). I asked for reaction to the reading. The general response was that people agreed with it, especially about the need for people to care about others. Then I read "Do not set yourself apart from the community; do not be sure of yourself until the day of your death. Do not judge your fellow man until you have been in his position" (p. 25). Several participants connected the reading to the group's activities, which was what I had hoped would occur. I pointed out that within the group, individuals sought to be part of a community, regardless of whether or not they believed in God or practiced any religion. I summarized the Talmudic principle about how their mutual support removed one-sixtieth of another's illness.

Then, since "Somewhere Over the Rainbow" was so successful at the last group, I distributed it again. The TR Leader expressed her experience of singing the song as uplifting. I shared that I felt the group, through the sense of community it had built, had already reached a place over the rainbow. The song was a great success again. Staff, other patients and visitors in other parts of the room joined in the singing. Those who could or would not speak mouthed the words. When we concluded, I asked them to share where "over the rainbow" was for them. The answers were as follows.

Rose: "Reality, reaching out and within"

TR Leader: "Restoring" myself back to who I really am"

Stuart: "When I feel happy"

Sophie: "Hearing the stories about other peoples' lives -- it makes me realize how good my life is."

Lena: "My son. There is nothing he wouldn't do for me. He is my rainbow."

Irving: "Dream during the day. Hope"

Gordy: "My son --he can do everything."

Sigmund: "When I am in a position to help people."

The TR Leader commented on the inspiring messages everyone shared. I followed by expressing that I was over the rainbow when I felt at one with God, which I was experiencing at that exact moment. I attributed my state to their presence. At that point, I verged on tears, so touched was I by their apparent connection to one another and what appeared to be a very successful experience at transcendence for many. To compose myself, I sang the *misheberach* blessing, and asked each one to say his/her name in Hebrew or English. I wished everyone a sense of peace for at least the balance of the day.

I wheeled the three first-timers to their rooms. They thanked me and indicated that they would like to join us the next time.

REFLECTION

When Stuart attempted to speak this week, I suddenly thought about Jean-Dominique Bauby (1997), who was trapped within his body, unable to move or speak, yet productive enough to write *The Diving Bell and the Butterfly*, one of the most meaningful books I have read about people under his circumstances. While Stuart's situation was tragic, when one viewed Bauby, there was hope for Stuart to transcend his body, especially given his positive attitude and engagement with the group over the weeks. Yet it was hard to understand his poor post-group ratings, which had dropped this week, given his apparent involvement during the session as manifest in his facial expressions and alertness.

When I commented on the witnessing and care expressed through facial expressions and body language, I thought about those who cannot reveal their feelings at all through any physical means and again recalled Bauby's (1997) entrapment in his body. Each of us is filled with a vast array of emotions, only some of which are expressed in communication with others. We take so much for granted about another's feeling based upon his/her facility with language.

Several of the participants described how their children motivated them to continue living. I am concerned when people contend that they are living for this reason since I believe that one can easily be disappointed and at a loss when dependent upon another for one's own will to live. I wonder if they really mean what they are saying, or are they unable to claim their own strength and source of life?

I also am concerned about the effect of these discussions, in which children play so prominent a part, on those present (usually at least two) who do not have progeny.

Have they gotten accustomed to being alone? Does one ever? Is it painful for them to hear about the devotion of others' children? Perhaps, I think, I should curtail or redirect these discussions for the sake of those who are alone. Based upon my knowledge of groups, any manipulation on my part would fly in the face of the participants' needs and the natural flow of discussion.

I also questioned Gordy's seeming disorientation within the group when she reverted to speaking in German. It was hard to know whether her lack of involvement was a language barrier, dementia or some other unknown issue. I can only conjecture what her dismissive gesture towards me meant at the post-assessment. Was it symbolic of her attitude towards the group process?

When the TR Leader suggested that everyone hold hands, I was troubled. Although there were times when I had thought about doing this, I did not, because I realized that it could bring great discomfort to those incapable of extending their arms, as well as those who have a negative response at the thought of holding hands with a stranger. But it was too late to prevent this, for the TR leader immediately took the hands of the people who sat next to her. The woman next to Sigmund could not reach him, so I stood near him and held his hand, while also awkwardly and unsuccessfully trying to reach hers. I would never do this again. Too many people are left out.

Observing Sigmund's frailty and decline from only a few months ago reminded me of the fragility of all their lives, and how the "group" may only be a band-aid for their souls. Then I remembered how Sigmund's mood had dramatically improved by the end

of the session, and how valuable those moments were for him. At his stage in life, especially, every moment is another moment alive. In fact, the band-aid was a blessing.

It also occurred to me that including a few words of Torah at each session would enhance the group. The readings I selected from *Pirkei Avot* were quite successful, since the themes connected so well to our discussions.

Finally I closed by revealing how much I had thought about the group while I was on vacation the previous week. It was very significant that a few of them had gathered to talk with the TR Leader and the rabbinic intern during my absence. This pointed to the validity of the group process.

This particular group had a very strong emotional impact on me, possibly because of their rallying behind Sigmund. I was struck by the energy and dignity of these very elderly people, several of whom were in their mid to late 90's, as well as their empathy for each other.

SUMMARY

ASSESSMENT TOOL

The pre- and post- evaluation written tools provided a guidepost for me for the reactions of the lucid patients. But those who had even slight cognitive impairment did not seem able to discern the nuances of the rating scale, which requested a response of one to five, one being the highest: e.g., 4) Yes a little vs. 3)Yes, some, vs. 2)Yes, quite a bit" etc. on the questionnaire when I presented the assessment to them. Furthermore, I

often observed a discrepancy between what patients indicated on the assessment versus their appearance and how they had they behaved. Some had a downcast affect and participated little, yet presented high ratings on the pre- and post- assessment. Others appeared to be in very good spirits and were highly interactive but gave medium ratings. From this I have learned that appearances are often deceiving, especially with this age population, whose facial expressions are ingrained at this point in their lives and who have express what they believe is socially acceptable.

At the first session I used the same tool for both pre- and post-evaluations. As I attempted to use it, I realized that three out of the four questions did not seem to apply, so I reduced the questions to one, a simple how are you feeling now? I used that alone as my post evaluation for two sessions. Realizing that it was inadequate because it did not provide sufficient information, I amended it to four questions based upon a discussion with Douglass Clark. As it turned out the fourth questions was confusing, so at the fourth session I omitted it (**Appendix**). In addition, it was difficult to focus the patients' attention at the conclusion of the group. Another problem I encountered in the post-evaluation was that most patients wanted to go back to their rooms to rest, while others wished to stay and continue talking. They did not seem to have interest in or patience for the few post-evaluation questions. Thus, In fact, the most meaningful data was gathered during follow-up conversations, both immediately after the group, while wheeling them back to their rooms, and during accidental encounters in the hallway, when we engaged in casual conversation. From four groups which averaged eight participants a group, we received 31 pre- and 27 post-evaluations.

In the main those patients who seemed to have a more positive attitude throughout their lives tended to join the group. This paralleled their general inclination to seek as much stimulation and activity as they could physically handle. These patients usually comprised about half of each group. They tended to be more participatory during the sessions – both in their willingness to divulge information about themselves and in their interactions with and responsive to the others. Furthermore, their pre-group responses reflected higher scores. As a consequence there was less room for their post sessions to substantially change upward.

Of the remaining 50% of the group, those who came into a session with lower initial scores, about 25% of the entire group, derived obvious benefit from it, as reflected in the post-evaluation scores. The remaining 25%, those whose post evaluation did not increase, were more likely to be demented, hard of hearing or less fluent in English. They did not appear to be as positively affected by a session as the others did, although the group did not seem to have a negative effect. It is noteworthy that not one patient's post evaluation score was lower than the pre-assessment.

FOLLOW-UP DISUCSSION

In follow-up discussions the higher functioning patients were consistently enthusiastic about the group's value, indicating how much they got out of participating in the session. The individual group discussions detail the number of repeaters and new patients as well as more specific responses. In general their comments indicated that they:

- Left the session in a much better mood
- Continued to attend the group because it helped them feel better
- Liked getting to know the other people
- Felt supported by the other patients and the staff (the TR Leader and me)
- Thought more patients would benefit by coming to the sessions
- Wanted the group to be held more frequently

I was able to better ascertain the positive affects of the group on these patients through anecdotes and their consistent attendance at the group. Of tangential interest is that on average only 30% of the group participants attended religious services, regardless of their religion. This leads me to suspect that for the remaining 70%, the group served some kind of religious/spiritual purpose.

Comments derived from conversation with the lower-functioning patients were similar to those above. A different response and variations on it were liking the group but being in too much pain or too sick to feel better. No one explicitly stated that he/she did not appreciate it afterwards. Since their ability to verbalize was diminished however, this conclusion is somewhat subjective. As with the written evaluations, the remaining 25% of the entire group, the demented, the hard of hearing and the non-English speakers were more difficult to draw out through discussion. In contrast those whose self-expression was curtailed due to aphasia did appear to benefit from the group. This leads me to believe that self-expression may be less important than understanding others.

Finally, while no one explicitly stated that he/she felt worse after the, it is unlikely that they would feel free to do that due to social restraints.

GOALS ACCOMPLISHED

In sum I conclude that my goals were met, except were indicated, as noted in the individual group discussions.

SOCIALIZATION AND COMMUNITY BUILDING

- Approximately eight out of 36 patients on the rehab units attended the group, thus fulfilling the goal of bringing patients out of the rooms to socialize with one another. (It is important to note that of the 36, a substantial number, probably 50%, are bedridden or too weak to participate in any activities outside of therapy.)

CATHARTIC DISCUSION

- The patients discussed the facts and their feelings regarding their circumstances at JHHLCS.

VALIDATION AND AFFIRMATION

- The staff validated the patients' feelings and they also did this for one another.

SPIRITUAL UPLIFT/TRANSCENDCE

- They were given the opportunity to connect with a Higher Power and offered a variety of methods for renewing hope.

- God's presence was invoked several times in each session.

While it was not possible, obviously, to assess anyone's actual experience of God or of an ability to transcend their circumstances, through my observation I gleaned that there were a number of instances when individuals were deeply moved beyond the preoccupation with their own health and recovery and experienced hope. There is little doubt in my mind that these groups are very helpful. As Israel Kestenbaum says," Gatherings of people facing similar life concerns, from substance abuse to child loss, have become central to recovery and healing...Support groups are not, by definition, designed to offer solutions; rather, they create a context in which the estranged can feel a sense of belonging. For many sufferers, they offer the only sense of solace" 2001, p, 7).

CHAPTER V. FINAL DISCUSSION

"Rise before the aged and show respect to the elderly" (Lev.19:32)

CONGRUENCE

I undertook this demonstration project believing that it would make a difference in the lives of the patients at The Home, who, for the most part, are in dire need of emotional and spiritual support. Filling this need for them is immensely important because of the extreme constraints and painful realities of end-of-life conditions that have evolved for the elderly in contemporary society. Many residents' and patients' lives are barren and filled with despair at the very time the hope of project is helping to address that when,, they should be in a period of acceptance, peace and closure. Hamlen notes:

> There is no standardized template of function for the aging population. There is also no way to predict decline and functionality for an individual or group...Loss of function at any age requires an adjustment and adaptation process. In addition to the physical realities that must be faced, the aging individual must also develop 'a new understanding of the meaning of life and God's activity in it' (2004, p. 327).

I have appreciated the opportunity to review the relevant literature, to focus on a spiritual support group and to write about this project. Doing so has helped me to solidify my conviction about the worth and the essential elements of such a group. It was difficult to measure precisely the group's impact on individual participants at each session. But our (the TR leader's, rabbinic intern's, assorted staff's and my) observations, as well as the testimony of many of the participants, revealed an exceptionally positive assessment. Given the success of this project, I am now in a

position to significantly increase my activity in this area, and to advocate for other such groups.

My intense focus on this kind of group reinforced my belief that this is an efficient means of helping the ill elderly to explore their spiritual yearnings while providing them with emotional support. Writing up several cases in detail helped me to clarify some key elements of the process. It also impressed upon me the poignant impact that so many of the encounters had on the participants as well as on the staff. These are depicted in the individual group write-ups.

From analyzing my experience in the nursing home and with these groups, I am now much better equipped both to deal with difficult and unexpected situations that inevitably will arise. I am also in a position to advocate for replicating the groups in other appropriate settings.

During the five-week period of this study, the TR Leader, the rabbinic intern and a few patients convened a group while I was on vacation. The group's momentum took precedence over my absence while I was on vacation, which was precisely what made it so valuable. Although the format that I used was not adhered to assiduously, some of my materials were utilized. The staff reported observing and experiencing congeniality and emotional bonding among the patients and between the participants and them. The TR Leader had learned of the death of a resident with whom she was very close immediately before the group met. Thus the focus of the discussion was on grief and mourning.

Our format evolved to a pattern which included discussing problems and dealing with painful issues early in the session and creating an uplifting focus towards the conclusion. This allowed the patients to transition from exploring personally difficult matters to feeling empathy concerning others' problems and greater awareness of the positive aspects of their lives. The use of humor through telling short jokes for a few minutes was another tool that I initiated midway which worked very well The jokes served as a wonderful ice breaker that fostered a congenial feeling early on in the session.

My repeatedly experimenting with new material, as exemplified by using the song "Somewhere Over the Rainbow," also seemed to make the group more meaningful. While all new material may not be successful – in one of the original groups prior to the study, I lit candles and another time played background music, neither of which worked particularly well – the continuous search for new and better aids is worthwhile and has the potential to add enormously to the group, especially to add variety when there are repeaters over a long period of time.

There was great value for patients in raising issues about often considered taboo topics surrounding bodily function, such as constipation and the humiliation surrounding the need to be assisted to the toilet. Opening up these common problems, with which many become obsessed in a hospital, freed participants' from embarrassment and enabled them to realize that so many others are grappling with the same issues.

INCONGRUENCE

When I originally conceptualized this project, I expected that the group process itself and the information that was disseminated through it, in the form of shared conversation, prayers and song, would have an enduring effect on the participants. Since I was not able to measure the group's long-term impact on the participants, my observations lead me to believe that it had a temporary effect as one therapy among many others.

Although patients do not come to JHHLCS seeking psychological or spiritual support, the vast majority is in need of spiritual guidance due to the crisis in their health; more often than not, they experience a yearning that they cannot identify. In fact, those who are the neediest sometimes are the least willing to participate in this very activity that could offer them solace. Their reluctance was demonstrated repeatedly when certain patients declined to join us, indicating that they did not feel up to it, or a support group was not for them. Yet those who were the most resistant, but whom we did persuade to join the group, seemed to get at least the same, if not more comfort, from it than the others.

One area that failed to meet my own expectations was the evaluation instrument I used. In undertaking the project, I was advised to utilize a tool that would help me quantify the effects of my efforts. I did this despite my own inclination as expressed by Gleason. "Eyebrows are sometimes raised when words representing spirit and science are placed together in a phrase like 'pastoral research.' This pairing of words may even be perceived by some as a contradiction in terms... [It is] often viewed as a tension

between the 'head' and the 'heart.' (2004, p. 295) But, of course, what the essence of these groups is difficult to quantify.

Most significant in administering the instrument were the participants' disabilities and limitations. Although the pre- and post-evaluation instrument I used was recommended by the psychiatrist at JHHLCS, the five-point scale of low to high responses was too nuanced for the respondents. Even the most lucid individuals lacked the patience to select among five options. This complexity became even more apparent when I attempted to utilize the same evaluation form following the session, and was given a major brush-off by the first few patients I approached.

Therefore, I simplified the assessment, asking how they felt after the group and used that response as a means of evaluation. Douglass Clark, a mentor for this project, however, indicated that my evaluation was insufficient and offered more pointed questions which I utilized for sessions three and four. I discovered that, regardless of the instrument, most patients were incapable of or disinterested in focusing at that time due to tiredness, pain, therapy appointments or a desire to continue talking with one another.

In addition, momentary fluctuations in mood due to a participant's physical condition could change his or her response from one minute to the next. Intense pain or a half-hour wait for a nurse's aide to assist a patient to the toilet could easily alter his or her state and cause any equanimity the patient obtained during the group to dissipate.

Therefore my most reliable sources of assessment were observation during and after the group, individual follow-up discussions with the patients and later debriefing with the rabbinic intern and the TR leader, who spends several hours a day with the patients on a daily basis.

Also, discrepancies existed regarding individuals' responses to the instrument, as well as their appearance and what they expressed during and after the sessions. With the elderly, appearance is often deceiving, especially because as we age our facial expressions become ingrained. Thus someone might appear to be despondent to the observer but express feeling in a great mood. Furthermore many who have conformed to social expectations throughout their lives may have felt compelled to express what they believed was socially acceptable.

RELIGIOUS AND CLINICAL PRINCIPLES REVISITED

Maimonides states that, "[Jewish law] as a whole aims at two things: the welfare of the soul and the welfare of the body" (Maimonides, 1963, p. 511). In introducing the practice of spiritual support through these groups to JHHLCS, I made a contribution toward the "welfare of the soul."

My devotion to this project was based upon the following Jewish principles that I incorporated into both my personal and professional life: *avodah* (service to God); *B'tzelim Elohim* (Each person is precious, because he or she is created in the image of God); *tikun olam* (engaging in "repair of the [injustices in the] world); *gemilut chasidim* (performing acts of loving-kindness); *tefilla* (prayer) and *(kehillah)* community.

At the fourth session I introduced *Torah* (Jewish texts). As Carol Ochs (1997) says "Through study we come to know the self and develop a relationship with God. That is our ultimate goal (p. 120)." Both Jewish and non-Jewish patients responded with animated discussion to the *Pirkei Avot* (Talmudic "Ethics of our Fathers") selections.

I realized that, just as I had fulfilled the above mentioned Jewish principles by implementing the spiritual support groups, so too did the participants for attending them. For in their care for one another, they formed a community that served God and revered the One's image through words, prayer and song. Their acts of kindness were healing to one another and, therefore, furthered repairing the world.

Clearly, peer support was extremely important for these patients, who were able to empathize with and respond to one another as they all struggled along the same continuum of poor health and loss of control over their lives. As Yalom notes, "The group functions best if its members appreciate the valuable help they can provide one another" (1995, p. 125). Through listening and by sympathizing with one another in the group, participants laid the foundation for establishing relationships outside it. They often referred to helping one another, or expressed admiration for another's attributes. Participants' interactions outside the group enhanced connections that were established during the session, and vice versa.

To further the sense of group cohesion while reinforcing each one's personal identity, I instituted the practice of individual's stating his/her name after the *misheberach* (blessing for health). According to Henry T. Close, "Speaking a person's name frequently is an important means of rapport. I do this with people who are awake as well as with people who are asleep, unconscious, or in a hypnotic state. Several people told me this was very supportive to them...Even the imagined used of person's name has power" (1998, p. 176).

REMAINING QUESTIONS

Some questions that remain following this project with which I will continue to wrestle are listed below, in no particular order.

How can I best balance time and focus during these one hour groups? Yalom recommends debriefing with the co-facilitator and the group participants at the end of each session (1995 pp. 478-479). While this sounds like a useful post-evaluation tool, I am not sure of how it can be incorporated into a session that is only an hour in length and during which there are often interruptions. It was sometimes difficult to determine how much emphasis to place on an individual's psychological issues versus exploring those that were common to the group; on psychological versus spiritual issues; on facts versus feelings, on reality (of illness) versus hope (for recovery). Furthermore some sessions were so compelling that they ran over the hour, and other times the hour dragged, seeming endless.

Finally I need to learn how to refrain from my tendency to direct the group in adhering strictly to the format in order to get everything accomplished and to advise individuals through direct suggestion, which Yalom (1995, p. 11) indicates is not effective. Further I have to curb my own feelings of fear, repulsion and pity, and repeatedly relearn to peel away the obvious layers to reach and bond with the essence of the divine within each patient in the group.

NEXT STEPS

My involvement in the spiritual support groups has significantly affected me, as well those who have participated in it. I am committed to continuing to facilitate and, hopefully, to expand these groups. I also believe that others should try to implement similar groups at The Home and elsewhere. Doing so would help a larger universe of seniors who are facing sickness and the end of their lives. As a practitioner, I would benefit from exchanges with others who bring different sensitivities and expertise to the task of facilitation. Inevitably they, too, will discover or intuit tools and techniques to enhance the spiritual and psychodynamic support processes.

My work on this doctoral project has helped me to hone in on the core elements of a session; to lay out a set of guidelines for dealing with routine and not-so-routine situations that arise; and to assemble a set of ancillary materials that other practitioners can use, or that may spur them to find other resources. Through my position at the JHHLCS, I will take the opportunity to describe the work I have done and to encourage other clergy to undertake this type of group process. For the unknown power of the spirit is what helps transform tragedy into joy.

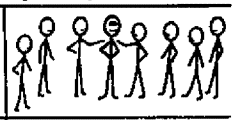
APPENDIX A

PRE-EVALUATION INSTRUMENT

Exhibit 9.8 The Dartmouth COOP Charts

SOCIAL SUPPORT

During the past 4 weeks . . .
Was someone available to help you if you needed and wanted help? For example if you
- felt very nervous, lonely, or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself

Yes, as much as I wanted	
Yes, quite a bit	
Yes, some	
Yes, a little	
No, not at all	

FEELINGS

During the past 4 weeks . . .
How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue ?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

DAILY ACTIVITIES

During the past 4 weeks . . .
How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health ?

No difficulty at all		1
A little bit of difficulty		2
Some difficulty		3
Much difficulty		4
Could not do		5

SOCIAL ACTIVITIES

During the past 4 weeks . . .
Has your physical and emotional health limited your social activities with family, friends, neighbors or groups ?

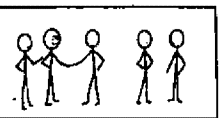
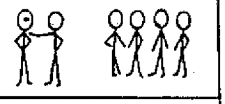
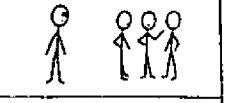
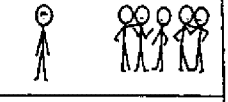
Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

Exhibit 9.8 *(Continued)*

POST-EVALUATION INSTRUMENT

1) My mood has lifted 1 2 3 4 5

2) I feel more connected to the other residents and leaders 1 2 3 4 5

3) I gained a new insight 1 2 3 4 5

4) Revelation of new information 1 2 3 4 5

APPENDIX B

SAMPLE PRAYERS

A PRAYER FOR PRAYER

by Rabbi Sheldon Zimmerman

O my God

My soul's companion

My heart's precious friend

I turn to you.

I need to close out the noise

To rise above the noise

The noise that interrupts

The noise that separates -

The noise that isolates.

I need to hear you again.

In the silence of my innermost being,

In the fragments of my yearned for wholeness,

I hear whispers of your presence -

Echoes of the past when you were with me

When I felt your nearness

When together we walked –

When you held me close, embraced me in your love,

Laughed with me in my joy.

I yearn to hear you again.

In your oneness, I find healing.

In the promise of your love, I am soothed.

In your wholeness, I too can become whole again.

Please listen to my call -

Help me find the worlds,

Help me find the strength within,

Help me shape my mouth, my voice, my heart

So that I can direct my spirit and find you in prayer

In words only my heart can speak

In songs only my soul can sing.

Lifting my eyes and heart to you.

Open my lips, precious God, so that I can speak to you again.

PRAYERS

by Naomi Levy

1.

Teach me always to believe in my power to return to life, to hope and to You, my God, no matter what pains I have endured, no matter how far I have strayed from You. Give

me the strength to resurrect my weary spirit. Revive me, God, and I will embrace life once more in joy, in passion, in peace.

2.

When I am lost, help, me, God, to find my way. When I am hurt, shelter me with Your loving presence. When my faith falters, show me that You are near. When I cry against You, accept my protest, God, as a prayer, too, as a call for You to rid this world of all pain and tragedy. Until that day, give me the will to rebuild my life in spite of my suffering, to choose life even in the face of death.

3.

When the pain is intolerable, God, help me to bear it. When I feel lost and empty, teach me to see that I am not alone. Show me that You are with m e. Help me to believe that there is a way out of this hell. If only I could see that my pain will end, then I think I could learn to live with this awful agony. Kindle within me the flame of hope, God, and I will carry on.

HEALING PRAYER

by Marcia Falk

As those who came before us were blessed

In the presence of the communities that sustained them

So we offer our blessings

For those among us needing support

May your spirit be calmed

And your pain eased,

May you receive comfort

From those who care for you,

And may you drink from the waters

Of the ever-giving well

Closing Blessing

May the blessings of peace and kindness, graciousness, goodness,

And compassion flow among us

And all the communities of Israel,

All the peoples of the world.

As we bless the source of life,

So we are blessed.

***ASHER YATZER*: WE ARE THANKFUL FOR THE GIFT OF OUR BODIES**

Praised are You, our God, who rules the universe, fashioning the body in wisdom, creating openings, arteries, glands and organs, marvelous in structure, intricate in design. Should but one of them fail to function by being blocked or opened, it would be impossible to exist.

Praised are You, God, healer of all flesh, sustaining our bodies in wondrous ways.

***ELOHAI NISHAMA*: WE ARE THANKFUL FOR THE GIFT of OUR SOULS**

The soul that You, my God have given me is pure. You created it, You formed it, You breathed it into me; You keep body and soul together. One day You will take my soul from me, to restore it to me in life eternal. So long as this soul is within me, I acknowledge You, my God, my ancestor's God, Master of all creation, Sovereign of all souls. Praised are You, Holy One, who restores the soul to the lifeless, exhausted body.

(FROM THE JEWISH MORNING PRAYER SERVICE)

PRAISED BE THE LORD OF IMPERFECTION

by Danny Siegel

Praised be the Lord Of Imperfection.
God's flaws are everywhere:
In the elm's unbalanced foliage
And the asymmetric faces of God's creatures.
God forms the ripping floods
That tear the forests
And bend tornadoes in a twisted dance.
The lion is blotched with age and mud,
And the silverware lies stained
As a reminder.

Praised be God's teachings of scratches
And scars.

Praised be God's discolorations,

For they are puzzles and poems

Of God's sacred character.

TEACH ME TO ASSUME TOMORROW

By Danny Siegel

O Lord,

Teach me to assume tomorrow

Will be rich and sunshot as today.

Twist my heart to feel that Life,

Even in the midst of tragedy,

Is crystal fine?

And colorful as blue wild flowers on the mountains.

The words change,

The names are new each hour,

But the song

Is still a Psalm.

So may it be tonight,

Next week,

In eighty years.

HEALING

Give ear, O Eternal, to my prayer,

Heed my plea for mercy.

In my time of trouble I will call You,

For you answer me.

When pain and fatigue are my companions,

Let there be room in my heart for strength.

When days and nights are filled with darkness,

Let the light of courage find its place.

Help me to endure the suffering and dissolve the fear,

Renew within me the calm spirit of trust and peace.

We praise you, O God, Healer of the sick.

A PRAYER FOR STRENGTH

O God, our refuge and strength, and an ever-present help in times of trouble, how much I need Your strength and presence in my life right now. I feel weak, depressed, anxious, frightened. I need help to face the upcoming hours and days. So I claim Your promises that I can bear whatever comes, that Your support will be sufficient, and that my despair will give way to your peace that passes all understanding. Amen.

(FROM GATES OF HEALING)

SORROW CAN ENLARGE THE DOMAIN OF OUR LIFE

Our sorrow can bring understanding as well as pain, breadth as well as the contraction that comes with pain. Out of love and sorrow can come a compassion that endures. The needs of others previously unnoticed, the anxieties of neighbors never before realized, now come into the ken of our experience, for our sorrow has opened our life to the needs of others.

Sorrow can enlarge the domain of our life, so that we may now understand the triviality of the things many pursue. What is important is not luxury but love; not wealth but wisdom; not gold but goodness.

And our sorrow may clear our vision so that we may, more brightly see the God, of whom it is said, "Beyond the hurry and turmoil of life rises the Eternal. There is a God in a world in which human beings could experience tenderness. There is a God in a world in which two lives can be bound together by a tie stronger than death.

Out of love may come sorrow; but out of sorrow can come light for others who dwell in darkness. And out of the light we bring to others will come light for ourselves - the light of solace, of strength, or transfiguring and consecrating purpose.

WE RENDER THANKS

We must often revive the gladness of gratitude

And retrain our lips to utter words of thanks.

God's gifts often go unnoticed in our haste;

And disappointments may blind us to our blessings.

We render thanks for life itself,

For sight, hearing, smell, and touch.

For the certainty that an ever-renewing vital force

Infuses us and vibrates in the glory about us.

We give thanks for the beauty of nature and its gifts,

Pray that we may share as richly as we have received.

We stand in wonder before the birth of children,

The miracle of their growth, their love, and laughter.

We give thanks for freedom, while knowing its frailty.

And recognize the need to nurture and protect it.

We are grateful for the gifts of knowledge & conscience,

Enabling us to know truth from lies, right from wrong.

We give thanks to God who shares with us

A small spark of the Holy One's glory and wisdom.

IN SICKNESS I TURN TO YOU

In sickness I turn to You, Oh God,

for comfort and help.

Strengthen within me the wondrous power of healing

that You have implanted in Your children.

Guide my doctors and nurses that they may speed my recovery.

Let my dear ones find comfort and

courage in the knowledge that You are with us at all times,

in sickness as in health.

May sickness not weaken my faith in You,

nor diminish my love for others.

From my illness may I gain a fuller sympathy for all who suffer.

I praise You, O God, the Source of healing.

(From *On the Doorposts of Your House,* Chaim Stern, ed.)

A PRAYER FOR STRENGTH

O God, our refuge and strength, and an ever-present help in times of trouble, how much I need your strength and presence in my life right now. I feel weak and depressed, anxious even frightened. I need your help to face these hours and days.

So I claim Your promises that I can bear whatever comes, that Your strength will be sufficient, and that my despair will give way to Your peace that passes understanding. Amen.

KEEPING PERSPECTIVE

O God, how helpless I feel! I am so dependent on my physician, my nurses, and all the hospital staff. I need medication to alleviate my discomfort and pain, and to help me rest. I'm not as strong as I was; I'm not as free as I was; I don't feel as well as I did.

But help me, O God, not to lose perspective. Keep me aware of the strength I do possess, what I am able to do, and the blessings that still are mine. Amen.

APPENDIX C

SONGS

MISHEBERACH

Misheberach avoteinu, m'kor habracha l'imoteinu

May the source of strength, who blessed the ones before us

Help us find the courage to make our lives a blessing

And let us say Amen.

Misheberach imoteinu, m'kor habracha l'avoteinu

Bless those in need of healing with refua shleima,

The renewal of body, the renewal of spirit

And let us say Amen.

T'FILAT HADERECH

May we be blessed as we go on our way

May we be guided in peace

May we blessed wit health and joy

May this be our blessing, Amen.

May we be sheltered by the wings of peace

May we be kept in safety and in love

May grace and compassion find their way to every soul

May this be our blessing, Amen.

Debbie Friedman

THIS LITTLE LIGHT OF MINE

This little light of mine,

I'm gonna let it shine,

This little light of mine,

I'm gonna let it shine,

This little light of mine,

I'm gonna let it shine,

Let it shine, let it shine, let it shine

Everywhere I go, I'm gonna let it shine

Everywhere I go, I'm gonna let it shine

Everywhere I go, I'm gonna let it shine

Let it shine, let it shine, let it shine

KUMBAYA

Kumbaya, my Lord, Kumbaya, (3 times)

Oh Lord, Kumbaya.

Someone's singing Lord, Kumbaya,

Someone's singing Lord, Kumbaya,

Someone's singing Lord, Kumbaya,

Oh Lord, Kumbaya.

Someone's praying Lord.....

(Residents are invited to make up their own verses.)

HE'S GOT THE WHOLE WORLD IN HIS HANDS

He's got the whole world in his hands

She's got the whole world in her hands

(2 more times)

She's got the itty bitty baby in her hands (3X)

She's got the whole world in her hands.

He's got you and me sister in his hands

He's got you and me brother in his hands.

He's got sister and brother in his hands.

He's got the whole world in his hand.

OVER THE RAINBOW

Somewhere over the rainbow way up high

There's a land that I heard of once in a lullaby

Somewhere over the rainbow skies are blue

And the dreams that you dare to dream really do come true.

Someday I'll wish upon a star

And wake up where the clouds are far behind me.

Where troubles melt like lemon drops

Away above the chimney tops,

That's where you'll find me.

Somewhere over the rainbow bluebirds fly

Birds fly over the rainbow,

Why then oh why can't I?

If happy little bluebirds fly beyond the rainbow

Why oh why can't I?

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